

How to... understand and measure impact

**Integration and
Better Care Fund**

Edition 2: August 2019



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Integration and Better Care Fund series

This series of guides was originally developed to support the mobilisation of Better Care Fund programme plans across the country. These guides continue to be of practical use to everyone involved in planning and delivering joined-up, integrated care for individuals and communities, person-centred care as part of BCF plans as well as other programmes that foster collaborative cross-system working under the new goals and ambitions of the NHS Long Term Plan. This includes frontline professionals and managers, commissioners, as well as councillors and board members in local government and the NHS, community and voluntary groups, independent providers and groups speaking for people who use health and care services.

- [How to... lead and manage better care](#)
- [How to... bring budgets together and use them to develop coordinated care provision](#)
- [How to... work together to achieve better joined-up care](#)
- [Sharing risks and benefits of integrated care: quick guide](#)
- [Transfers of care: signposting resource](#)



1 Introduction

Measuring success is key to performance management, service improvement and accountability. Health and care managers who have a considered, systematic and proportionate approach to monitoring and evaluation can:

- manage services more effectively
- focus efforts of staff and stakeholders across the system to work together to deliver impact
- build ownership, buy-in and support for greater integration and person-centred care.

This guide provides practical tools and tips on how to measure the impact of integrated health and care. It covers the following:

- articulating the outcomes
- identifying the right measures
- developing a monitoring and evaluation framework
- using results to continuously improve.

In integrated care, measuring impact is complex. Compared to the private sector – or even to individual public service organisations – integrated care is never achieved by any

one agency or person working in isolation. There are also very different definitions of what ‘success’ looks like among stakeholders across the system – from commissioners, providers and regulators to patients, service users, carers and community groups.

Engagement, consultation and co-production are critical to not only achieving integrated care but also to measuring impact. It is vital to work with stakeholders from start to finish, acknowledge and discuss competing priorities and trade-offs, and focus on finding answers to these key questions:

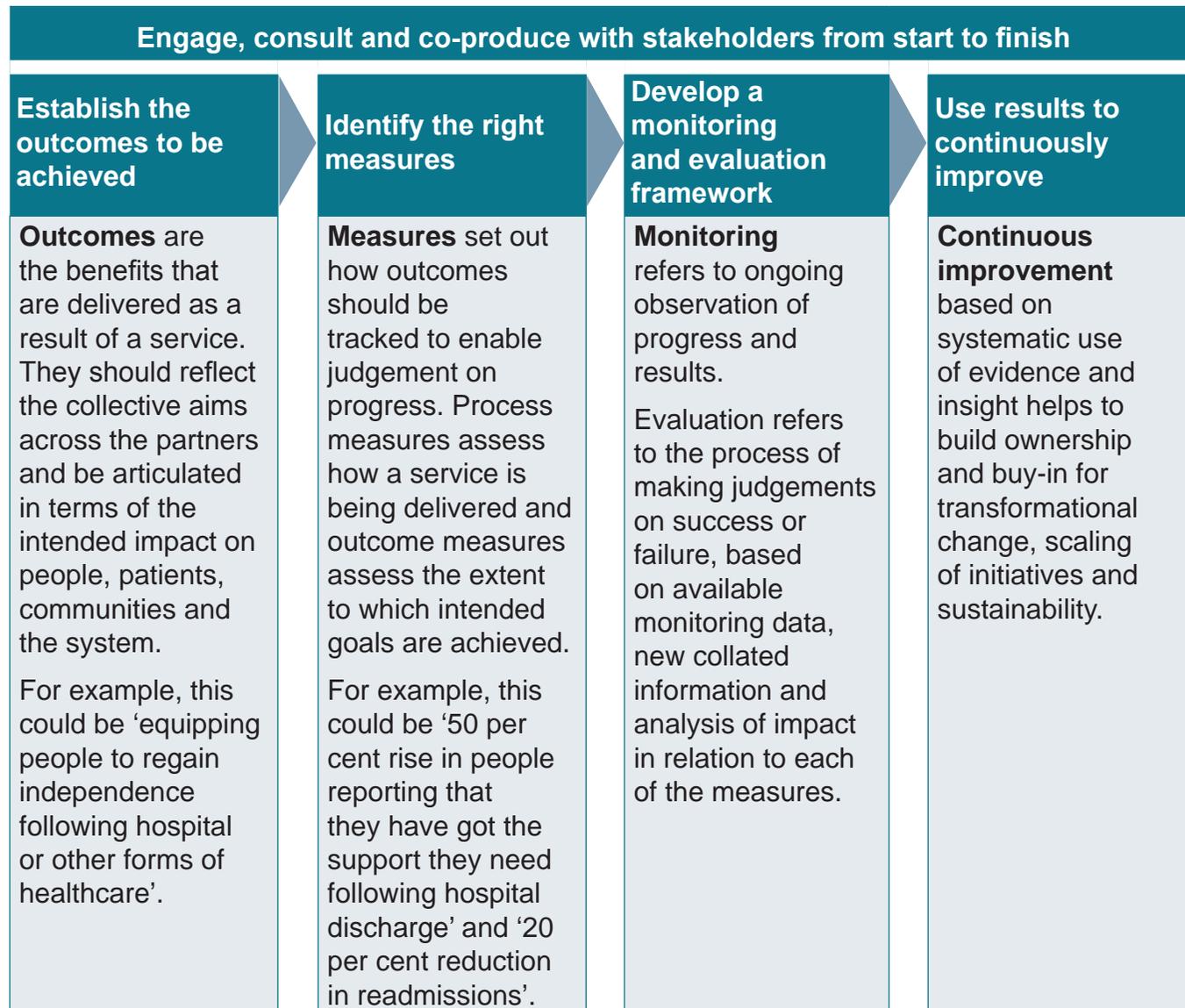
- What are the desired outcomes?
- What measures will be used to track progress and impact?

The answers to these questions are necessary to build and implement a strong approach to monitoring, performance management and evaluation. This, in turn, will help providers understand what works and what should be changed to deliver real, sustainable improvement in integrated, person-centred care.



Key messages

- **Work with partners and other stakeholders** to build a shared view of what 'good' looks like, how to achieve this, how it should be measured and how learning should be used.
- **Engage and listen to local populations** from start to finish. Ask what 'good' looks like to them, include their views and experiences on progress and impact, and engage them in the process of analysing results and working out what that means for services, people and communities.
- **Prioritise the most important measures** when building a monitoring and evaluation framework. Use a mix of both quantitative and qualitative information and evidence. This should include a combination of local, regional and national measures.
- **Use the evidence** to drive improvement. Reflect on progress, learn about what works and what doesn't, and build on this learning to find out what should be built upon, what should be improved and what should be prevented.
- **It is a journey of discovery.** And it is hard. Delivering change and measuring impact is an evolutionary process and it will be important to try, test, reflect and change as time progresses.



“When done well, monitoring and evaluation can drive successful delivery of integrated care. The range of outcomes and measures should be selected with that in mind. These should include: people’s experiences of care; care outcomes in terms of changes to people’s health and wellbeing; and better use of resources.”

Dr Nick Goodwin, CEO, The International Foundation for Integrated Care



2 Establishing outcomes

Building local outcomes for better care

Over the last decade, there has been a wealth of national, regional and local initiatives to deliver integrated care. Though challenging to deliver, integrated care is critical to achieve high quality and sustainable service now and in the future – not just in England, but across the UK, and in every major health and care system in the world. This section provides tips and tools for how to articulate the outcomes providers seek to deliver.

- **What do we mean by outcomes?**

Outcomes are the benefits that are delivered as a result of a service.

Outcomes can range from broad lifestyle goals (e.g. supporting people with chronic conditions to live active and fulfilling lives in their homes and communities) to specific quality of care outcomes (e.g. patient care in the right setting at the right time).

Outcomes are fundamentally different from outputs which measure the levels of activity of a service or intervention (e.g. number of personalised care plans or levels of delayed transfer of care).

- **Why do we need whole-system outcomes?** Failure to plan and coordinate services with and around people's needs leads to fragmentations in care and sub-optimal outcomes. Redesigning care around the delivery of outcomes requires a multidisciplinary 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.

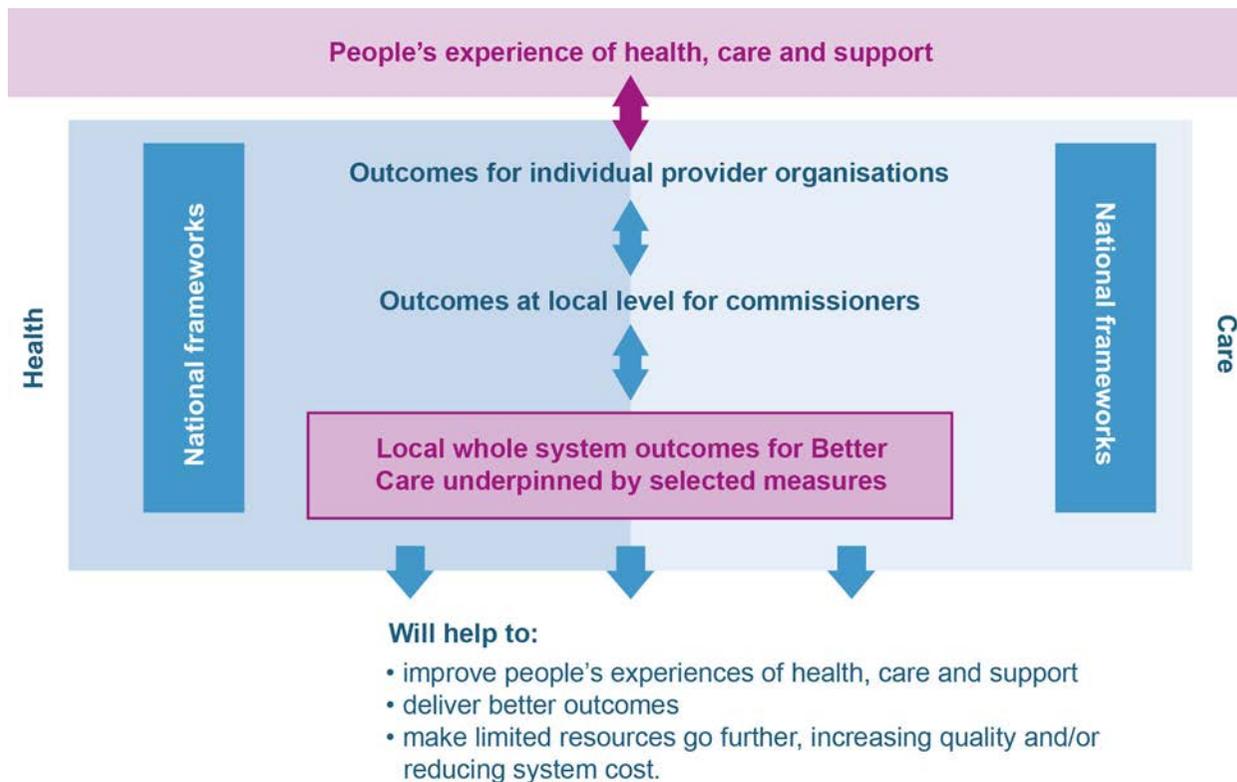
Outcomes should achieve the following:

- **Link to improved experiences of care, as defined by people.** Person-centred health and care should be anchored in what people want and need. In other words, people's own narratives should be at the centre. The outcomes defined should reflect the philosophy, overall aims and mission of that narrative. The **narrative for person-centred coordinated care** and accompanying 'I-statements' developed by National Voices help define goals from a user-based perspective. See also the **How to ... lead and manage better care**.

- **Capture expected changes to people's health and wellbeing.** These can be direct care outcomes for people (such as improved health and wellbeing, ability to manage own chronic illness, independence, quality of life, ability to die in a place of their choosing) or indirect care measures – or proxy outcomes – such as reduced hospitalisations/nursing home placements and other avoidable utilisation of services.
- **Consider use of the resources.** Value for money is critical to the sustainability of health and care. As such, financial measures should be included alongside quality and user experience measures in an outcome framework, with a clear outline of when, how and what benefits will be realised.

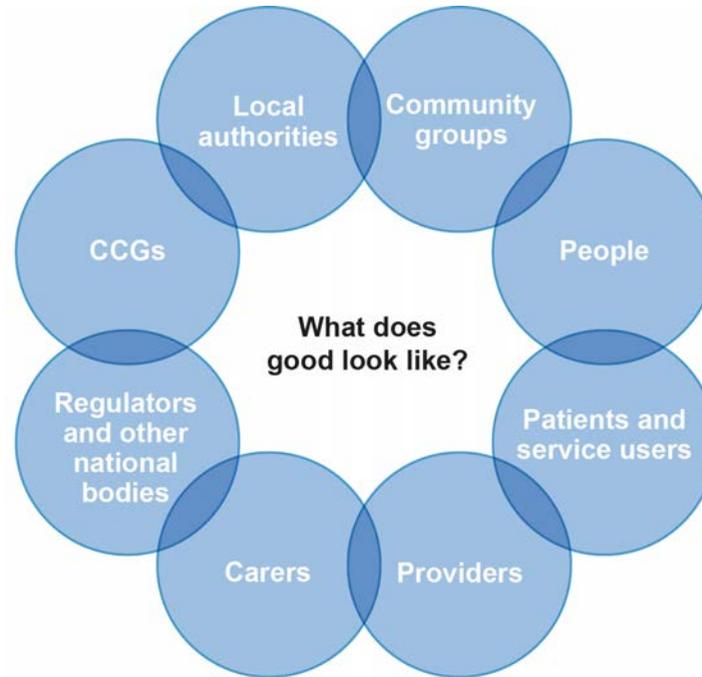
What are whole-system outcomes?

Outcomes should include individual and whole-system definitions of what ‘good’ looks like. They should combine locally articulated goals with those set out in national frameworks and include measures related to quality of care, patient wellbeing and experience as well as financial sustainability. This is expanded upon in the diagram below.



Collaboration

Integrated, person-centred care can never be achieved by one agency working in isolation. Because of this, outcomes should be co-produced or agreed to by the range of stakeholders involved. This is easier said than done: partners across health and care often have different goals, lines of accountability, cultures and ways of working. It is important to identify and acknowledge differences and complexities, and work together to negotiate a set of measures which are anchored in a common purpose – to improve health and wellbeing for individuals and communities.



“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 input 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 to 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

Using a logic model

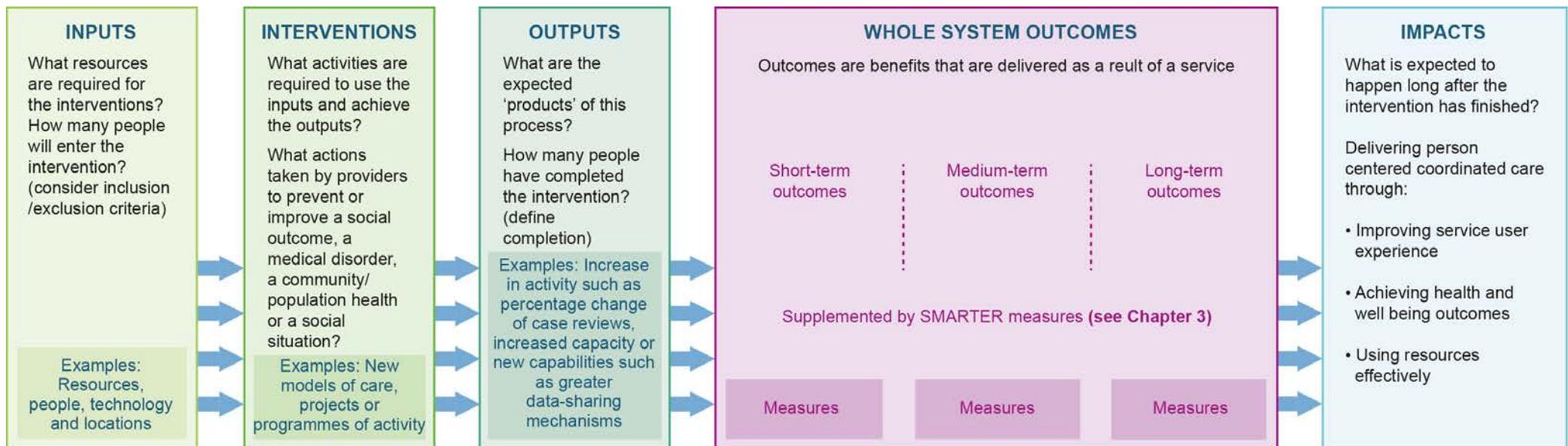
Logic modelling, or programme logic, is a tool to help establish outcomes and consider impact – i.e. articulating how a project or programme is intended to achieve its outcomes and impact. As a tool, logic modelling has been used widely to help shape interventions and related monitoring and evaluation activities, including new models of care in many vanguard areas.

A logic model is a diagrammatic representation of the key components of a

programme and the way that actions are intended to lead to outcomes. It helps set out plans and thoughts about what inputs (resources and target groups) will deliver the interventions (projects or programmes), which in turn will produce a set of outputs, outcomes and impacts. This logic chain, and the links between its different elements can help programme leads and stakeholders test assumptions and ‘reality check’ whether the programme’s interventions are adequate to achieve its intended outcomes.

A logic model is designed to:

- clarify ‘what’ results a programme or project intends to achieve and ‘how’ these will be delivered
- assess the strength of the assumptions being made about how a programme will achieve change and if the resources invested (inputs) are adequate
- identify cause-effect relationships
- raise awareness and build a common understanding among stakeholders about what needs to be delivered





- provide a framework for clarifying outcomes and related measures.

Logic modelling often takes place at an early stage of the process. However, it is also possible to use logic modelling at a later point to review the relevance and strength of existing programmes. Read more here about [How logic models deliver care changes that work](#).

The main problem I see in many local 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

Five steps to build a strong logic model

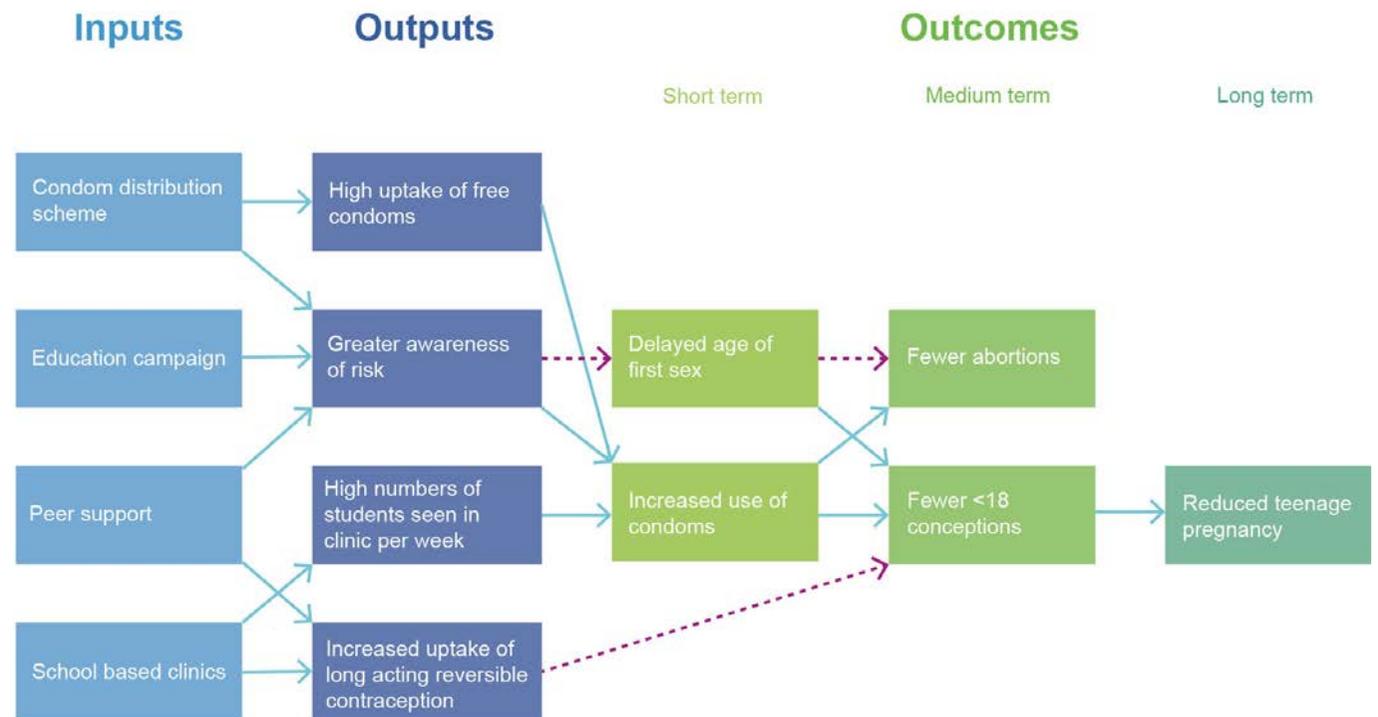
- Be clear about the starting position. What is the target audience for the work, what is the baseline and context for the work?
- Establish the inputs required to deliver the work. What interventions are needed to achieve the outputs, and what will the outcome and impact be?
- Consider how inputs will resource the interventions that will deliver specified outputs, outcomes and impact.
- Consider what resources are available. Where possible, evidence any assumptions with reference to pilot initiatives or evaluations from similar work undertaken elsewhere.
- Engage with patients, service users and carers – and other stakeholders – to develop a robust logic model that reflects a shared vision of success.

Logic modelling in practice

Healthwatch has developed an **outcomes and impact development tool** to assist local organisations in understanding what outcomes and impacts they can achieve through the delivery of their functions. The table below 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.

| 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 | | |
| Medium-term outcome | Inputs/ Interventions | Output |
| Longer term IMPACT | | |
| Long-term Impact | Measures | Output |

For more tips on how to use logic models, please see Midlands and Lancashire Commissioning Support Unit's **guide to using Logic Models**. It provides key insights into the theory and principles, as well as practical use.





To establish outcomes, remember the following:

- Build engagement through co-producing measures of quality across organisations.
- Articulate outcomes and measures that are relevant and meaningful for all, including: users; carers and communities; planners and commissioners; health and care providers; clinicians and care professionals; and national bodies.
- This is an evolutionary process. Measuring success is an ongoing process and not something that is 'ticked off' once.
- The power of citizens. For care to be coordinated around citizens, they need to be involved in the development of how that coordination takes place.



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

Source: **Leadership and engagement for improvement in the NHS**, King's Fund (2012)

The Social Care Institute for Excellence (SCIE) **Co-production in social care** resource gives recommendations on how to develop co-productive approaches in organisations and projects based on a framework for change management.



In summary: top tips to establish whole-system outcomes

- Identify outcomes at an early stage of the process rather than retrospectively fitting them to a predetermined and funded set of activities or interventions.
- Identify stakeholders involved in delivering – or who are affected by – the programme of change. Engage with them to co-produce measures of success. Acknowledge that different partners have different needs, definitions of success, lines of accountability and traditions regarding information governance, data and ‘evidence’.
- Set out clearly the rationale for the programme. Map how investments (inputs) will be used (activity) to deliver results (outputs, outcomes and impact).
- Align local whole-system outcomes with national frameworks and other local outcomes (including those of individual providers and at commissioner level). Identify up front what is already collected in the system, what can be shared and in what form – across health, care and the voluntary sector. Existing lists of defined outcomes can be used as a ‘menu’ of possible options, but choices must be made locally.
- Clarify reporting arrangements, roles and accountabilities and agree a plan up front for how data is to be collected, analysed and used.



3 Selecting the right measures

Once whole-system outcomes are established, providers need to identify the measures that will enable them to monitor progress and make evidence-based judgements on the extent to which outcomes have been achieved.

Agree measures from the outset

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.

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 that are framed in terms of the people and the systems the interventions 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 aligned with outcomes
- the time frame over which such outcomes can reasonably be expected to be achieved in order to understand which measurement categories have the potential to be improved
- how chosen measures can enable analysis of what has made a difference (attribution between the interventions developed and the outcomes observed)
- how the measures can help drive improvement activity in the system, and avoid perverse incentives
- the importance of simplicity and ease of measurement – where possible, data that is already being collected should be used
- who holds responsibility for achieving the targets set within each measure.

Why do we need measures?

Measures define the data that should be collected to develop an understanding about progress and impact. A mix of measures is usually needed to cover the complexity of projects and programmes, and ensure that evidence gathered is sufficiently detailed and meaningful for the wide range of stakeholders involved in, or affected by, the changes.

Good measures:

- help to collect evidence in a systematic way about what works and what should be improved or decommissioned
- enable judgement on progress towards outcomes
- set out clearly who 'owns' the measure and is responsible for achieving the goals
- reflect local priorities as well as national requirements
- are signed up to by partners and stakeholders involved and anchored in a common purpose: to improve health and wellbeing for individuals and communities.

Metrics for better care

While there are many care integration initiatives in local areas and across sustainability and transformation partnerships (STP), the Better Care Fund is explicitly put in place to facilitate care integration. Local areas are asked to agree and report metrics in the following four areas:

- delayed transfers of care
- non-elective admissions (general and acute)
- admissions to residential and care homes
- effectiveness of reablement.

For more information, see: [2019–2020 Better Care Fund Policy Framework](#).

The metrics, in isolation, will not provide a full view on progress and performance. Local areas will need to supplement these with other national or local metrics related to improvements in health and care, experiences of care and cost-effectiveness.

“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

“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.”

H. James Harrington, international author on performance

| 10 key questions | Answers and examples |
|--|--|
| 1. What is being measured? | Example: Prevalence of diabetes. |
| 2. Why is it being measured? | Example: 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 defined? | Example: From recorded levels in general practice. |
| 4. Who does it measure? | Example: 17+ only. |
| 5. When does it measure it? | Which day/month/year? In the diabetes example, data is collected annually. |
| 6. Will it measure absolute numbers or proportions? | Example: Proportions: Percentage of GP-registered population. |
| 7. Where does the data come from? | Example: Collection and collation from Quality Outcome Framework (QOF) data in general practice via NHS Digital. |
| 8. How accurate and complete will the data be? | <p>Example: In 2016–17, the QOF dataset includes data from 95.4 per cent of GP practices in England that were open and active at some point in the reporting period.</p> <p>However, The accuracy of QOF information depends on:</p> <ul style="list-style-type: none"> • clinical case finding by GPs; for example, information from QOF diabetes registers or about QOF diabetes indicators depends on people with diabetes being diagnosed • clinical coding; for example, when patients are diagnosed with diabetes, the quality of QOF data about people with diabetes depends on the GP practice maintaining accurate and coded clinical records. <p>It is also worth noting that not everyone is registered with a GP – especially some groups with particular needs.</p> |
| 9. Are there any caveats/warnings/problems? | Think about 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? | For example, when comparing small numbers, in small populations, or to distinguish inherent (common cause) variation from special cause variation. Note that this is not related to the above diabetes example. |

Guidelines for selecting and using indicators.



Six key domains to consider when assessing integrated care

Dr Nick Goodwin has identified six key domains through which to assess progress on people-centred and 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 behaviour.
- Service proxies for improved health outcomes, such as avoidable admissions to hospital, 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 medication reconciliation.
- User and carer experiences of, for example, shared decision-making, care planning, communication and information-sharing, and care coordination.

Are measures SMARTER?

| | |
|-------------------------------|--|
| Specific | Measures can be clearly articulated to people with a basic knowledge of better care. |
| Measurable | 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 time frames have been set and are evident to stakeholders. |
| Evaluated and Reviewed | Evaluation is happening on a consistent basis and regular review cycles are planned for. |

Getting a fuller picture

Qualitative and quantitative data can complement each other, with qualitative data giving meaning and richness to quantitative data. By combining the two, 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. See **Building greater insight through qualitative research** for more information on how qualitative information has become increasingly important.

Quantitative information can be characterised by the question, 'What happened, where, when and who with?' An example would be a patient experience survey in which multiple choice questions that can be measured on a scale (e.g. 1 to 5).

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

However, quantitative information isn't always enough: views and experiences matter.

Qualitative information can be characterised as 'Factors or reasons affecting behaviour or outcomes – the how or why'. An example would be a patient experience survey which uses free text answers.



Dissatisfied 1 ● 2 ● 3 ● 4 ● 5 ● Satisfied



Patient and service user experience of care and support

In the publication **Measuring patient experience**, the Health Foundation articulates the strong evidence base supporting the measurement of patient experience: '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.'

Tracking user experience enables you to:

- improve communication between communities, patients, service users, commissioners and providers
- allow performance to be monitored over time and improvements demonstrated
- give patients, carers and their families a better understanding of their conditions and treatment plans to achieve better outcomes

- increase understanding of patients and the public about health and social care services
- empower communities to have a say in the delivery of local services
- encourage 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 impact.

Patient/service user experience can be measured in the following ways:

- **using an existing national measure** such as the **Family and friends test**
- **using an existing local measure** from data which has already been collected (interviews, service reviews, surveys etc.)
- **using a newly developed local measure**, i.e. new case studies, interviews, service reviews etc.

If providers are developing a new local measure, they can consult the **Picker framework** to access the 18 questions developed by the Picker Institute and Oxford University.

Developing person-centred health and wellbeing outcomes that matter most to people' in Tower Hamlets

In 2015, Tower Hamlets became a Vanguard for a multispecialty community provider (MCP) new model of care. Tower Hamlets started by considering the strategic context, vision and goals for the MCP through a review of local strategy and policy documents, patient and public engagement reports, existing incentive schemes, and interviews with key stakeholders – including frontline staff and users – across the Tower Hamlets health and care economy. Based on this, four dimensions of outcomes were identified. These were:

- Experience of services
- Fairness and equity
- Clinical outcomes
- Personal and functional goals.

For each of these dimensions, 'I statements' were developed describing key outcomes from a patient and service user point of view. For example: "I have a good level of happiness and wellbeing". Following this, key performance indicators were agreed, against which to measure progress towards the articulated outcomes in the 'I statements'. The



indicators were selected based on stakeholder insights, as well as validated national sources – e.g. Public Health outcomes framework (PHOF), NHS outcomes framework, local plans. For the statement “I have a good level of happiness and wellbeing”, for example, the PHOF measure on self-reported wellbeing (people with a low happiness score) was suggested and agreed. As part of the indicator development, it was considered what data is already collected, and whether local surveys are in place to avoid data collection burden.

An Outcomes Reference Group (ORG) was established to lead the development and implementation. This group had representation across provider organisations, including clinical practitioners, public health, the voluntary sector, primary care, the local authority, CCG, lay partners and service user representatives. Outside of this, the developing framework was discussed at public engagement events, attending local community groups, staff events, and a clinical engagement workshop. For more information please contact: Richard Fradgley, Director of Integrated Care from ELFT (Richard.Fradgley@elft.nhs.uk)

Checklist: Selecting the right measures

- **Seek input and buy-in from a wide range of stakeholders, including health and care commissioners, providers, regulators, patients, carers and community groups.** At minimum, providers should communicate widely and clearly at the start, throughout and at the end so that everyone understands the ‘shared measures’ and this filters down to trigger culture change (leadership, champions, trailblazers, evaluation networks etc.).
- **Acknowledge individual/local/national priorities.** Identify common ground and any potential conflicts across stakeholders.
- **Set realistic targets.** These should be based on a considered assessment of the starting point (the baseline) and the likely timescale for progress and benefit realisation. Consider the long term, but identify opportunities for quick wins too. This will help to create momentum, engagement and enthusiasm.
- **Select a mix of outcomes, outputs and process measures.** Process measures and proxy measures for the system are entirely legitimate. Consider both quantitative and qualitative data. Often, it is more efficient to use existing data sources for quantitative measures and gather new information in relation to qualitative measures (through interviews, focus groups or case studies, for example).
- **Be practical and prioritise the most important measures.** This helps to focus efforts and minimise the additional burden of data collection and analysis.
- **Be creative and flexible.** Measures may need to evolve over time as and when learning evolves.
- **Bear in mind how the data can be collected and analysed.** A time lag regarding system data could mean that it is not possible to report as quickly on new measures or that some data cannot be aggregated.
- **Keep it simple.** Build on existing frameworks, findings and experiences of others. Identify what works, build on that, and share learning.

4 Developing a monitoring and evaluation framework

Why do we need an evaluation framework?

A well thought-out monitoring and evaluation framework will guide effective and systematic data collection and form the evidence base for assessment of progress and impact over time. It should be developed up front, as part of the programme design phase, to help clarify assumptions about how investments and initiatives are likely to deliver intended outputs, outcomes and impacts.

An evaluation framework captures key information about how progress and impact will be evaluated. There are different types of monitoring and evaluation, including:

- point-in-time through to a programme of ongoing data collection and assessment
- focus on a single project or a range of programmes
- summative evaluation (to assess if outcomes and targets have been met)
- formative evaluation (to identify how and why progress has been made)
- formal audits, external evaluations, internal reviews or performance assessments.

Due to the developmental nature of integrated care, most evaluations will have a formative element – one that helps to understand what works and why – to build evidence for what should be scaled up, what should be improved and what should be decommissioned.

Evaluation planning

An evaluation framework – or matrix – sets out the plan for how to measure an outcome, as well as collect and analyse data. For each level, it sets out the aim, outcomes, measures, and a plan for data collection, analysis and reporting.

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

Counterfactual analysis

How do we know what has made a difference? Counterfactual analysis enables judgements to be made about what changes are a direct result of the intervention(s). This helps establish which changes in outcomes are directly attributable to a project or a programme, versus those which would have occurred anyway. In other words, an analysis of the counterfactual takes an evaluation beyond just understanding whether outcomes have been achieved and allow an assessment of the extent to which observed changes in outcomes are a result of the intervention or of other factors.

While counterfactual analysis takes time and resources, it provides a stronger evidence base for decisions about whether there is value in continuing or scaling up an intervention. The Public Service Transformation Academy has an **introductory guide on evaluation**, a section of which is dedicated to understanding the counterfactual. It highlights the following approaches.

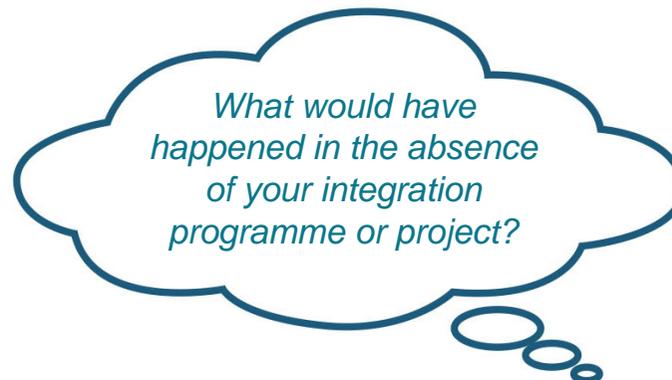
- **Randomised controlled trials (RCTs).** These are the 'gold standard' of evaluation. Several people are randomly assigned to two or more groups to test a specific

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. RCTs are the most methodologically challenging form of evaluation, and need expert input to design and deliver.

- **Matched group comparisons.** Where RCTs identify target and control groups and collect data over time, matched group comparisons use existing data sets to select similar groups or cohorts of patients or service users, some of which are users/recipients of the service evaluated and others who are not. Matched group

analysis can also focus on comparing a geographical area with a similar area elsewhere. This often involves significant statistical analysis and may be difficult to design and deliver without significant evaluation expertise.

- **Experimental or quasi-experimental approaches.** The basic structure of a quasi-experimental evaluation involves examining the impact of an intervention by taking measurements before and after it is implemented. This type of 'time series' analysis can be a very effective method and may not be as expensive to implement as other methodologies. It can be delivered without significant evaluation expertise.



Case study: Evaluating Sunderland’s All Together Better Vanguard Programme

The evaluation of Sunderland’s All Together Better Multi-Specialty Community Provider (MCP) Vanguard programme ran between November 2016 and June 2017. The evaluation, which was co-developed with specialist research and consulting organisation Cordis Bright, had a number of aims:

- Consider the context of the Sunderland Care model
- Review the Recovery at Home/Older People’s Assessment and Liaison service
- Review the Community Integrated Teams
- Review the programme of Enhanced Primary Care
- Consider the leadership and governance functions specific to Sunderland
- Review the overall outcomes of the Vanguard programme, performance against expectations, and any unintended outcomes

A collaborative approach, based on the principles of action research, was taken to deliver the evaluation. All research approaches, methods and tools were

agreed with an evaluation steering group before use in the field. The diagram below outlines the approach and evaluation activity undertaken.

| A collaborative evaluation approach | |
|---|--|
| Phase 1. Baseline report and evaluation framework (Dec 2016) | <ul style="list-style-type: none"> • Project launch • Review of documentation • Literature review of ‘what works’ in implementing an MCP • In-depth interviews with key senior stakeholders • Deliver draft baseline report and evaluation framework • Circulate and meeting with steering group for feedback • Evaluation framework and baseline report signed off |
| Phase 2. Implementation of evaluation framework (Jan–Mar 2017) | <ul style="list-style-type: none"> • Review of documentation, performance management and budget information • In-depth interviews with stakeholders • e-Survey of staff and stakeholders • Analysis and reporting • Delivery of draft final report |
| Phase 3. Delivery of final report and dissemination (Apr–Jun 2017) | <ul style="list-style-type: none"> • Circulate draft report for feedback • Sense-testing workshop with senior stakeholders • Finalise and sign off final report • Presentation of report findings |

Key learning

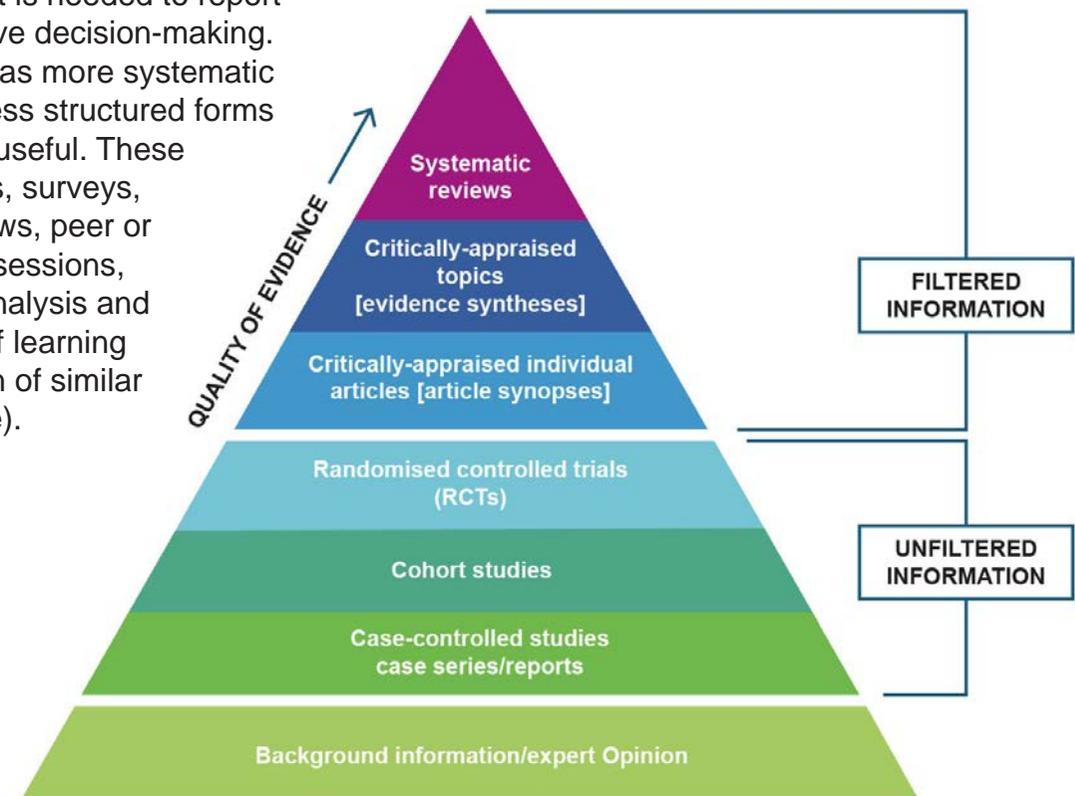
- Collaborative approach meant that the evaluation addressed and answered the key evaluation questions
- Development of a clear SMART evaluation framework meant that all evaluation stakeholders understood the key evaluation questions, activity and outputs as well as how process, impact and outcomes were going to be demonstrated and evidenced
- Sense-testing workshops with stakeholders helped to ensure a set of grounded, practically useful recommendations which also increased ‘ownership’ and ‘buy-in’ among stakeholders

See [Sunderland All Together Better](#)

When is evidence ‘good enough’?

The quality of evidence varies depending on the evaluation design and methodology. At times, it is not possible to do more extensive impact evaluations, yet evidence about progress and impact is needed to report on progress and drive decision-making. While not as robust as more systematic evaluations, other less structured forms of evidence can be useful. These include case studies, surveys, stakeholder interviews, peer or stakeholder review sessions, point-in-time data analysis and literature reviews (of learning from implementation of similar initiatives elsewhere).

The example of a Better Care Fund programme review in Hounslow illustrates how good quality information is gathered without undertaking a full impact evaluation.



NIHR: [Levels of evidence pyramid](#)



Point-in-time programme reviews – Hounslow

At times it is not possible to undertake a full evaluation over a longer period. Point-in-time reviews enables leaders to take stock on a project or a programme, and identify learning about what works well and what works less well. In 2016, leaders in Hounslow decided to undertake a review of all their BCF schemes. The straightforward but systematic approach can be used in a number of different settings.

The aim of the review was to inform a revised approach to the BCF in 2016/17. Over a period of five weeks, the key stakeholders involved in the BCF came together to explore what was working well and where there were issues and performance challenges.

The review aimed to answer the following key questions:

- Are the BCF programmes delivering what they set out to deliver?
- How does the BCF need to evolve to reflect what is happening on the ground?
- How can we maximise the impact of the schemes that are working for 2016/17?

- How can we ensure that the BCF effectively enables the vision for whole-systems integration?
- How can the BCF be best used to support the Hounslow health and social care economy?

In addition to the workshops with key stakeholders, project leads, staff and other stakeholders were interviewed and performance data and existing reviews were collated. An analytical framework was used to map all the evidence gathered for each project against the overall goals of the BCF plan.

Against the analytical framework below, schemes were rated on a scale of 1 – 10 where 1 is 'not at all' and 10 is 'to a great extent'.



| | Is working as planned and delivering on outcomes | Represents value for money in the long term | Builds long-term capacity for integration locally; enables new models of health and social care | Evidently supports people effectively, improving patient/ service user satisfaction | Has buy-in from all stakeholders and workforce: frontline staff and political, clinical, managerial leaders | Reflects a truly whole-system approach | Supports shift towards prevention/ early help and community support/self-help | Total |
|--------------|--|---|---|---|---|--|---|-------|
| Scheme one | | | | | | | | |
| Scheme two | | | | | | | | |
| Scheme three | | | | | | | | |
| Scheme four | | | | | | | | |
| Scheme five | | | | | | | | |
| Etc. | | | | | | | | |

The results of the qualitative assessment and the costs of each scheme were mapped against a cost/impact matrix as set out below.

| | | Impact | | |
|------|--------|--------|--------|------|
| | | Low | Medium | High |
| Cost | High | 1 | 2 | 3 |
| | Medium | 2 | 4 | 6 |
| | Low | 3 | 6 | 9 |

The findings were used to inform decisions about what schemes should continue and be scaled up (schemes with highest impact and lowest cost scores) and which ones should be improved or decommissioned (schemes with lowest impact and highest costs).

In summary: top tips to develop a monitoring and evaluation framework

- Consider evaluation up front.** What information is needed about progress and impact? How will the information be used?
- Be systematic.** Providers should draw up an evaluation plan or framework to set out the aims, expected outcomes, measures and targets and a plan for how they will monitor and analyse the results.
- Be realistic.** It is not always possible or practically feasible to implement a best-in-class evaluation framework. Instead, partners should think carefully about which key measures could be used to monitor progress.
- Flexibility is important.** Include both qualitative and quantitative measures and consider what the evidence is indicating as the evaluation progresses. It is important to be able to adapt and change an approach over time, if required.
- Take time to understand the data.**



5 Using results to continuously improve

Ultimately, the value of monitoring and evaluation activity rests on how the evidence is used to do the following.

- **Monitor activities and results to manage budgets and performance on an ongoing basis.** Depending on the nature of the programme and the scale of the investment, monitoring should be done daily, weekly, monthly or quarterly. It should be clear who is responsible for delivering in relation to – and reporting on – each measure. It is also important to establish lines of accountability and reporting arrangements.
- **Report on progress for purposes of local and national accountability.** This means ensuring that the local evidence in relation to activity and results is collected and submitted to relevant stakeholders both within the local area, the STP area or region, and nationally.
- **Inform decisions about commissioning and decommissioning.** It is critical to set out a plan for how the progress reports should be used to ensure that the evidence is actually utilised to inform investment decisions and drive improvement and sustainability.

- **Underpin a culture of learning across the system that supports continuous improvement and transformational change.** This involves honesty and openness about how to deliver the health and care outcomes most cost-effectively and sustainably.

Using results to drive continuous improvement is an ongoing challenge that requires continuous commitment and effort across the system. This section sets out a few examples of how to use evidence to inform change.

Whole-system dashboards

Across health and care, there are numerous different quality, performance and finance measures, systems and cultures. In some areas, key measures have been pulled together into an integrated 'dashboard' which can provide an overview on progress and may replace some of the current reporting arrangements. Consider aligning measures to cover the six domains to assess integrated care. An integrated dashboard can help provide a whole-system view at a glance and inform tactical and strategic decisions to accelerate improvement.

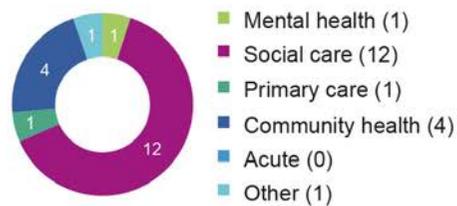
A dashboard:

- provides relevant and up-to-date information on a page
- can engage system leaders through infographics and data bridges
- reflects the range of services provided across the pathway with an increasing focus on health outcomes
- includes the range of measures and standards to be achieved and monthly/yearly to-date performance and forecasting information
- uses a data quality 'kite mark' system to help provide a good sense of the quality of the data being used
- includes further measures as it develops.

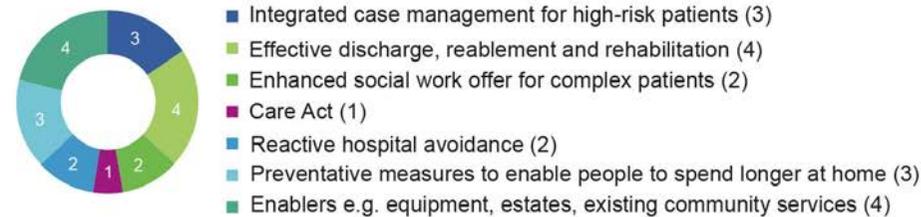
Better Care Fund Dashboard

OVERVIEW

Number of Schemes by Delivery Area

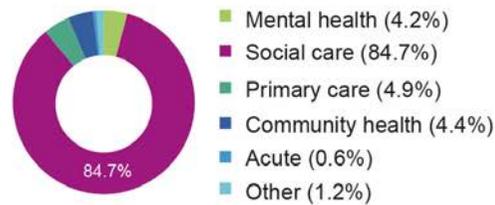


Number of Schemes by Focus

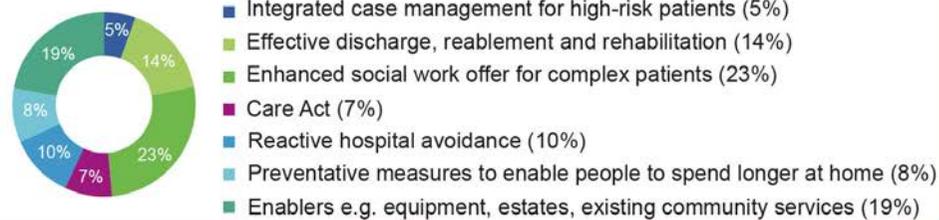


FINANCE 2014-2015

BCF Combined Finance by Delivery Area



BCF Combined Finance by Scheme Focus



BCF – Overall Spend Against Planned Budget (in £000)

- Actual
- Planned by Quarter
- Variance

SCHEME OVERVIEW



Establishing a learning culture

The NHS and local authorities have a long tradition of innovation and improvement. Over recent years, this has accelerated with a range of pilots, innovation test-beds, new models of care and new ways of working. There is a growing evidence base about what works (local, regional, national and internal), and the challenge to localities is to make use of this evidence to learn and improve on an ongoing basis.

It is important to build a process for continuous learning, training, evaluation and development. This means:

- using local insights and research, improvement theory and the growing evidence base about what works
- creating spaces for a broad range of stakeholders (people, frontline staff, managers and leaders) to reflect on every stage of the journey, based on data, evidence and impressions
- encouraging frontline staff to share feedback and capture results
- acting on what has been learned

- identifying best practice and sharing it widely.

Action learning sets can help build a learning culture. They are defined as a ‘continuous process of learning and reflection, supported by colleagues, with an intention of getting things done’ (see McGill and Beauty: Action learning – a practitioners’ guide). 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 for, and make time for, active reflection to solve their own problems. Action learning sets can be linked with coaching/mentoring. Participants are recruited to a ‘set’ and meet regularly (every six to eight weeks) to sustain momentum and commitment. Less often than this and a group can often repeat the cycle of trust formation and not get any further.

There are three key benefits of action learning sets:

- **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.
- **Changing methods of interaction with others**, by asking open, probing and challenging questions – all of which help to draw out what has been referred to as ‘exploratory insight’ which in turn leads to action (see Revans: ABC of Action Learning).
- **Enabling people to both reflect on a work-based issue and share it with others**, and thus formulate actions and decisions that they can take back to their workplaces, which results in change.



Checklist: using results to continuously improve

- Make sure that evidence is presented in a clear way.
- Recognise the value of different forms of evidence: performance data, evaluations, case studies, user feedback, staff feedback and impressions.
- Create spaces for individual and joint reflection through formal and informal routes.
- Anchor decisions in references to evidence and learning.
- Share learning about what works within your locality and nationally.

‘Reflect, measure and learn rapidly about what is and is not working to help implementation become more successful.’

Improving quality in the English NHS – A strategy for action.



Tools and resources

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**
- **Public Health Outcomes Framework**
- **Adult Social Care Outcomes Framework (ASCOF)**

Cross-government resources

- **The HM Treasury Green Book: Central Government Guidance on Appraisal and Evaluation.** This provides a substantial overview of approaches to appraisal and evaluation.
- **The HM Treasury Magenta: Guidance for Evaluation.** The recommended central government guidance on evaluation that sets out best practice for departments to follow.

- **Rapid Evidence Assessment Toolkit,** (Government Social Research Unit). Information about REA and other secondary research methodologies.

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.

- **How will outcomes be tracked and measured?** In the USA, the Magellan dashboard for Serious and Enduring Mental Illness measures key performance indicators, such as the number of non-elective admissions, performance of primary care and performance of prevention measures. It is publicly accessible, providing information to patients, families, staff and providers on areas that are working well and those that need improvement. Each dashboard includes indicators grouped into balanced scorecard categories.
- **Value-based purchasing analytics.** In the USA, in wake of the Affordable Care Act,

the Arkansas state adopted the Medicaid programme to improve quality of care and reduce costs. To aid the state's efforts, General Dynamics Health Solutions crafted an advanced analytics solution, 'Quality Care Insight', to collect clinical and quality data, and share the results and related best practices with providers.

- **Development of a survey instrument to measure patient experience of integrated care.** In the USA San Francisco Origin, BMC Health Services Research developed a survey instrument to measure patient experience of integrated care.
- **The measurement of New Zealand health care** (2015). In New Zealand (NZ) the use of quality and safety indicators (QSIs) measures progress toward the NZ triple aim – page 51, figure 1 page 52.
- **Population health systems: going beyond integrated care.** The King's Fund uses examples from organisations and systems in other countries that are making a shift to integrated care. A key aspect to consider is that improving population health is not just the responsibility of staff or providers. It requires co-ordinated efforts across population health systems.



Toolkits

The Policy Innovation Research Unit (PIRU) provides advice on measures of integrated care for individual and collective progress monitoring, using routine data.

The Nuffield Trust undertook a series of evaluations looking at case studies of integrated and community based care. The **Evaluating Integrated and community-based care** 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.

King's Fund: Integrated care map: examples of new models of care in practice

Picker Institute Europe: Developing measures of people's self-reported experiences of integrated care

The Health Foundation: Measuring patient experience

North West London Toolkit. How do we define outcomes and metrics?

BMC Health Services Research: Selecting process quality indicators for the integrated care of vulnerable older adults affected by cognitive impairment or dementia

Public sector Transformation Network: introductory guide to evaluation

National Collaborating Centre for Methods and Tools: Guidelines for selecting and using indicators

NICE Standards and Indicators



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