QORU | quality and outcomes of person-centred care research unit

The system-level evaluation of the Better Care Fund

Julien Forder

20 Nov 2018

BCST Thematic National Workshop

University of Kent

LSE The London School of Economics and Political Science

University of Oxford

Acknowledgement

- The research was commissioned and funded by the NIHR Policy Research Programme (*Quality and Outcomes of person-centred care policy Research Unit).* The views expressed in the publication are those of the author(s) and not necessarily those of the NHS, the NIHR, the Department of Health and Social Care or its arm's length bodies or other government departments.

Introduction

- The Better Care Fund (BCF) 2015/16 was implemented as a new approach to the national funding of care and services for people that use both NHS health care and local authority (LA) social care.
- The BCF comprises:

  (a) a fund to be used to pay for services involving both health and social care, with money provided by the NHS and LAs with national conditions for access,

  (b) approved plans for how the fund will be used,

  (c) funding made partially conditional on performance, and

  (d) a central support package available to help local sites.

- In 2015/16 the Better Care Fund (BCF) was £5.3bn

Aims of the study

- Describe how health and wellbeing board sites were planning to configure and spend their BCF (work package 1);
- Assess the impact/outcomes of the BCF based on the processes and mechanisms put in place, given local circumstances (WP 2);
- Examine the effects of the BCF on two types of outcomes: delayed transfers of care (DTOCs) and non-elective emergency admissions (WP 3).

Methods

Work package 1: Typology analysis

- Developed a classification-coding framework for BCF activity. Classified the BCF plans of each local health and wellbeing board area. We assessed primary activities supported by the BCF:
  - Intermediate care
  - Prevention, low-level
  - Coordination, assessment, care planning
  - Assistive technology
  - 7 days working
  - Changes/implementing new care pathway
  - Core/General (incl. social care) services
  - Implementing the Care Act (the new duties)
  - Palliative care
  - Carers support

Methods

Work package 2: Process Evaluation

- Thematic analysis using in-depth, semi-structured interviews among organisational representatives
  - BCF Project leads (9)
  - Commissioners (9)
  - Directors / Chief execs (6)
  - Senior managers (12)
  - Clinicians (3)
  - Middle managers (1)

- Interviews conducted over 12 months between January 2017 to January 2018

Methods

Work package 3: Comparative System Evaluation

- Expect areas with higher levels of BCF to produce better outcomes than areas with lower BCF expenditure, *other things equal.*
- Main impact indicators:
  - Delayed transfers of care (DTOCs)
  - Emergency admissions (EAs)
  - Quality of life: care-related quality of life (ASCS), health-related quality of life (GPPS)
- Statistical analysis of data from 150 HWB areas over 16 quarters (Q1 2012/13 to Q4 2016/17)

Results

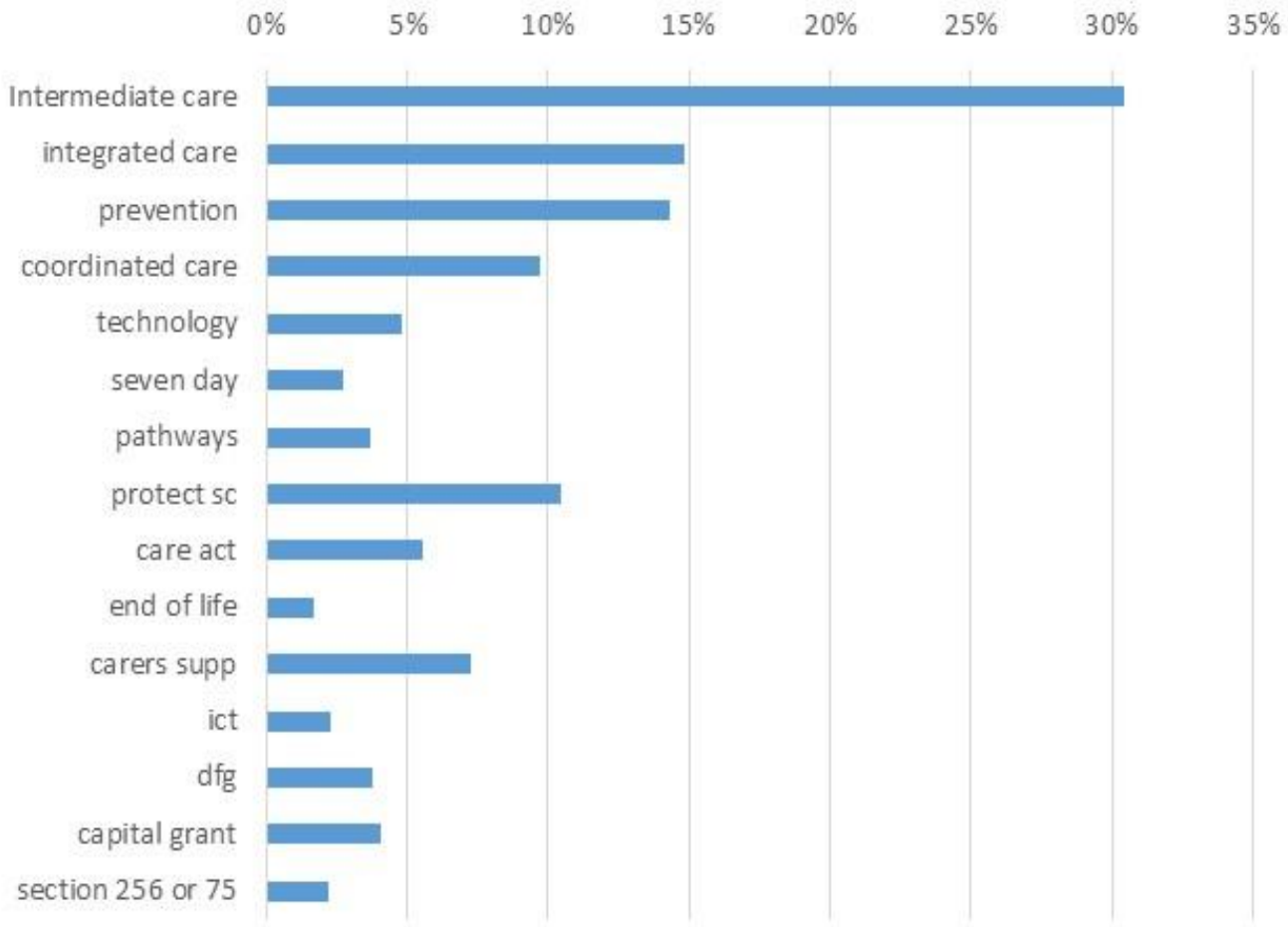
Classification

- Overall, 4,216 schemes were listed within the planned expenditure spreadsheets provided by NHS England.
  - 1,176 BCF schemes were classified manually using the framework approach
  - 3,296 were classified using the keyword classification approach.
- We measured
  - (a) the proportion of schemes classified by type and
  - (b) the proportion of planned expenditure by scheme, classified by type.

Results

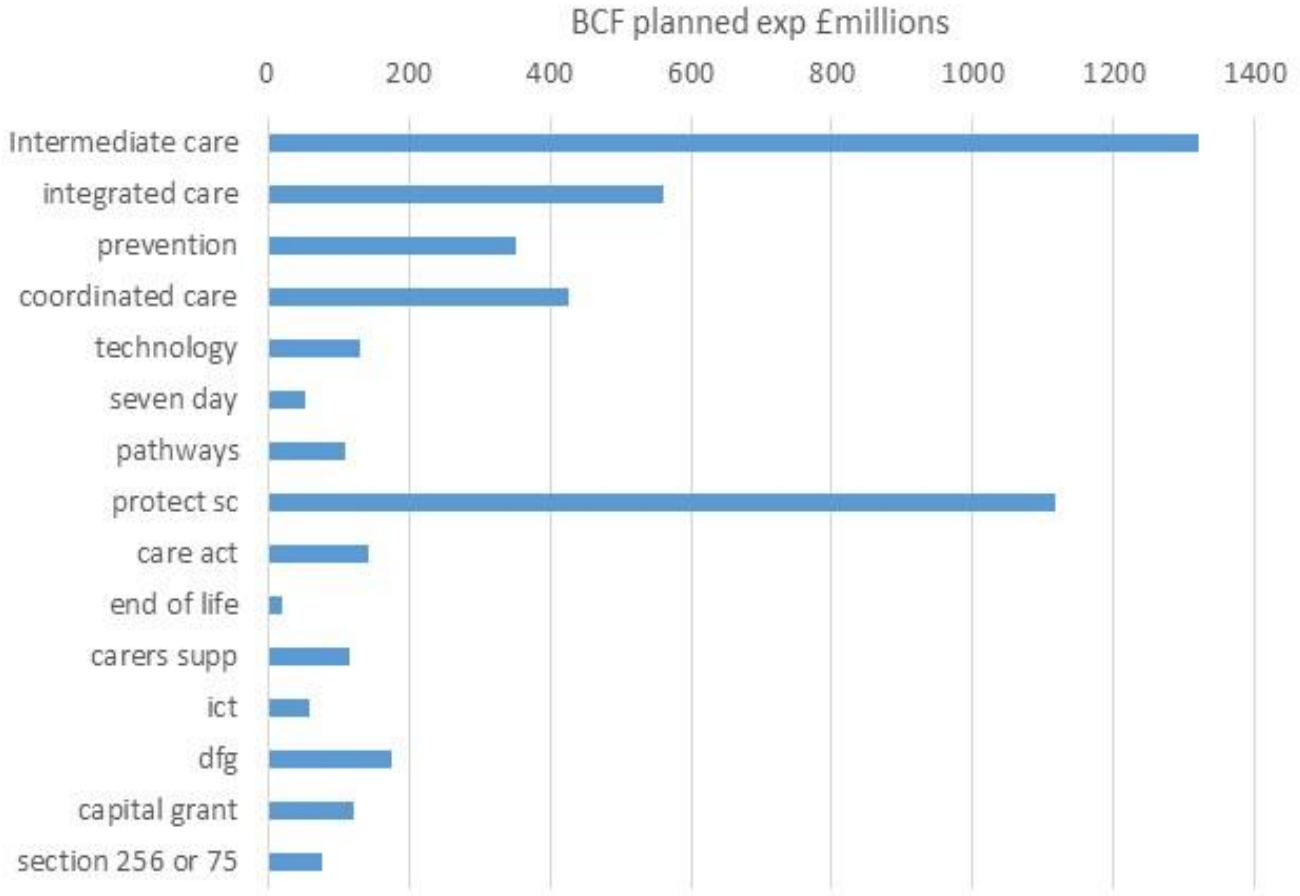
Work package 1: Proportion of schemes

- Keyword coded
- Proportion of schemes
- N = 3,296 schemes



Work package 1: Proportion of planned expenditure

- Classified 86% of BCF planned expenditure



Classification: overall

- Identified a large proportion of schemes as being intermediate care and coordinated care
  - In practice, the distinction between coordinated care and intermediate care is a fine one.
- Identified significant *expenditure* going to protecting social care

Results

Process and implementation

- Areas where BCF had a local impact:
  - The BCF helped facilitate communication, joined-up working and collaboration between health and social care providers in some areas;
  - The BCF increased opportunities to jointly commission services for some areas;
- The principle aims of the BCF were positively received

Process and implementation

- A number of challenges were reported by sites:
  - Financial pressures, managing the budget and negotiating spending could be a source of tension;
  - Concurrent, overlapping policy initiatives with the overall aim of increasing integration were sometimes viewed as conflicting in competing for local resources;
  - National metrics were viewed as potentially cumbersome tools with which to measure the 'impact' of the BCF programme
    - did not capture outcomes such as improved patient experience, working relationships etc.

Process and implementation

- Key enablers for implementation:
  - Establishing and maintaining good relationships with colleagues, particularly across organisations;
  - a shared vision with strong senior leadership;
  - open and transparent inter-organisational communication;
  - appropriate 'buy-in' from the right people (in the right roles) and engaging key stakeholders early on; and,
  - being open to cultural change where required

Results

Comparative impact – Perceived effects

- Increased opportunities for collaboration and joint commissioning of services
- Improved patient experience
  - particularly of care pathways and avoiding the need to repeat case histories to different practitioners
- In some cases, increased efficiencies across organisations - streamlining discharge, needs assessment and care monitoring processes (through for example, multi-disciplinary teams and single assessment processes).

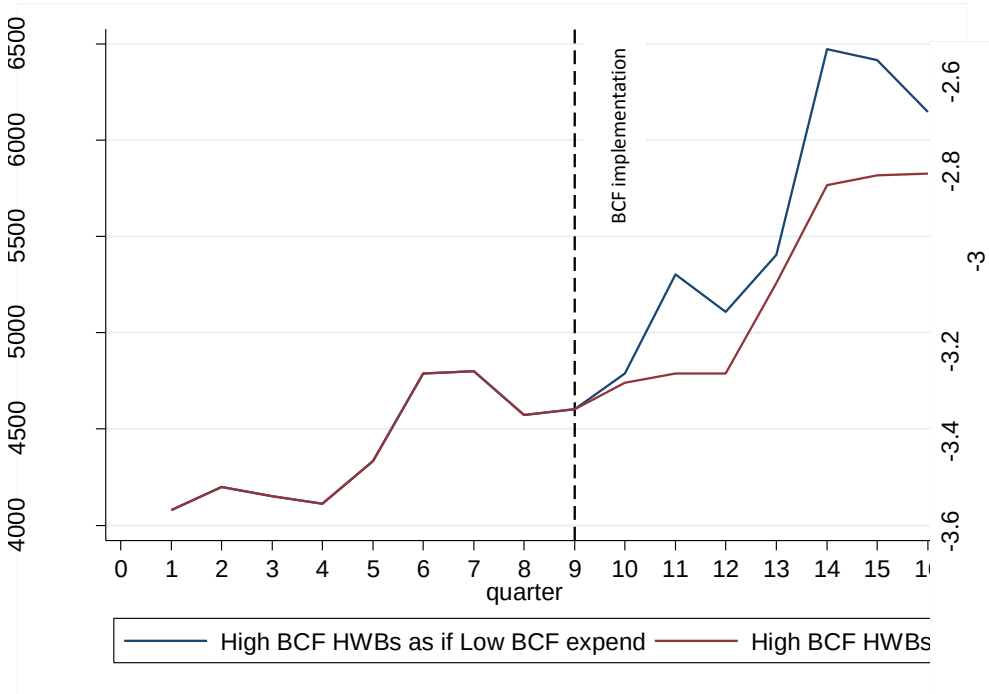
Results

Comparative impact

- Found that DTOC (delayed days) rates per head were *negatively* related to BCF expenditure per person
  - … areas with higher BCF expenditure per person had lower DTOCs than areas with lower BCF expenditure per person.
- Statistically significant – unlikely to be a chance result… but at the lower end of confidence range
- No support for the hypothesised effect of BCF expenditure on non-elective admissions.

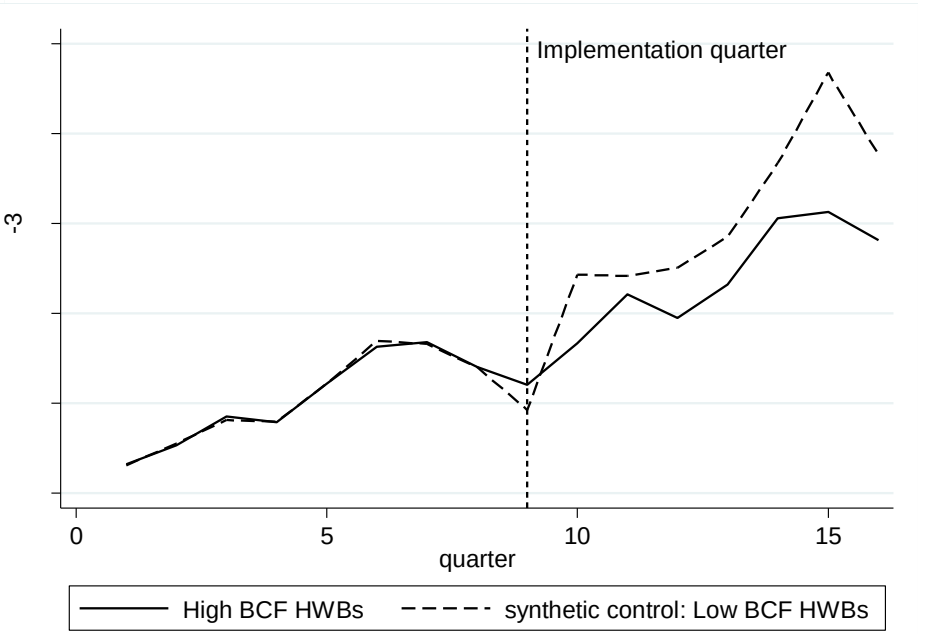
Impact on delayed days per person 65+

Regression (fixed effects)



DTOC values for High-BCF areas as though with: mean level of high-area BCF expenditure versus mean level of low-are BCF expenditure

Synthetic control

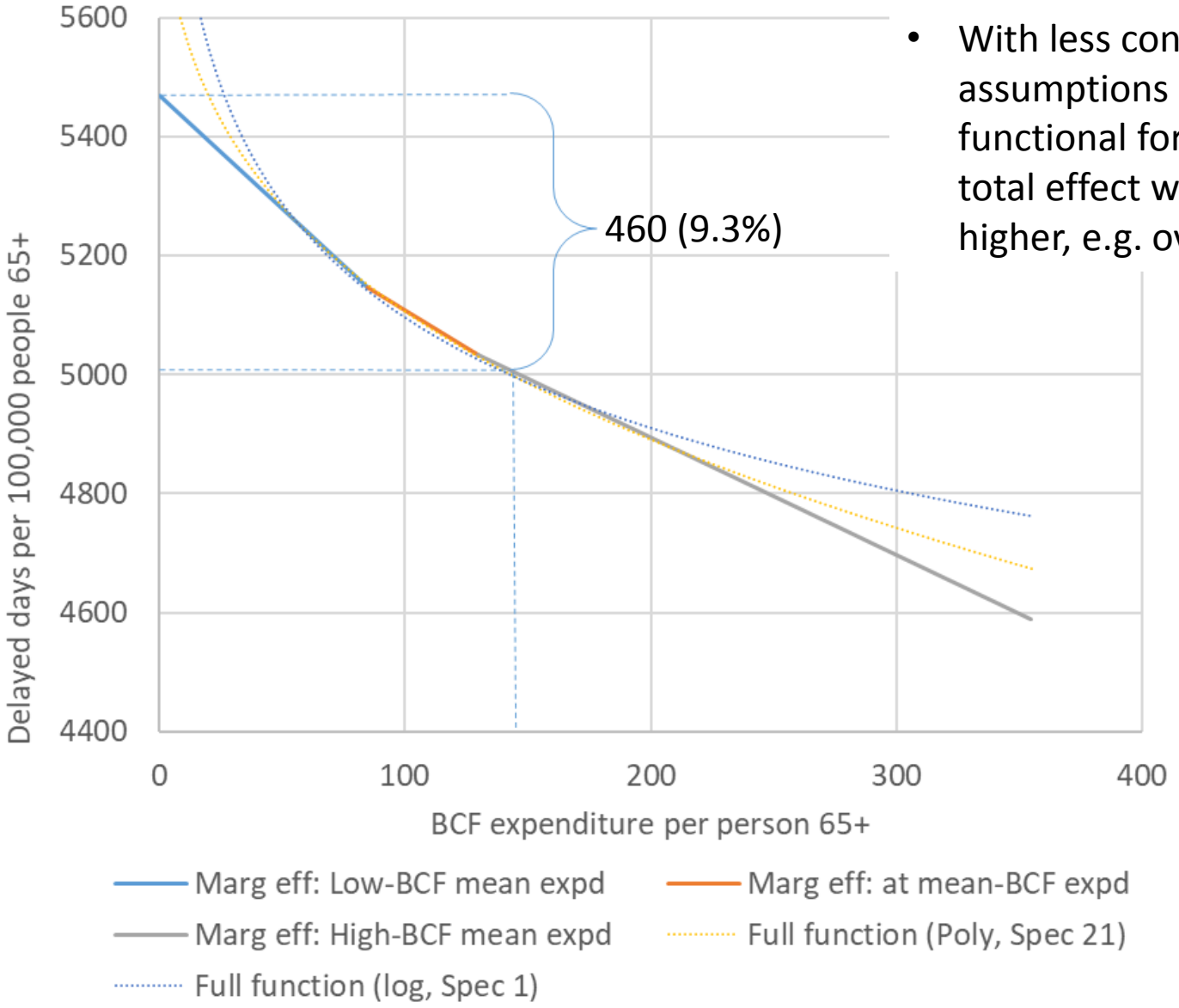


Actual DTOCs for high BCF-expd areas versus DTOCs of those low-expd areas that are matched with high-expd areas

Effect sizes: marginal effects

- Relationship between BCF expenditure and reduced DTOCs showed a strongly diminishing effect
- The 'effect size' of the BCF depends on what we compare…
- Incremental effects (taking centre point of the statistical uncertainty range):
  - An extra 1% of BCF expenditure = 0.073% reduction in DTOCs
  - A larger change in BCF expenditure would not produce a proportional change in delays, *but if it did* – say a 100% change in BCF expenditure, this would be equivalent to a 7.3% reduction in delays
- Total effects are bigger…

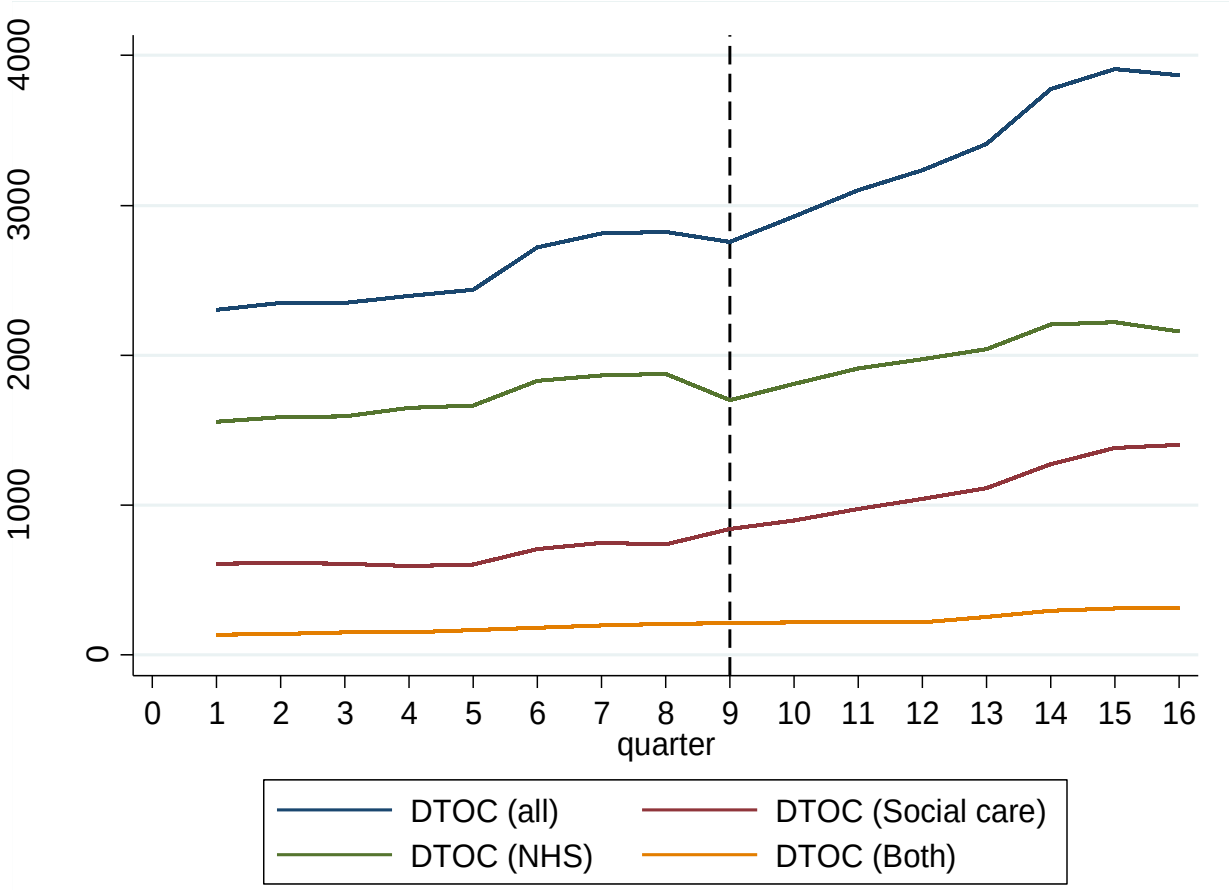
Total effects



- With less conservative assumptions about functional form, the total effect would be higher, e.g. over 10%.

QORU

Impact on delayed days per person 65+, by responsible organisation



Different types of BCF expenditure

- Delays *due to the NHS*:
  - Intermediate care and prevention activities are more effective than other forms of BCF funded activity (excluding protecting social care)
  - Protecting social care activity was no more effective than other BCF spending
- Delays *due to social care*
  - Protecting social care was more effective than other types of BCF funded activity (excluding intermediate care and prevention activities)
  - Intermediate care and prevention activities were no more effective than other BCF spending at reducing these delays.

Discussion

- The extent and nature of progress with implementation of the BCF programme across local sites was mixed.
- The majority of sites attempted to develop their existing joint services through the BCF programme.
  - many participants reported that the BCF programme had prompted sites to extend/build on what they were already doing in partnership
    - including discharge to assess schemes, case management and care coordination, and intermediate care services.
- We identified a number of challenges (e.g. prior relationships) and also enabling factors for implementation
- It was clear that many areas were planning to implement intermediate care
  - just under a third of total expenditure was allocated this way
- But also significant 'protection of social care' funding

Discussion [cont.]

- Impacts:
  - Evidence of an effect on 'step-down' transitions (DTOCs)
  - No effect found on 'step up' transitions (emergency hospital admissions)
  - DTOC results are in keeping with our hypotheses about *BCF change mechanisms*.
    - E.g. the results support a policy of funds to protect social care in order to reduce delays due to social care