Chronic Conditions Management Demonstrators
Toolkit

Results Based Accountability Toolkit
A resource for health professionals

December 2010

Prepared by: Ruth Jordan
Cardiff Chronic Condition Management Demonstrator

ABBREVIATIONS

RBA	Results Based Accountability
CCM	Chronic Conditions Management
SDD	Service Development Directive
PSU	Partnership Support Unit
WLGA	Welsh Local Government Association
DNA	Did Not Attend
NICE	National Institute for Health and Clinical Excellence
LSB	Local Service Board
GP	General Practitioner
DToC	Delayed Transfers of Care

Contact for further information

Ruth Jordan,
Cardiff Chronic Condition Management Demonstrator Lead
Email: Ruth.Jordan@wales.nhs.uk

Contents

INTRODUCTION

The Cardiff Chronic Conditions Management Demonstrator has been working to establish how Results Based Accountability (RBA) can be used to drive improvements in the management of people with chronic conditions. This toolkit has been developed to share the Demonstrator teams learning and practical tips with people from other areas who wish follow this approach. Whilst the Demonstrator is focussing on the management of chronic conditions the toolkit is not solely for people working within this area but for any people who wish to use RBA performance accountability.

PURPOSE

The toolkit is designed to give practical tips and advice to people who are about to start using RBA Performance Accountability. It does not attempt to fully describe the detail of RBA which can be found in '*Trying Hard is Not Good Enough – How to Produce Measurable Improvements for Customers and Communities*' by Mark Friedman and at the websites www.resultsbasedaccountabilty.com and www.raguide.org .The tips and case studies in the toolkit are based on the experience of the Cardiff Chronic Conditions Management (CCM) Demonstrator.

RESULTS BASED ACCOUNTBILITY (RBA)

What is RBA? How will it help?

Mark Friedman (2005) describes RBA as a disciplined way of thinking and taking action that can be used to improve the quality of life in communities and also the performance of programmes and services. It has a number of basic ideas:

- It starts with ends and works backward, step by step, to means. For communities, the ends are conditions of well-being for the community such as Children being Healthy. For programmes or services, the ends are how service users are better off when the service works the way it should
- It provides step by step processes to enable partners to get from talk to action quickly
- It uses plain language and avoids jargon
- It uses common sense methods that everyone can understand
- It's an inclusive process where diversity is an asset and everyone in the community/service can contribute
- It places importance on the collection, baselining and understand of data as without it we don't really know if things are getting better or worse.

Population v Performance Accountability

RBA has two components: population accountability and performance accountability. In population accountability, a group of partners takes on responsibility for the well-being of a population in a geographic area. In performance accountability, a manager or group of managers takes responsibility for the performance of a programme or service.

Population accountability is about a geographic area, e.g. all children in Wales, all adults in Cardiff, whole populations without regard to whether they are getting service from anyone or not. This first kind of accountability is bigger than any one department or programme.

Performance accountability is about our role as managers, and how well we run the programmes and services for which we are responsible. Performance accountability focuses on the well-being of customer populations, as distinct from whole populations.

The principle distinction here has to do with who is responsible. With programmes and services, we can identify the manager or managers who should be held responsible. For cross community conditions such as Health Children, there is no one person or agency that can be held responsible. Population accountability requires broad partnerships that take collective responsibility for progress.

This toolkit covers Performance Accountability and not Population Accountability although a number of the tips would be transferrable.

IMPLEMENTATION

The following section contains a step by step suggestion on how to implement RBA based on the experiences of the Cardiff CCM demonstrator.

Step 1. Determine whether population or performance accountability is appropriate. It is not always easy to do this and it is worth taking time at the beginning to make sure the decision you make is correct. Remember to ask yourself who is responsible.

Step 2. Decide who needs to be involved in developing the framework and invite them to the RBA sessions. Try and identify all of the partners that need to be involved at this point as it is easier to have everyone included at the beginning rather than have people join mid-way through the process**.** The number and length of the RBA sessions depends on the RBA experience of the group. An experienced group can complete a framework in one two hour session however a group new to RBA will need at least two sessions.

Step 3. If the group is new to RBA provide an introduction to RBA training session in advance. This can either be at the start of the first session or in a dedicated session before hand.

The 7 RBA Performance Accountability Questions

Question 1 – Who are our customers?
Question 2 - How can we measure if our customers are better off?
Question 3 – How can we measure if we are delivering our services well?
Question 4 – How are we doing on the most important of these measures and why?
Question 5 – Who are the partners who can help?
Question 6 – What works to do better?
Question 7 – What do we propose to do?

Step 4. Facilitate the group through the development of the RBA framework. Start at step 1 of the "7 RBA Performance Accountability Questions" and work through the questions in order. Don't underestimate how long it takes to agree on the customer group. It isn't always as straight forward as you anticipate.

Step 5. Complete questions 2 and 3 using the "5 Step Method for Identifying Performance Measures" (Appendix 1). The process challenges the data that is collected by organisations. Don't forget to create a data development agenda to cover this. Including information analysts in the group from the start may be beneficial when determining which performance measures are possible.

Step 6. When completing question 4 ask the group to use their experience to best guess the baseline and then collect the real data later. The best guess baselines are generally very accurate.

Step 7. Complete questions 5 – 7. Ensure the action plan developed in step 7 is clear with determined actions, timescales and ownership.

Step 8. Develop a report card for the framework. RBA advocates the development and use of one-page report cards as a tool to highlight the work undertaken to local people and professionals and as a reporting method to accountable Boards. The report cards can be used to highlight the area that is being considered, demonstrate and explain the data, promote the work plan and provide an update on progress.

Step 9. Collect and baseline the data for the performance measures. It can be difficult to do this when the information is held in various different information systems. Be prepared for this when choosing performance measures and don't let it hold up the rest of the work.

Step 10. Schedule meetings to review any additional data and progress against the action plan. Be prepared to re-visit aspects of the framework if things change e.g. if data is unavailable, if curves are not turned as predicted or if the story behind the baseline changes.

THE CARDIFF AND VALE EXPERIENCE

The Cardiff Chronic Conditions Management Demonstrator
The delivery of co-ordinated, comprehensive and consistent Chronic Conditions Management (CCM) services in the community is an integral part of effective mainstream service delivery in the community. This is a key Ministerial priority, the basis of which was drawn from international evidence and published in *Improving Health and the Management of Chronic Conditions in Wales: an Integrated Model and Framework for Action* (WAG).

Improving CCM across Wales depends on good integrated planning and management in partnership with all stakeholders. The aim of the strategy was to improve health and well-being and reduce the incidence and impact of chronic conditions and the inherent inequalities that exist across Wales.

To help deliver and drive improvements in CCM across Wales in an action centred way, three large scale Service Improvement Demonstrator Projects were established, one in Cardiff, one in north Wales and one in Carmarthenshire. This provided an opportunity to focus effort, support and resources in localities to test and learn from concerted effort across organisational and professional boundaries. Lessons and practical solutions were worked through and used to develop the business case for change which supported further mainstreaming across Wales. The aim of this was to;

"Provide and test a sustainable, affordable generic CCM service model that supported patients' needs locally and promoted independent living within the community in order to communicate and inform service change across Wales"

The Cardiff CCM demonstrator was tasked with establishing how Results Based Accountability (RBA) could be used to drive and support implementation of the CCM strategy to ensure services deliver on meaningful outcomes for the population.

CASE STUDY 1.
RESULTS BASED ACCOUNTABILITY AND THE WELSH EPILEPSY UNIT

The Welsh Epilepsy Unit is a tertiary referral centre for specialist epilepsy services in south Wales. The immediate catchment population covered is 700,000 but many referrals are also taken from elsewhere in Wales. The unit offers a multi-disciplinary approach to epilepsy care and offers a very broad range of services to people with epilepsy, their family and carers.

Getting Started with RBA
In the summer of 2009 a multi-agency steering group was formed to develop and test service improvement opportunities in line with the Epilepsy Service Development Directive (3). One of the core objectives of the group was to establish an RBA framework for monitoring performance and evaluation of epilepsy service improvement. Prior to undertaking any RBA training or workshops a comprehensive service mapping exercise was carried out to ensure the steering group had a common understanding of the gaps in current service provision.

Support was provided by Richard Morton from the Partnership Support Unit (PSU) in the Welsh Local Government Association (WLGA) to deliver an introduction to RBA session to steering group members. Following this session, trainers were trained within the Health Board and all further training and facilitation was carried out internally by the author (CCM Demonstrator Project Lead for Cardiff).

Following discussion it was clear that performance accountability was appropriate. Discussions then focussed on whether the epilepsy "customer group" should be divided to ensure that the needs of patients at different points along the care pathway were met. Using information from the service mapping and gap analysis exercise members of the steering group determined that the group should be split and that "patients with a first suspected seizure or unexplained blackout" would be the customer group for the first RBA exercise.

The Process

A facilitated session was held with the steering group to work through the 7 performance accountability questions for this customer group. Participants completed up to question 6 of the exercise during the 2 hour workshop. A number of tasks were identified regarding the collection and baselining of information and an action plan (question 7) was developed at a further meeting.

The 7 question process for performance accountability was repeated at 2 hour facilitated sessions for other customer groups within the epilepsy service:

- Women taking medication for epilepsy between the ages of 14 – 45 who may become or who are pregnant
- People who are admitted to hospital as a result of a presumed seizure

A further introduction to RBA session was held when new partners joined the group after 6 months. The introduction session followed the same format as the original session.

A report card (Appendix 2) was developed for each of the epilepsy customer groups. Data for these report cards are monitored by the steering group on a monthly basis. All of the Epilepsy report cards and details of the epilepsy developments are available at www.ccmdemonstrators.com.

Benefits and Outcomes

Curves have been turned for the first customer group. Preliminary outcomes include:

- The average length of time from seizure to a confirmed diagnosis has decreased by 81 days from 111 days to 30 days
- The number of patients who have been seen by a specialist within the NICE guideline of two weeks has increased from 35% to 61%
- The average waiting time to see a specialist has decreased from 22 days to 11 days
- The number of admissions following a seizure have decreased from 5 a month to 2 a month on average

Other benefits that have been observed include:

- All stakeholders are fully engaged and have ownership of the service
- The team have felt committed and empowered to drive service development
- Performance management is now positively viewed by the team as a tool to enable improvement
- The development of a clear line of sight between Board and LSB priorities and patient outcomes at a departmental level

Challenges
Challenges experienced by the team included:

- Knowing how to start the process was difficult and needed support from the PSU e.g. 'how long does it take?', 'who needs to be in the room?' etc.
- The lack of availability of patient outcome data was an issue. During the process the performance measures chosen were changed to enable meaningful data collection.
- Whether partners that joined the group mid-process needed "training" in RBA. One additional training session was undertaken as described above but partners joining later on have not had access to this.

Next Steps
The Epilepsy Steering Group continue to collect and monitor data for the performance measures and develop the agreed actions.

CASE STUDY 2.
RESULTS BASED ACCOUNTABILITY AND THE CARDIFF WEST NEIGHBOURHOOD TEAM

The Cardiff West neighbourhood team are a newly developed multi-disciplinary and multi-agency team supporting the development and delivery of community based services for patients registered with 9 GP practices with a practice population of approximately 50,000. The decision was made to provide a framework for the team using RBA.

Getting Started with RBA
In September 2010 a list of stakeholders in the Cardiff West neighbourhood was drawn together and all people identified were invited to take part in two facilitated RBA sessions. In advance of the session participants were asked to consider "from your perspective how will we know if we are improving things for the patients/clients in Cardiff West".

Participants were not trained in or given any information about RBA in advance of the session. This was incorporated into the first of the two sessions which was facilitated by the CCM demonstrator lead (Ruth Jordan).

It was agreed in advance that a performance accountability framework was appropriate as the team could only be responsible for their service users as opposed to all residents in the Cardiff West neighbourhood.

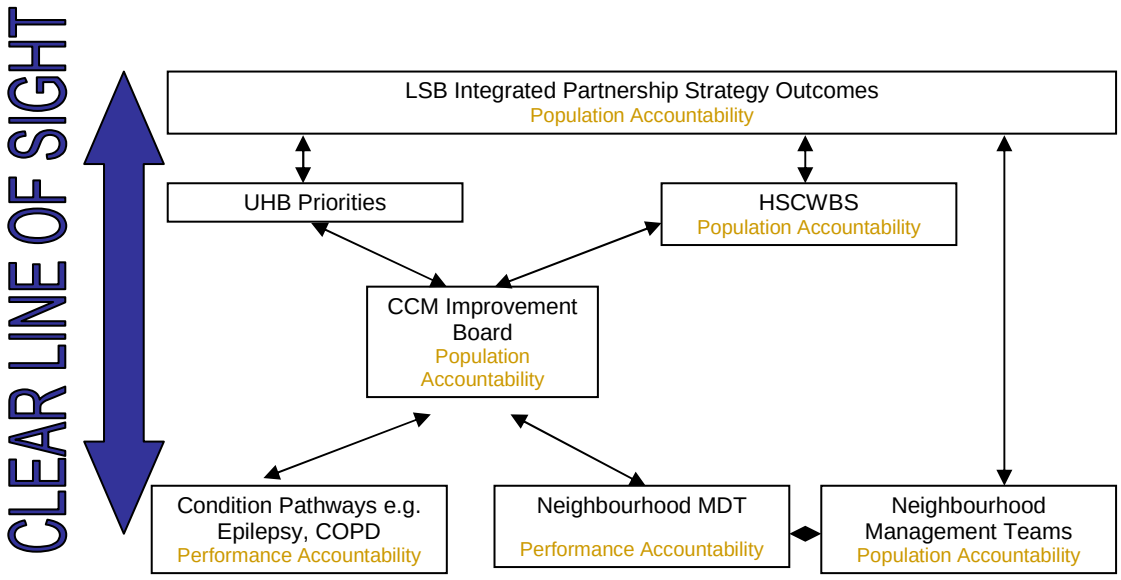
The Process
Two facilitated sessions were held 10 days apart. The first session began with a presentation on RBA. The group then determined the customer group - "People who use health and social care services in Cardiff West" and then agreed the performance measures using the five step method.

During the second session the rest of the framework was developed including an agreed action plan. The framework was incorporated into a report card that is available at www.ccmdemonstrators.com. Project groups have been set up by the neighbourhood and they are monitoring progress.

Benefits and Outcomes

Benefits that have been observed include:

- RBA has facilitated team development and engagement. It has enabled conversations to begin between stakeholders to develop a joint understanding and accept joint responsibility for outcomes for patients within Cardiff West.
- RBA has enabled the community based team to take responsibility for outcomes that were traditionally seen as hospital based responsibilities. This will begin to facilitate the "*Setting the Direction"* (4) strategy in an operational setting.
- The development of a clear line of sight between Board and LSB priorities and patient outcomes at a departmental level. The Cardiff West Neighbourhood Management Team are developing an RBA population accountability framework and members of the health & social care team are also involved in this.



Challenges

Challenges experienced by the team included:

- Some members of the team did not attend both sessions. This meant that those who missed the first session did not get any training into RBA and therefore struggled to participate fully.
- The agreed actions were only "first steps" towards improving patient outcomes. Further actions will need to be developed before any improvements are seen in the performance measures.
- Defining the performance measures was difficult. Traditional measures e.g. Delayed Transfers of Care (DToC) had different definitions for different stakeholders. It may have been beneficial to attempt to correlate and ensure a common understanding of language in advance.
- The session facilitator has not been involved in monitoring progress of the action plans. This has meant a reliance on team members to understand RBA to follow it through. In future it may be beneficial to develop a level of focussed RBA expertise in the team rather than just provide a base level of training to everyone.

Next Steps

- Progress with the RBA framework is being monitored and supported by the Locality team. A review meeting is planned with the session facilitator to update the framework if necessary.

WEBSITES AND FURTHER INFORMATION

Websites
Information on RBA can be found on the following websites:
www.resultsbasedaccountabilty.com
www.raguide.org
www.resultsleadership.org (publications)

Information on the Chronic Conditions Demonstrator and the Cardiff Epilepsy/RBA workstream:
www.ccmdemonstrators.com

CCM strategy document "Improving Health and the Management of Chronic Conditions in Wales: An Integrated Model and Framework for Action":
http://www.wales.nhs.uk/documents/Chronic_Conditions_English.pdf

Epilepsy Service Development Directive:
http://wales.gov.uk/topics/health/publications/health/strategies/epilepsy/?lang=en

Setting the Direction – Primary and Community Services Strategic Delivery Programme
http://wales.gov.uk/topics/health/publications/health/strategies/settingthedirection/;jsessionid=g12cMr2FxTZMHHsZH24bjK88JvFhMQbm1Mzs26lBxpvTQL7KQbFn!-971712554?lang=en

Further information
Ruth Jordan, Project Manager Chronic Conditions, Cardiff and Vale University Health Board
ruth.jordan@wales.nhs.uk

BIBLIOGRAPHY

Friedman M (2005) 'Trying Hard is not Good Enough – How to Produce Measurable Improvements for Customers and Communities'

WAG (2010) 'Setting the Direction – Primary and Community Services Strategic Delivery Programme'

WAG (2009) 'Designed for People with Chronic Conditions Service Development Directive – Epilepsy'

WAG (2007) 'Designed to Improve Health and the Management of Chronic Conditions in Wales: An Integrated Model and Framework for Action'

Appendix 1

Identifying Performance Measures – The Five Step Method

Put yourself in the place of being an organisation or agency accountable for delivering a service to the customer group identified. Your task is to complete the Performance Measures quadrant for the customers being served by that organisation in five steps.

First of all, draw the Performance Measure Quadrant template on a piece of flip chart paper (see fig. 1)

1. **How much did we do?**
   In the Upper Left Quadrant, under "Number of Customers Served" consider if there are any specific categories of customers you should specifically identify (e.g. number of patients with chronic conditions).

   Next, under "Number of Activities", ask what activities are performed and convert each activity into a measure (so "training people" becomes "number of people trained" etc). Don't try and include every single detail – pick the most important categories of customers and activities.

2. **How well did we do it?**
   Review the "Common Measures" listed in the upper right quadrant of the "Summary of Performance Measures" grid (Fig. 2). Write in the upper right quadrant of the flip chart grid (under % Common Measures) all those that apply.

   Next, under "% Activity Specific Measures" on the flip chart (upper right quadrant), list what measures tell us how well the activities you've identified in the upper left quadrant are carried out. If you're struggling, use the list of measures on the Fig 2 grid as a guide. (If you're not sure if a measure belongs in the top right or bottom right quadrants, just put it where you think best and move on – we'll consider both equally in steps 4 and 5).

3. **Is anyone better off?**
   Ask yourselves "if this service is working really well, in what ways are the lives of our customers better off: How could we observe this? How could it be measured?" This will be expressed as a number in the lower left quadrant and as a percentage in the lower right. As a guide, think about the four measures of "better offness" listed in the bottom quadrants in fig. 2 (skills/knowledge; attitude/opinion; behaviour; circumstances). If you get stuck try the reverse question – if the service was terrible how would that reflect on the lives of our customers?

4. **Headline measures**
   Review the list of both upper right and lower right quadrant measures you've come up with and identify those for which there is timely and reliable data available. Draw a circle alongside each one of these measures (big enough to put a number inside the circle later on).

   Next ask: "If we had to talk about the performance of the service in a public setting (such as a conference or scrutiny committee) and we could use only one of the measures with a circle next to it, which one would we choose?" Put a number 1 inside the circle. Then if you could have a second of the circled measures, which one would you choose? Mark

this with a number 2. Carry on identifying no more than 3 to 5 of the circled measures in this way, numbering correspondingly.

You should now have a mix of upper right and lower right headline measures identified in numbered priority from 1 to no more than 5.

5. **Data Development Agenda**
   Finally, review the right hand quadrant measures without a circle next to them (the ones for which you don't have good data). Consider "If we could buy data for only one of these measures which one would it be?" Write alongside this measure (in a different coloured marker) "DD1". Next consider, "if I could buy a second measure what would it be?" Mark this "DD2" and carry on to identify no more than 3 to 5 measures. You now have your data development agenda in priority order.

You now have a three part list of performance measures:

- **Headline Measures**: Those 3 to 5 most important measures for which you have good data, the ones you would use to present the services performance in a public setting.
- **Secondary Measures**: All other measures for which you now have good data. These measures will be used to help manage the service and inform the story behind the baseline.
- **Data Development Agenda**: A prioritised list of measures where you need new or better data (your budget will determine how far down the list you can go!)

Flip Chart Template (Fig. 1)

<table>
<tr><td><u>How much did we do?</u>

Number of Customers Served
•
•
•
•
Number of Activities
•
•
•</td><td><u>How well did we do it?</u>

% Common measures
•
•
•
•
% Activity Specific Measures
•
•
•</td></tr>
<tr><td colspan="2"><u>Is Anyone Better Off?</u></td></tr>
<tr><td>(Quantity)
•
•
•
•
•
•
•</td><td>(Percentage)
•
•
•
•
•
•
•</td></tr>
</table>

Summary of Performance Measures (Fig. 2)

How much did we do?	**How well did we do it?**
Number of Customers Served	% Common Measures Workload ratio, staff turnover rate, staff morale, percentage of staff fully trained, worker safety, unit cost, customer satisfaction: Did we treat you well? etc.
Number of Activities	% Activity Specific Measures Percentage of actions timely and correct, percentage clients completing activity, percentage of actions meeting standards etc.
Is Anyone Better Off?	
(Quantity) • Skills/knowledge • Attitude/Opinion • Behaviour • Circumstances	(Percentage) • Skills/knowledge (e.g. parenting skills) • Attitude/Opinion Including customer satisfaction: Did we help you with your problems? • Behaviour (e.g. school attendance) • Circumstances (e.g. working, in stable housing etc)

THE WELSH EPILEPSY UNIT

Service Description: The Welsh Epilepsy Unit is a tertiary referral centre for specialist epilepsy services in South Wales. The immediate catchment population covered is 700,000 but many referrals are also taken from elsewhere in Wales. The Unit offers a multidisciplinary approach to epilepsy care and offers a very broad range of services to people with epilepsy, their families and carers.

Chronic Conditions Management Demonstrator
Arddangoswyr Rheoli Cyflyrau Cronig
CARDIFF | CAERDYDD

GIG CYMRU NHS WALES

DEFINED SERVICE USERS: Patients with a first suspected seizure or unexplained blackout

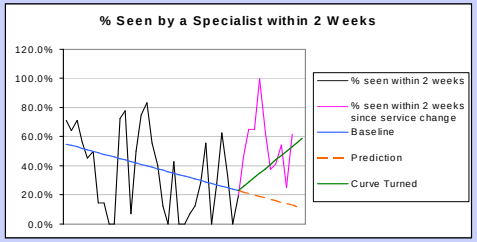
HEADLINE PERFORMANCE MEASURES

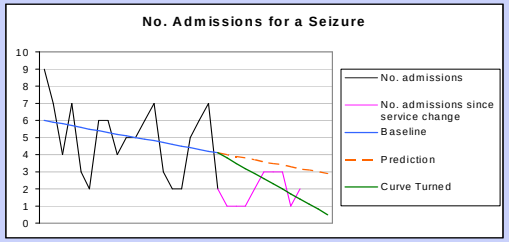
1. % seen by a specialist within 2 weeks (NICE guideline)
2. No. admissions to hospital for a seizure
3. Average waiting time to see a specialist
4. % did not attend (DNA) first seizure clinic

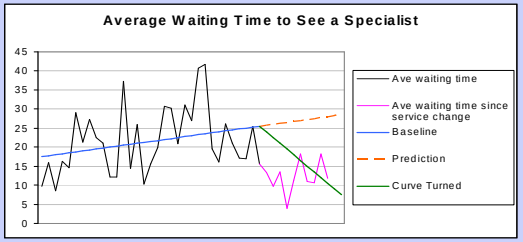
DATA DEVELOPMENT AGENDA

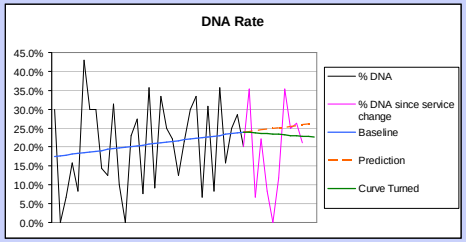
1. Seizure frequency
2. Death rate
3. % prescribed incorrect medication
4. % who report they feel satisfied or better off

HOW ARE WE DOING?









STORY BEHIND THE BASELINE

Limited clinic capacity with unpredictable demand
Small team – unable to cover absence to prevent clinic cancellation
Low frequency of clinics causing delay if appointment not suitable for the patient
Clinic booked by Epilepsy Unit admin staff – if admin staff on leave the clinic slots are not filled
Consultant triage's fax referrals – delay if unavailable
Patient anxiety and concern re implications of a diagnosis e.g. driving
Stigma attached to Epilepsy
Patients put off by unit name – diagnosis seems pre-determined
Nurses unable to refer for EEG leading to delay in diagnostics and confirmed diagnosis
New nurse led emergency unit assessment service for first seizure patients has improved performance measures but out of hours service reverts to old pathway
Primary Care does not have fast track access for first seizure clinics
Primary Care are not made aware if a patient DNA's so can't follow up

PARTNERS WHO CAN HELP US

Emergency Unit, Radiology, Neurophysiology, Medical Records, A&C staff, Consultants, Specialist Nurses, Ambulance Trust, Cardiology, Psychology, Care of the Elderly, Neurosurgery, Prison, Voluntary Sector, Practice Nurses, GP's, Family members/witnesses, Drug & Alcohol Services, Occupational Health, Referral Management Centre, Obstetrics, Management, Communications Department, Patients

WHAT ARE WE GOING TO DO TO DO TO IMPROVE PERFORMANCE?

1. Change the name of the "Epilepsy Unit" to the "Alan Richens Unit"
2. Develop nurse led first seizure clinics to cover when Consultants unavailable
3. Develop dedicated fast track clinic for Primary Care referrals
4. Enable specialist nurse referral for EEG
5. Develop process to inform Primary Care of DNA