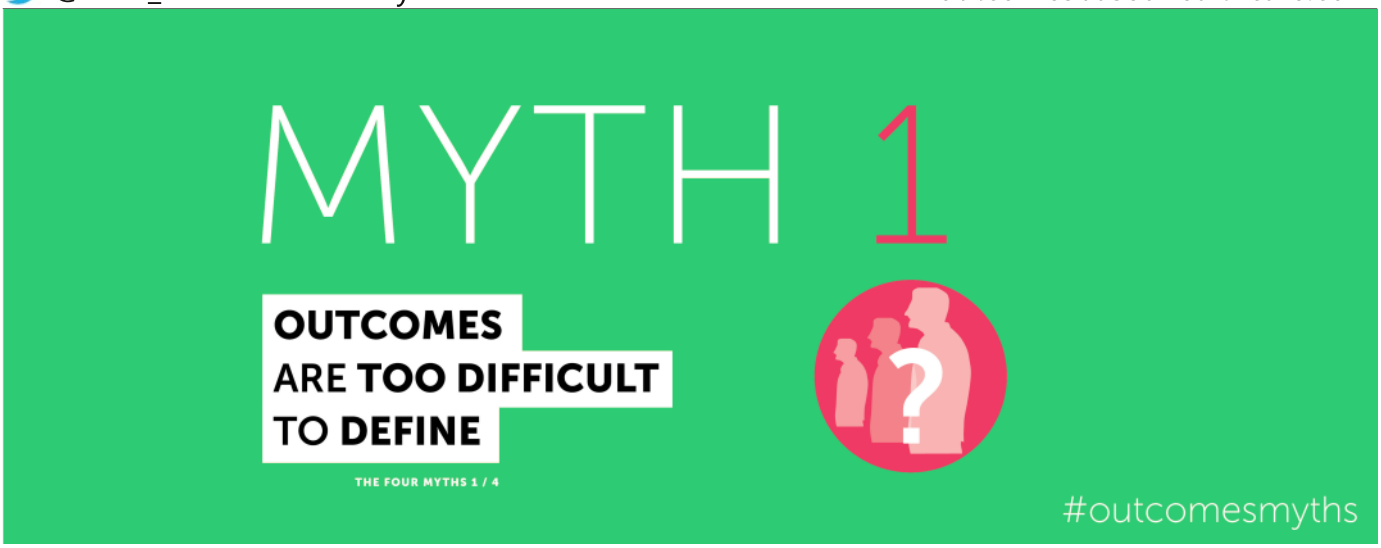

People often think outcomes are a bit nebulous or abstract, and therefore too difficult to pin down and use as the basis for commissioning a service. After all, designing a service that can deliver 250 hip and knee replacements per annum is a far more concrete task than designing a service that will restore people's mobility, independence and confidence.

The other common concern is that since everyone is different, everyone wants different outcomes, making them too much of a moving target to be useful as a way of managing performance against a contract. With diverse populations and a tradition of commissioning around specialties, services and providers, commissioning for outcomes therefore feels like an onerous task. This isn't helped by the fact that the language of outcomes has become confused and is often confusing.

Our experience proves otherwise. Defining outcomes is much easier when you identify and involve the right group of people and ask them the right questions. We have learnt that:

- There is a **real skill to defining outcomes** – it does not mean taking what people say they want at face value
- Defining useful, meaningful and measurable outcomes is possible once you **identify groups of people with similar needs**, otherwise known as segmenting your population. And those outcomes are remarkably consistent across similar groups of people in different localities
- **Designing services on the basis of outcomes** is trickier than designing services to deliver specified activity or outputs, but it is also more likely to **result in a better and more cost-effective service**

WHAT IS AN OUTCOME ANYWAY ?

At its simplest, a positive outcome is a change for the better in a person's health. Getting back on their feet after a fall; feeling back in control of their life after an episode of mental health illness; spending less time in hospital despite having COPD and diabetes. The outcomes that matter to people depend on their starting point, like their age and medical condition (or conditions). Their outcomes will be the result of a whole series of health interventions and experiences they have as they travel through the healthcare system.

> *Outcomes are the results people care about most when seeking treatment, including functional improvement and the ability to live normal, productive lives.*
> ***International Consortium for Health Outcomes Measurement (ICHOM)***

Outcomes are distinct from people's experiences of healthcare and whether they feel satisfied with those experiences. They are also distinct from the 'process' of healthcare – an outcome does not tell us whether x or y happened, it simply focuses on the result. Experience, satisfaction and process measures are key to measuring quality, but they are not the same as the results that matter most to an individual.

Outcomes are about results

If I have diabetes, I may feel positive about the kindness of a nurse or GP and how quickly I can get to see them. I may be getting all the right blood tests e.g. HbA1c, cholesterol and blood pressure checks required by best-practice guidelines, but these are not outcomes. The outcomes that really matter to me might be feeling free from anxiety about how to manage my care or maintaining my eyesight.

NHS Patient

> *Reframe the conversation from "What is the matter?" to "What matters to you?"*
> ***Maureen Bisognano, Chief Executive, Institute for Healthcare Improvement, 2013***

SEGMENTATION MATTERS: '…BUT EVERYONE WANTS A DIFFERENT OUTCOME, DON'T THEY?'

Successful outcomes-based approaches depend on identifying groups of people with similar needs. This approach recognises that such groups share characteristics that influence the way they interact with health care services.

To get the best health outcomes and minimise health care costs, the healthcare system should respond to the needs of different population groups in different ways. Often the best place to start is with conditions and demographics – getting your segmentation right is key.

> *"The most valuable lesson health systems can learn from insurance may be to recognize that "one size will never fit all", and a more personalized approach can be successfully achieved by recognizing that groups within the population vary widely and health services need to be structured using a variety of approaches in order to meet the unique needs and values of all segments within a population."*
> ***Snowdon, Schnarr & Alessi, 2014***

The NHS has traditionally categorised populations by the health services they use at a point in time – and providers are reimbursed on the basis of services delivered at specific locations at a specific point in time. People receiving a given service can therefore vary hugely in the nature of their needs or health circumstances: for example, an older man with several co-morbidities having rehab after a fall would fall into the same group as a fit young woman having rehab after a sports injury.

This can mean people having unnecessary appointments, delays and inconvenience because they may be seen:

- by services not tailored to their particular needs
- in settings that do not have appropriate ancillary services
- in acute settings when they could more appropriately be seen in the community.

Segmentation, by contrast, aims to categorise the population according to health status, healthcare needs and priorities. This means you can tailor care to that group and provides a stronger foundation for responding to individuals' needs.

The number of segments identified needs to be limited. The criteria for effective population segmentation include[1]:

- **Homogeneity**: each segment shares common health prospects and priorities that can be addressed through careful system planning
- **Distinctiveness**: each segment has unique health and health service delivery needs
- **Completeness**: the set of population segments must include every person, acknowledging that individuals will move between segments as their health needs change

[1] Using Population Segmentation to Provide Better Health Care for All: The "Bridges to Health" Model, Lynn et al (2007), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690331/

CASE STUDIES AND REFERENCES: SEGMENTATION AND OUTCOMES FRAMEWORKS

Outcomes hierarchies[2] are a useful way of thinking about the outcomes that matter to people – this is from Professor Michael E Porter at Harvard Business School, the authority on outcomes and value in healthcare.

The Heart BMJ recently published: From volume to value? Can a value-based approach help deliver the ambitious aims of the NHS cardiovascular disease outcomes strategy[3], which discussed the importance and implications of focusing on people with similar needs.

North Central London CCGs – defining outcomes for three population groups

A group of five CCGs (Camden, Islington, Barnet, Haringey and Enfield) worked together to design outcomes-based care for three population groups:

- older people living with frailty
- people with diabetes
- people with mental health problems

Expert reference groups worked with OBH on the segmentation, drawing on public health and informatics expertise to identify useful data sources such as existing population data and disease registers. They also advised on 'entry' criteria, such as selecting appropriate frailty scoring systems, and defined common needs or health circumstances that may be shared by people with different diagnoses.

Once those segments were identified, the next step was to involve people with a relevant condition, their advocates and professionals in defining the outcomes they care about. We ran a series of interactive workshops (some people call them 'outcomes parties') led by experienced facilitators and outcomes experts. We also designed and distributed surveys, using a variety of technologies, to collect as broad a range of outcomes ideas as possible. In the first instance, these generated lists of raw outcomes which needed further work to make them meaningful, relevant and measurable.

We worked together on categorising and prioritising the raw outcomes and then refining and agreeing them with local experts. This involved representatives from the commissioner, provider (including consultants, GPs, specialist nurses and social care providers) and patient communities. Their collective knowledge and experience base resulted in robust outcome frameworks that are truly co-produced and 'co-owned' with the local health economy and which can now be used as the basis for designing services.

Dr Caz Sayer, chair of Camden CCG, says two things struck her from this process: "Even vulnerable people were willing and able to participate and to articulate very clearly what was important to them – and this included recovering users and current drinkers. Some of the outcomes that have emerged are diametrically opposed to how some services are being delivered now – especially in mental health, where people told us they found short term, goal-based measures far more important than traditional longer term ones."

[2] What is Value in healthcare? ME Porter (2010) http://www.nejm.org/doi/full/10.1056/NEJMp1011024

[3] From volume to value? Can a value-based approach help deliver the ambitious aims of the NHS cardiovascular disease outcomes strategy, Dunbar-Rees et al (2014) http://heart.bmj.com/content/early/2014/03/11/heartjnl-2013-305269.short?rss=1

SOUNDS LIKE HARD WORK...

The good news is that work to define outcomes does not have to be repeated from scratch in every locality for every population group. In OBH's experience, something like 80 per cent of the work on outcomes for a specific population segment can be applied to that same segment within a geographically different population.

Moreover, standard outcomes sets for specific conditions and population groups are becoming more widely available, through work done nationally by OBH and internationally by ICHOM[4] . The emphasis will start to shift away from the creation of new outcomes sets, towards reviewing and adapting standard outcomes to fit the specific needs of local people.

> *"Service-driven descriptions of particular communities are just too much of a heterogenous group to have any sensible conversation with about needs or expectations, or any meaningful analysis of outcomes. So outcomes are often dismissed as just too hard- 'everybody just wants a different thing'. When we group people by similar sets of needs, suddenly what matters to different patients starts to make much more sense."*
> ***Dr Rupert Dunbar-Rees, Founder, Outcomes Based Healthcare***

HOW OBH DOES IT

Once a **segment** has been identified, the next step is to **involve people** with a relevant condition, their advocates and professionals in **defining the outcomes** they care about. At OBH, we do this through interactive workshops (some people call them "outcomes parties") led by experienced facilitators and outcomes experts. We also design and distribute surveys, using a variety of technologies, to collect as broad a range of outcomes ideas as possible. In the first instance, these generate lists of "raw" outcomes which need further work to make them meaningful, relevant and measurable.

We work together on **categorising** and **prioritising** the "raw" outcomes and then refining and agreeing them with local experts. This involves representatives from the commissioner, provider (including consultants, GPs, specialist nurses and social care providers) and patient communities. Their collective knowledge and experience base results in **robust outcome frameworks** that are truly **co-produced and "co-owned" within their local health economies**.

The South Somerset Symphony Project[5] analysed its entire population to identify population segments that could most benefit from more integrated care. This in-depth analysis, conducted with the University of York's Centre for Health Economics, made the important finding that it would be more fruitful to define population segments on the basis of the number of conditions each person has than on the basis of age.

Another good example of working with individuals to define outcomes can be found at Alliance Scotland[6].

[4] ICHOM, www.ichom.org

[5] South Somerset Symphony Project (2014) http://www.rightcare.nhs.uk/index.php/2014/03/research-finds-that-costs-of-health-and-social-care-are-driven-more-by-an-individuals-morbidity-profile-than-by-their-age/

[6] Personal outcomes and quality measures project (2013), http://www.alliance-scotland.org.uk/what-we-do/projects/personal-outcomes-and-quality-measures-project/