

# **Using information and intelligence to inform commissioning**

**North West Health and Social Care  
Commissioning Forum  
Jan 2009**

## The initial impetus

**“The DASS and the DPH will play key roles, with directors of children’s services, in advising on how local authorities and PCTs will jointly promote the health and well-being of their local communities.**

- **They will be responsible for a regular strategic needs assessment to enable local services to plan ahead for the next 10 to 15 years, and to support the development of the wider health and social care market, including services for those who have the ability to pay for social care services themselves.”**

Para 2.60, Our Health, Our Care, Our Say

## The need for a JSNA

- **“Commissioning for many older people’s services was primarily based upon historic patterns of service delivery and most councils were commissioning as single agencies and not in partnership with health, housing, independent and voluntary sector partners.”**

The state of social care in England 2005-06 - CSCI

## The need for a JSNA

- **“NHS commissioning is starting from a low base in relation to designing and purchasing services in a way that properly takes account of peoples needs and demands.**
- **It seems that needs assessment in NHS commissioning has to ‘move beyond public health’. That is not to say that epidemiological data analysis is not vital as part of health planning and commissioning but it is clearly no longer sufficient as the sole basis for making decisions about how priorities will be set and resources allocated through procurement and contracting”.**

HPF Making Commissioning Effective in the reformed NHS

In England, 2006

## The Expectation 'JSNA Guidance'

**“Building on the new duty placed upon local authorities and PCTs and commencing 1st April 2008, the key focus of JSNA includes:**

- understanding the current and future health and wellbeing needs of the population;**
- over both the short term (three to five years) to inform Local Area Agreements, and the longer term future (five to ten years) to inform strategic planning**
- commissioning services and interventions that will achieve better health and wellbeing outcomes and reduce inequalities”.**

## The Expectation: 'Putting People First'

**“The joint strategic needs assessment will inform the Sustainable Community Strategy. It will also be accompanied by an integrated approach with local NHS commissioners and providers to achieve specific outcomes on issues including:**

- relevant preventative public health policies, e.g. infection control and fall reduction strategies;**
- hospital discharge arrangements;**
- the provision of adequate intermediate care;**
- the management of long term conditions;**
- packages of support with a health and/or nursing care element;**

## **The Expectation: ‘Putting People First’**

**The joint strategic needs assessment will inform the Sustainable Community Strategy. It will also be accompanied by an integrated approach with local NHS commissioners and providers to achieve specific outcomes on issues including:**

- **co-located services, bringing together social care; primary care and other relevant professionals;**
- **community equipment services;**
- **universal information, advice and advocacy;**
- **carer support and public/patient involvement;**
- **complaints systems”.**



## The Expectation: World Class Commissioning

- **“Commissioning decisions should be based on sound knowledge and evidence. By identifying current needs and anticipating future trends, PCTs will be able to ensure that current and future commissioned services address and respond to the needs of the whole population, especially those whose needs are greatest”.**

World Class Commissioning: Competencies: Department of Health 2007

## The Expectation: Transformation

- ***“ ...everyone who receives social care support, regardless of their level of need, in any setting, whether from statutory services, the third and community or private sector or by funding it themselves, will have choice and control over how that support is delivered.***
- ***“In the future, all individuals eligible for publicly-funded adult social care will have a personal budget (other than in circumstances where people require emergency access to provision); a clear, upfront allocation of funding to enable them to make informed choices about how best to meet their needs, including their broader health and well-being.”***

## But

- ***The existing care and support system is not sustainable, because of the impact of changing demographics and expectations in our society.***

The Case for Change- Why England needs a new care and support system  
HM Government 2008

## But

- **The JSNA will form one part of this assessment, but when operated at world class levels will require more and richer data, knowledge and intelligence than the minimum laid out within the proposed duty of a JSNA. Fulfilling this competency will require a high level of knowledge management with associated actuarial and analytical skill.**

World Class Commissioning: Competencies: Department of Health 2007

## But

- ***“Personalisation must be delivered in a cost effective way. It is important to recognise that personalisation, early intervention and efficiency are not contradictory but will need to be more strongly aligned in the future”.***

LAC Circular 1 (2008) Transforming Social Care, Department of Health  
January 2008

## But

- **For working age people with physical and/or sensory impairments, IBs had positive effects on all dimensions of social care outcomes.**
- **Mixed outcomes were found for people with learning disabilities.**
- **Doubts and questions about the impact of IBs on older people.**

Glendinning, C., Challis, D., Fernandez, J., Jacobs, S., Jones, K., Knapp, M., Manthorpe, J., Moran, N., Netten, A., Stevens, M., Wilberforce, M. (2008) *Evaluation of the Individual Budgets Pilot Programme: Final Report*, Social Policy Research Unit, University of York, York.

## But

- **44% increase in our over 85 year old population over the next seventeen years.**
- **Not much change in terms of incapacity in the final years of life.**
- **In 2003-04 43% of all health care expenditure was spent on the over 65 population.**
- **We spend eight times more per head on over 85's than we do on 16-64 year olds.**
- **Slow but steady increase in the numbers and profile of the LD population.**
- **Funding crisis may drive more providers out of the market, make it harder for new players to enter, produce difficulties for older people to fund their care.**

## Our conundrums

- **The JSNA is supposed to influence and drive commissioning but how if the jump from the broad and general to the specific and targeted is too great?**
- **In a personalised health and social care world individuals should make the decisions about their health and care and be given choices. How does this fit with local authorities and PCTs ensuring there is sufficiency of provision. How does this fit when there are still many large block contracts around? How does this work in specialist areas such as dementia care where already there is little choice?**

## Our conundrums

- **If the bulk of service users are older people and they do not want personal budgets how do we deliver the policy, especially at a time when there is likely to be less money per head of service user?**
- **How do we deliver better outcomes when the focus, particularly in health, and via government targets is still very much on delivering outputs and defining processes?**

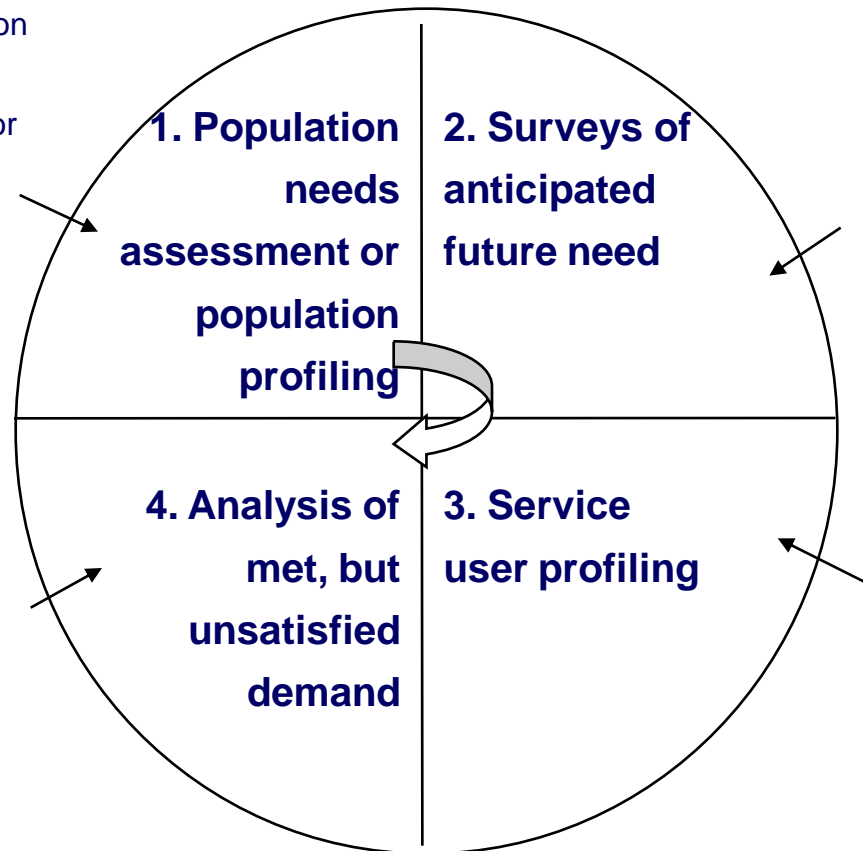
## Answers?

- **We need to be clear about what our primary goals are and why.**
- **We need to be able to identify the factors that lead to different groups of people not achieving those goals.**
- **We need to start focussing on measuring the outcomes of interventions and not inputs or treatments or processes.**

# IPCs Four Dimensions of Understanding Demand

Defines the total potential population for services based on the assumption that the presence of certain characteristics or conditions within the whole population are reliable indicators of demand.

Qualifies the results from 1, 2 & 3 through examining the key issues that influence demand, eg, does intensive domiciliary care really maintain people within the community.



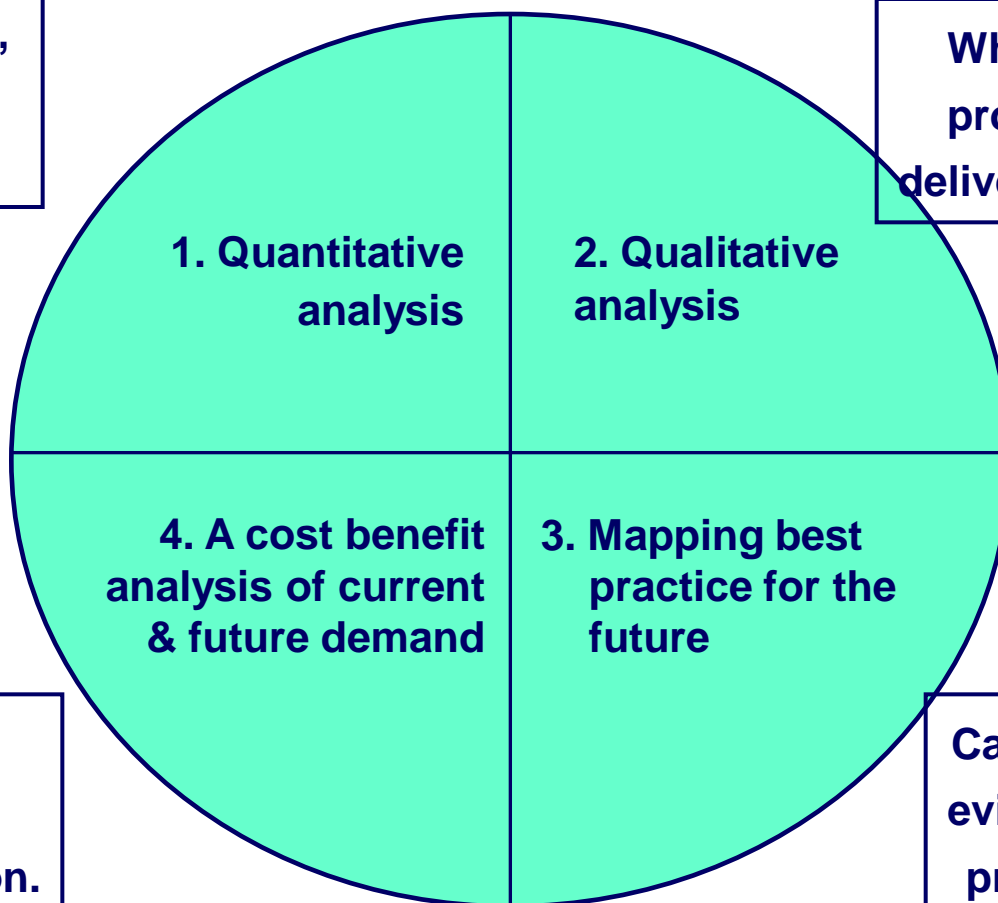
Refines the population based perspective on demand through tempering it with national and local research, surveys and audits.

Further defines need through analysing data concerning populations known to housing, health and social care.

# IPCs Four Dimensions of Understanding Supply

Who provides, what, where and in what quantities

What is the quality of provision and does it deliver desired outcomes.



What is the gain against cost of the range of provision.

Can we identify and evidence what good practice looks like.

## What are our outcomes and why?

- **More older people to remain within the community.**
- **Reduce the period of ill health and incapacity prior to death.**
- **Offer people with medium to high level learning disabilities greater choice of placement at lower overall costs.**
- **Reduce the number of people who go to hospital with repeat conditions, or who go for observation but then go on into care homes.**

# More older people to remain within the community.

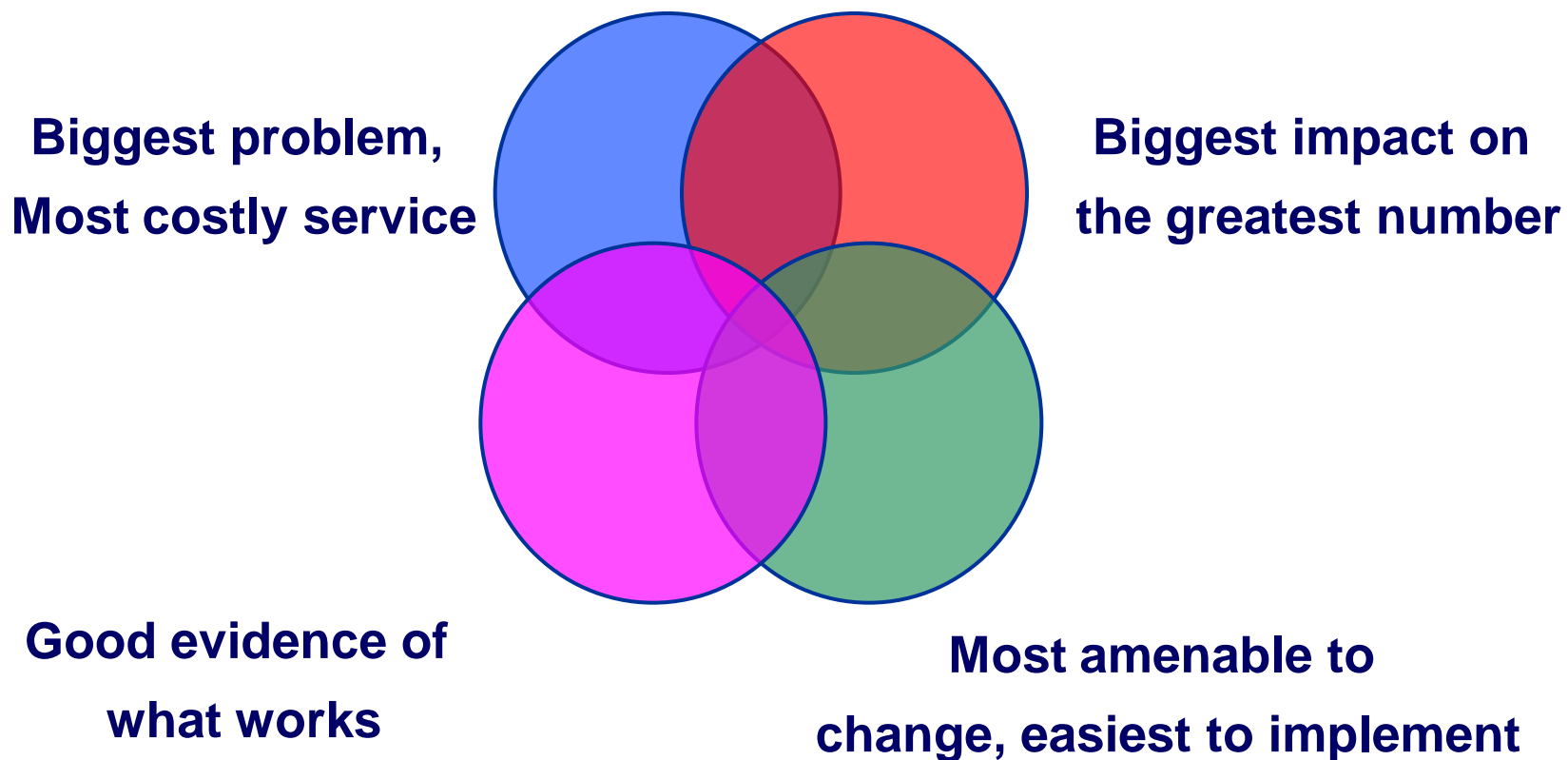
What are the factors that cause older people to leave the community?

- Falls and fractures.
- Isolation and loneliness.
- Continence.
- Inaccessible housing provision
- Carer breakdown.

## Falls and fractures.

- **When did people fall?**
- **Where did people fall?**
- **Had they fallen before?**
- **Where there multiple conditions before the fall.**
- **Where there multiple conditions after the fall.**

## Using knowledge to focus intervention



## Output v Outcome Measures

- **All bar three examples have a process focus.**
- **In process projects measures are about user feedback improved speed of access, different delivery mechanisms. Virtually all of those projects do not have measures in terms of improved outcomes or well being for patients or improved financial performance.**
- **The main exceptions in the process projects are where the focus was on avoiding A&E admissions.**
- **The three outcome projects all had good measures of improved health and two out of three were able to show cost benefits.**

Example from Transforming Community Services & WCC, Department of Health 2009

## Making the shift

Need to move from

- Measuring success in terms of number of hours, provision of a service, amount of service provided.
- Giving negative or perverse incentives to providers.

To

- Measuring have more people got better or have people not required further intervention.
- Giving positive incentives.



# Home Care as an example of perverse incentives.

- Buy in bulk a number of hours.
- We measure delivery rather than outcomes.
- Individual workers are encouraged to not carry out additional tasks.
- Focus is on care and support rather than rehabilitation and recovery.
- We fragment the activities that maintain people in the community so that no single service is responsible.

# Outcome Based Purchasing

**For IPC outcome based purchasing means...**

**...putting in place a set of arrangements whereby a service is defined by, and paid for, on the basis of a set of agreed outcomes rather than the volume or way in which it is delivered.**

## Examples of strategic outcomes

- **More people with dementia living in their own homes to death.**
- **Fewer older people who have had one stroke suffering from further strokes.**
- **50% of service users with a mobility problem at assessment have improved mobility six months later.**

## Examples of outputs and processes

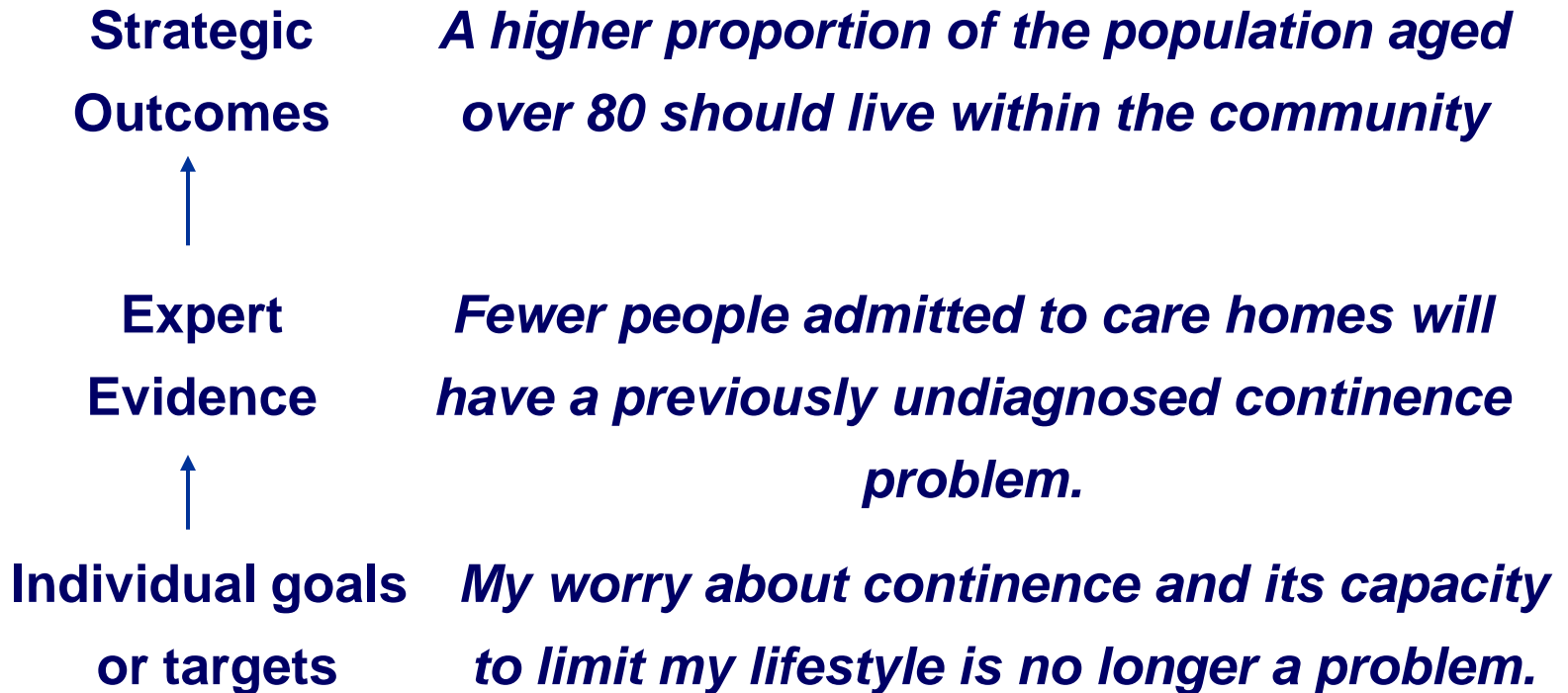
- We will develop a new specialist dementia focussed home care service.
- We will integrate our home care and supporting people commissioning by 2009.
- We will identify key carer populations that are at risk through doubling our number of carer assessments

## Examples of individual outcomes or goals

- **Able to walk at least two hundred yards further at the end of the year than could at the start.**
- **Able to meet with old friends at least once a fortnight.**
- **Able to have garden maintained to an acceptable standard and contribute to keeping it tidy.**
- **Able to choose to have a particular care worker to wash and bathe me.**
- **Able to go to bed when I choose and at different times each day.**

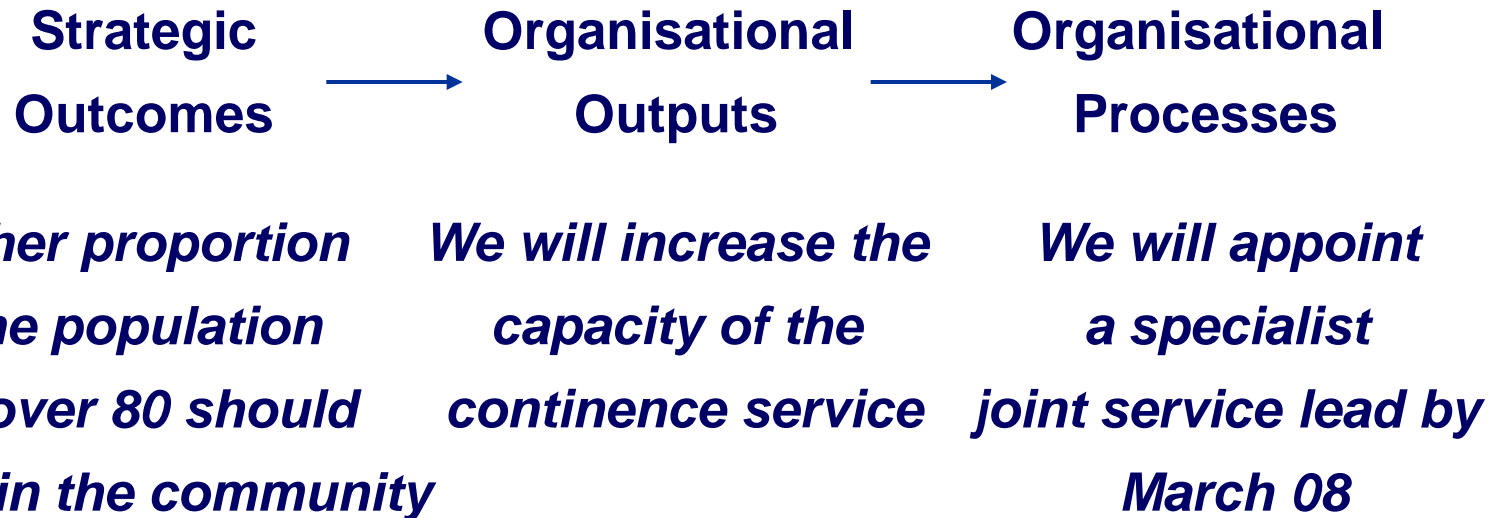


# Linking outcomes, outputs and individual goals together

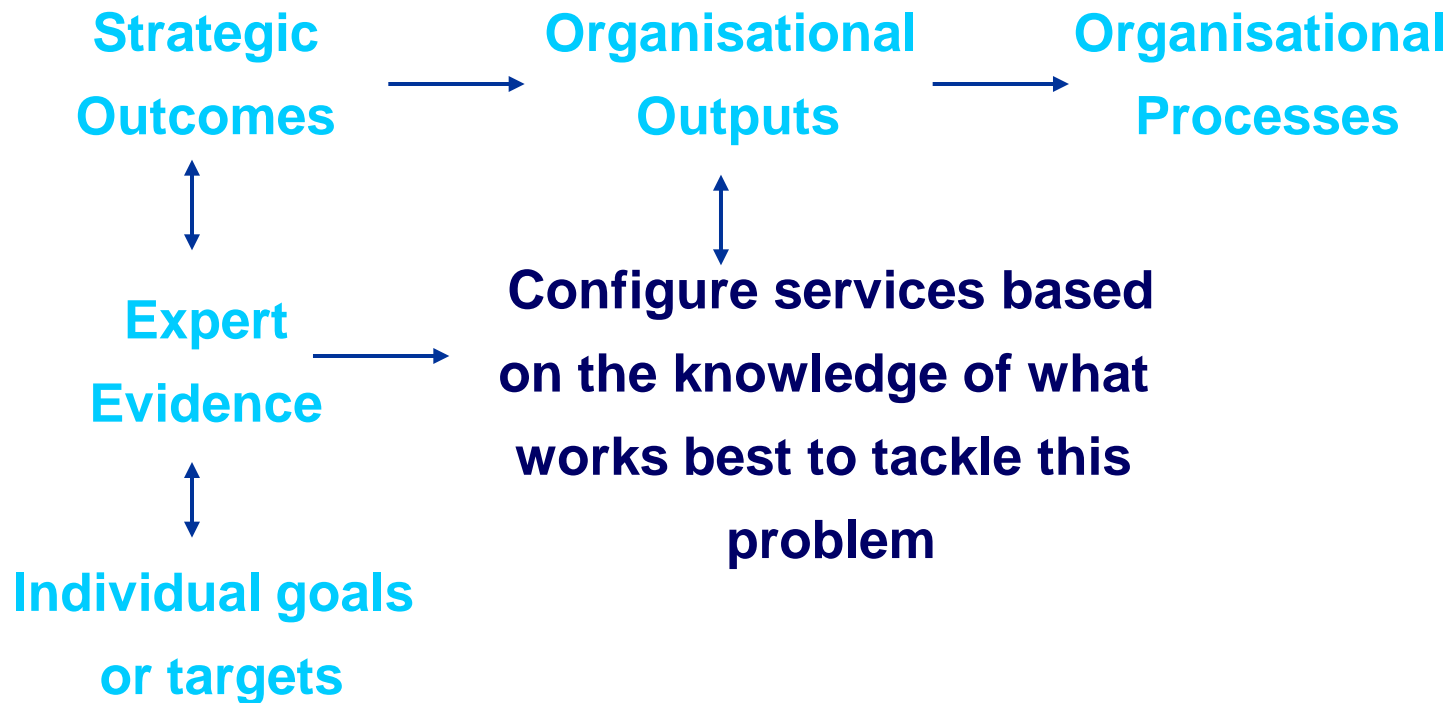




# Linking outcomes, outputs and individual goals together

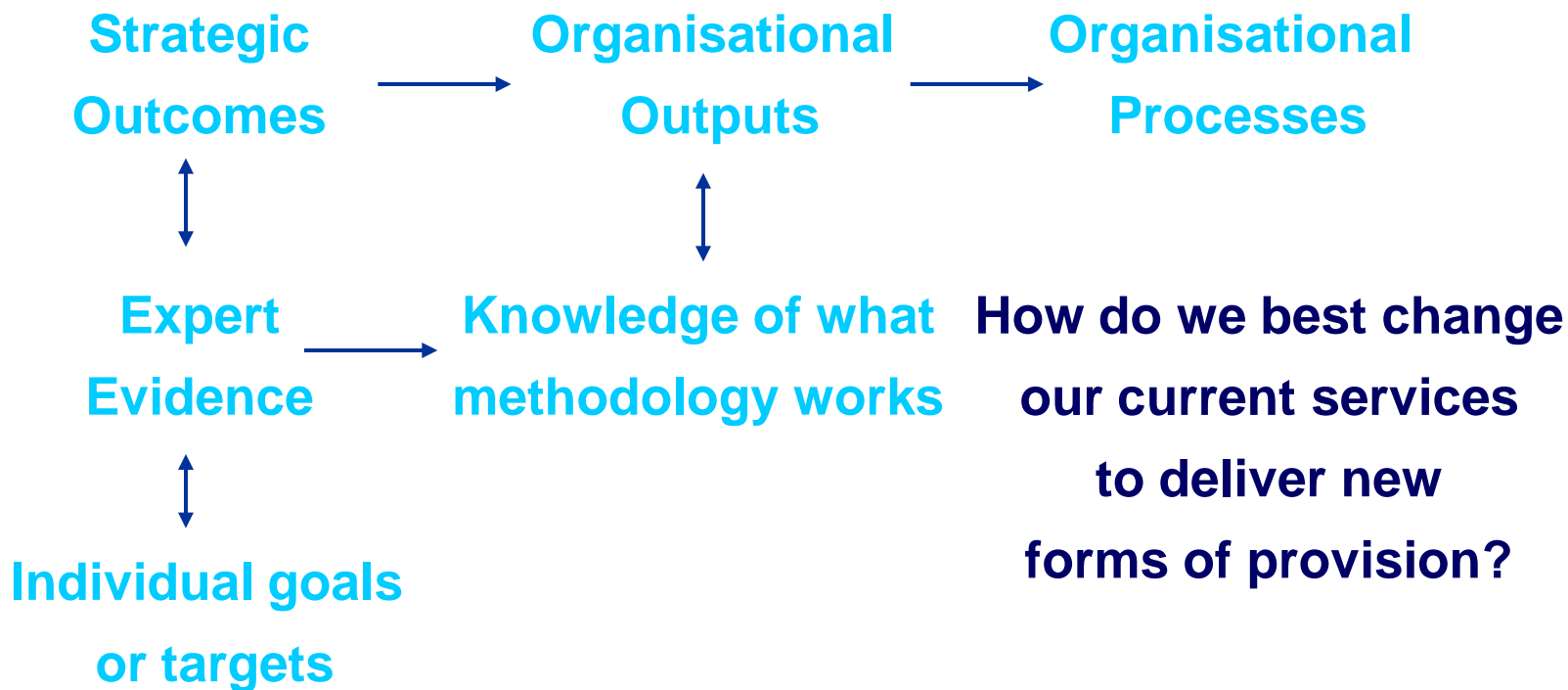


# Linking outcomes, outputs and individual goals together



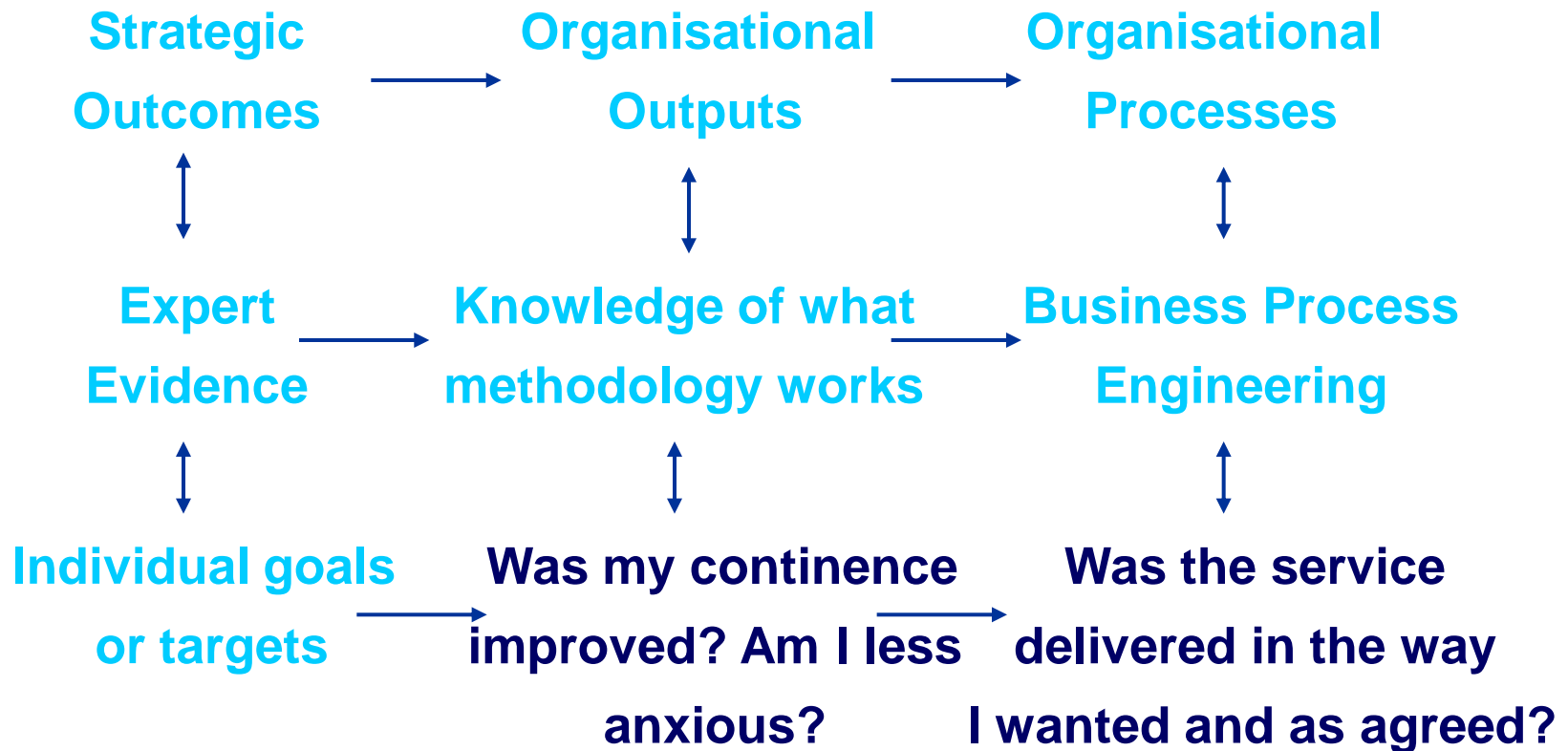


# Linking outcomes, outputs and individual goals together

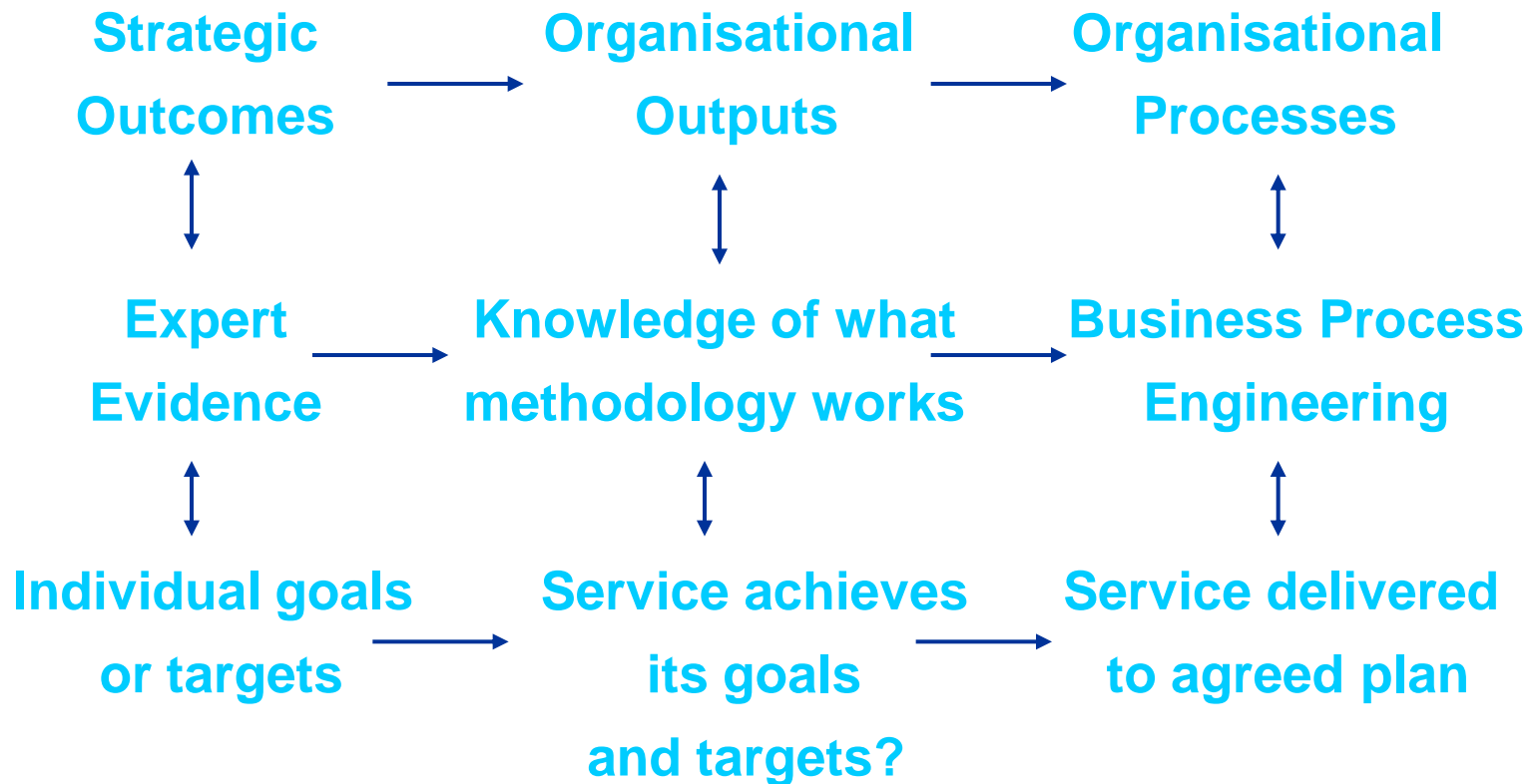




# Linking outcomes, outputs and individual goals together



# Linking outcomes, outputs and individual goals together



## Moving to outcomes might mean...

- **Developing an assessment process that looks at need in terms of what issues and problems are faced and what outcomes are desired / are achievable.**
- **Commissioners developing an improved knowledge of what outcomes might be achievable.**
- **Providers developing a greater repertoire of how outcomes might be delivered.**
- **Changing the basis on which we employ staff and widening the basis of skills.**
- **Giving organisations who provide services incentives for doing better than the agreed outcomes, and disincentives if they don't.**
- **May mean larger contracts that stretch across wider areas.**

## And finally ...

- **Measuring what benefit services deliver rather than what volume they are delivered in.**
- **Choice, control and quality are all important but the ultimate test is will this deliver the outcomes people desire and organisations need.**