Metrics for integrated care: What should we measure to know that care is improving?

Better Care Support Team Webinar
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Webinar learning objectives

- To understand what good integrated care is expected to deliver, using the SCIE Logic Model and its underlying evidence as a framework

- To identify the types of metrics you might select for assessing the progress and outcomes of integrated care, from the use of management data to national outcomes indicators

- To review emerging tools and survey instruments you might use to capture data in near real time

- Using a set of case studies, to illustrate how others have used metrics to chart their progress, build on what works and accelerate change.
Questions to think about as we get started

- What is our local integration ambition?
- What is our model of care? What are our interventions?
- What are the outcomes and impact we want to achieve – for service users, local services, system?
- What can we measure to know we're improving?
- How can we use metrics to encourage or accelerate service and system changes?
- Can we create our own local scorecard to enable us to track progress?
SCIE’s integration logic model

- The logic model focuses on integrated health and social care for older people, and is premised on the goal of achieving person-centred coordinated care.

- In our study, we asked: What is good integrated care, and what is it expected to deliver?

- The logic model was used to illustrate how an integrated health and care system is structured, the changes it will create and how it will function, and the outcomes and benefits expected for:
  - service users,
  - health and care services and
  - the wider health and care system itself.

- The logic model is based on research evidence (international and UK), extensive consultation and learning from the Vanguards, Integrated Personal Commissioning, Integration Pioneers and evaluation research.

- This approach enabled us to create an understandable framework for "what good looks like" and to propose a set of metrics for measuring progress towards integration.
Enablers

- Local contextual factors (e.g., financial health, funding arrangements, demographics, urban vs rural factors)
- Strong, system-wide governance and systems leadership
- Integrated electronic records and sharing across the system and with service users
- Empowering users to have choice and control through asset-based approach, shared decision making and coproduction
- Integrated workforce: joint approach to training and upskilling of workforce
- Good quality and sustainable provider market that can meet demand
- Joint commissioning of health and social care
- Joined-up regulatory approach
- Pooled or aligned resources

Components of integrated care

- Early identification of people who are at higher risk of developing health and care needs and provision of proactive care
- Emphasis on prevention through supported self-care, and building personal strengths and community assets
- Holistic, cross-sector approach to care and support (social care, health (and mental health) care, housing, community resources and non-clinical support)
- Care coordination: joint needs assessment, joint care planning, joint care management and joint discharge planning
- Seamless access to community-based health and care services, available when needed (e.g., reablement, specialist services, home care, care homes)
- Joint approach to crisis management: 24/7 single point of access, especially to urgent care, rapid response services, ambulance interface
- Multi-agency and multi-disciplinary teams ensure that people receive coordinated care wherever they are being supported
- Care assessment, planning and delivery are personalised and, where appropriate, are supportive of personal budgets and IPC
- Care teams have ready access to resources, through joint budgets and contracts, to provide packages of integrated care and support
- High-quality, responsive carer support

Outcomes

- Taken together, my care and support help me live the life I want to the best of my ability
- I have the information, and support to use it, that I need to make decisions and choices about my care and support
- I am as involved in discussions and decisions about my care, support and treatment as I want to be
- When I move between services or care settings, there is a plan in place for what happens next
- I have access to a range of support that helps me to live the life I want and remain a contributing member of my community
- Carers report they feel supported and have a good quality of life

Impact

- IMPROVED HEALTH AND WELLBEING
  - Improved health of population
  - Improved quality of life
  - Reduction in health inequalities

- ENHANCED QUALITY OF CARE
  - Improved experience of care
  - People feel more empowered
  - Care is personal and joined up
  - People receive better quality care

- VALUE AND SUSTAINABILITY
  - Cost-effective service model
  - Care is provided in the right place at the right time
  - Demand is well managed
  - Sustainable fit between needs and resources

Outputs to be determined locally

- The integrated care delivery model is available 24/7 for all service users, providing timely access to care in the right place
- The model is proactive in identifying and addressing care needs as well as responsive to urgent needs, with more services provided in primary and community care settings
- Professionals and staff are supported to work collaboratively and to coordinate care through ready access to shared user records, joint care management protocols and agreed integrated care pathways
- Integrated assessment, care and discharge teams report they are readily able to access joint resources to meet the needs of service users
- Transfers of care between care settings are readily managed without delays
- Integrated care improves efficiency because, by promoting best value services in the right setting, it eliminates service duplication, reduces delays and improves services user flow
- Effective provision of integrated care helps to manage demand for higher cost hospital care and to control growth in spending
- Integrated care shifts service capacity and resources from higher cost hospital settings to community settings
- The system enables personalisation by supporting personal budgets and IPC, where appropriate
The logic model has 4 components

- **Enablers of integration** – contextual factors such as leadership and governance, partnership arrangements, shared IT systems and joint budgets, and others.

- **Components of integrated care** – the types of interventions or activities that create integration, ranging from proactive management of care needs to effective behaviours of multi-disciplinary teams.

- **Outcomes divided into three groupings** – people who use services, integrated services and the wider health and care system to emphasise how integration and its effects must be understood from different perspectives.

- **Impacts, which are long-term benefits that are more difficult to measure** – improving health and wellbeing, enhancing quality and providing best value care.
Uses and impact of the logic model

- The logic model has provided a helpful “on a page” visualisation of what good system-wide integration arrangements should look like and what they should help achieve. What’s missing are the metrics specific to local interventions (outputs or improvement objectives).

- Seen as a framework for improvement, like a roadmap, SCIE is currently creating a digital resource to signpost towards the evidence, case examples, tools and resources relevant to each component.

- The logic model has been used as a tool to inform CQC local system reviews, was supported by the NHS Standards Board and the cross-government Integrated Care Programme Board, and has informed national policy discussions, such as the upcoming social care Green Paper.

- Commissioners and integration leads have welcomed the model. In some places, the model has helped guide the development of local dashboards (eg Wokingham).

- Many of the outcomes metrics in the model were proxy measures or presented caveats. SCIE is updating its research about the “state of the art” in measuring integrated care, looking at additional international evidence as well as UK programmes (eg Vanguards evaluation).
# Metrics from the logic model

<table>
<thead>
<tr>
<th>People’s Experience</th>
<th>Services</th>
<th>System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taken together, my care and support help me live the life I want to the best of my ability.</td>
<td>The integrated care delivery model is available 24/7 for all service users providing timely access to care in the right place.</td>
<td>Integrated care improves efficiency because, by promoting best value services in the right setting, it eliminates service duplication, reduces delays and improves flow.</td>
</tr>
<tr>
<td>I have the information, and support to use it, that I need to make decisions and choices about my care and support.</td>
<td>The model is proactive in identifying and addressing care needs, responsive to urgent needs, and providing more services in primary care and the community.</td>
<td>Effective provision of integrated care helps to manage demand for higher cost hospital care and to control growth in spending.</td>
</tr>
<tr>
<td>I am involved in discussions and decisions about my own care, support and treatment.</td>
<td>Professionals and staff are supported to work collaboratively and to coordinate care through ready access to shared records, joint protocols and pathways.</td>
<td>Integrated care shifts service capacity and resources from high cost hospital settings to community settings.</td>
</tr>
<tr>
<td>When I move between services or care settings, there is a plan in place for what happens next.</td>
<td>Integrated assessment, care and discharge teams report they are readily able to access joint resources.</td>
<td>The system enables personalisation by supporting personal budgets and IPC, where appropriate.</td>
</tr>
<tr>
<td>I am able to access the right resources and networks in my community to keep me well.</td>
<td>Transfers of care are managed without delays.</td>
<td></td>
</tr>
<tr>
<td>Carers report they feel supported and have a good quality of life.</td>
<td></td>
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</tbody>
</table>
The logic model is only a starting point...

What we know about integrated care and what we can measure are evolving, and recent studies confirm a mixture of quantitative and qualitative metrics is essential.

We need to differentiate between metrics for performance management and metrics that support improvement and accelerate change.

What can we measure in real time? How do we do this?

“What gets measured gets done.” (Peter Drucker)
Learning from international evidence

- Studies reinforce the importance of maintaining a focus on why integration matters and who it is for: improving patient’s/service user’s care experiences and care outcomes should be the driving force behind integration.

- Unfortunately, both in the UK and elsewhere, studies highlight the difficulties in truly understanding and measuring these experiences.

- Many studies suggest the greatest impact of any intervention is best observed in populations most likely to benefit from well-coordinated care across multiple care settings and specialities (e.g., people with complex conditions) – identifying these people is critical to success.

- Financial benefits are difficult to measure and confirm.
Learning from evaluations of Vanguards and Pioneers

The maturity of the health and care system

The system’s incentives, especially financial, that reinforce behaviours supporting integration

Success with integrated care is multi-factorial and partly dependent on a number of factors:

Clarity about what is being integrated: services and ways of working v. delivery systems and cross-organisational working

Prioritisation of personalisation and co-production as drivers of change
Lessons about measurement challenges from Vanguards evaluation:

- Only a small number of core metrics were used for the Vanguards evaluation nationally: total bed days, emergency admissions, now also emergency bed days.
- Meaningful aggregation of data at system level is difficult because care and care processes vary across small areas, such as GP practice level, neighbourhoods or localities.
- National survey data about patient experiences is not timely or helpful.
- Cannot confirm causality of interventions in relation to core metrics.
- 100s of operational metrics being used, with some obvious clustering – but great variation in reliability.
- Lots of rapid cycle improvement tools are being used, no consistent approach.
- Collecting and analysing data for management information is useful for focusing on improvements at locality level.
Lessons about system maturity: EU SCIROCCO (Scaling Integrated Care in Context) maturity model:
Another study that created a framework model with 18 core indicators for assessing successful implementation of integrated care across Europe.

Focused on identifying core indicators in four areas:
- advancement of integration
- use of care services
- health outcomes
- experiences of care and quality of life.

Project includes a proposed model to monitor and assess the allocation of funds and how it is linked to the performance of the integrated care initiative, and thus provide a financial evaluation to inform future expenditure decisions.
SUSTAIN Project (EU – underway)

- “Sustainable tailored integrated care for older people in Europe” – 7 countries, people living at home with multiple health and social care needs (including two sites in UK)

- How to transfer successful initiatives to other regions and health systems? (knowledge transfer)

- Focus on four areas: person-centredness, prevention approach, safety and efficiency

- Data for improvement, using embedded case study approach

- Developing new and using validated tools, such as P3C-EQ, Team Inventory Climate (TCI-14),
  - https://www.iijic.org/articles/10.5334/iijic.3090/#T3
Overarching framework we might use

Better personal experience of care

- System capacity and use of resources
- Continuity of care
- Coordination of care
- Proactive model of care (use of services)

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Which improvements are likely to accelerate integrated care?

1. Processes and activities that focus on care coordination and continuity out of hospital (community settings, at home, involving primary care and preventative services)

2. Processes and activities that focus on care coordination and continuity during transitions of care

3. System capacity and capability: eliminating specific barriers to integration
What are the change concepts associated with integrated care?

Laying the foundations
- Leadership
- Strategy and resources
- Digital records

Building relationships
- Involving patients/carers
- Team-based care

Changing care delivery
- Patient-centred care
- Proactive, “Right Care”

Reducing barriers to care
- Care coordination
- Enhanced access 24/7

Adapted from Patient-Centred Medical Home, MacColl Center for Healthcare Innovation
Minkman’s Development Model for Integrated Care (2016)
Improvement data collected in real time

- **Act**
  - What’s Next?
  - Ready to implement?
  - Try something else?
  - Next cycle?

- **Plan**
  - What will happen if we try something different?
  - What is our objective in this cycle?
  - What questions do we want to ask and what are our predictions?
  - Who will carry this out? (Who?)
  - When? How? Where?

- **Study**
  - Did it work?
  - Complete data analysis
  - Compare results to your predictions
  - Summarise your results

- **Do**
  - Let’s try it!
  - Carry out your plan
  - Document any problems
  - Begin data analysis

The process is cyclical, with the cycle starting again after each step. There are three cycles shown at the bottom, indicating the iterative nature of the process.
BCF Guide still relevant

*How to...* understand and measure impact

May 2015

The Better Care Fund

ISSUE 04

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What are the sources of data, their benefits and limitations

<table>
<thead>
<tr>
<th>Source of data</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>National datasets and surveys (NHS Digital)</td>
<td>Collected and reported already (no additional burden or costs)</td>
<td>Not timely or focused on people receiving integrated care</td>
</tr>
<tr>
<td></td>
<td>Metrics are understood and already used to judge system performance</td>
<td>System measures = acute care outcomes with multiple influences</td>
</tr>
<tr>
<td></td>
<td>Health indicators</td>
<td>Metrics not assessing integrated care <em>per se</em></td>
</tr>
<tr>
<td>Local indicators, drawn from validated tools and instruments</td>
<td>Programme or project-based, often qualitative</td>
<td>Requires collection of data locally</td>
</tr>
<tr>
<td></td>
<td>Most useful for testing interventions and making improvements</td>
<td>Aggregation challenges (not scalable)</td>
</tr>
<tr>
<td></td>
<td>Includes process measures</td>
<td>Problems with determining causality</td>
</tr>
</tbody>
</table>
Measuring system enablers/ foundations for integrated care

Assessing system enablers helps you understand what is working and what might be getting in the way.

- Self assessment tools like LGA’s “Stepping up to the plate” and SCIROCCO
- Relationship audit (CQC local area reviews)
- High impact changes
- Digital maturity audit
Measuring care coordination and joint working

Improving care coordination, especially for MDTs, requires building relationships and changing the way care is delivered. Successful joint working can be assessed by looking at skills and knowledge, effective communication, trust and behaviour change. We can also assess how well organisational support and infrastructure support team working.

- Many team development tools are available, but usually associated with external support.
- TCI-14 (Team Effectiveness Tool, being used by SUSTAIN)
- P3C-OCT (organisational tool, supports practice development, also being tested with SUSTAIN)
Measuring user experiences

Assessing patient experiences is an emerging field of metrics, with data mostly captured through surveys. National survey data may not be specific enough to the groups experiencing integrated care.

- P3C-EQ (experiences with person-centred coordinated care)
- CTM (care transitions)
- Carer Experience Scale
- Patient Activation Measures (knowledge, skills and motivation for self-management)
- PACIC/ACIC (designed in US, measuring experiences of patients with chronic care needs, instrument has been adapted for other health systems)
In the tabs above, we have produced shortlists of example measures in a range of categories.

In the turquoise tabs, we highlight the measures for person-centred coordinated care - "P3C" measures. First, there is a tab for "generic P3C" measures - i.e. measures that have a good coverage of most person-centred domains. Next, we have tabs in different domains of person-centred care, in categories that correspond to the National Voices "I" Statements.
Clinical Practice Change

PACIC Survey

In defining six aims for transforming healthcare in America, the Institute of Medicine Quality Chasm Report declared "patient centeredness" a central feature of quality, along with safety, promptness, effectiveness, efficiency and equity. Patient centeredness may be a first principle that can provide a lens to focus action, and as such be used as the guide for achieving all six aims.

Historically, patient centeredness has been regarded as the assessment of needs and preferences to consider social and cultural factors affecting the clinical encounter or compliance with treatment. There is a growing consensus that patients have a more active role to play in defining and reforming healthcare, particularly in chronic disease management, where patients provide the majority of care in day-to-day management of their illness.

Two versions: The 20-item PACIC and the 26-item PACIC+

The Patient Assessment of Care for Chronic Conditions (PACIC) measures specific actions or qualities of care, congruent with the CCM, that patients report they have experienced in the delivery system. The survey includes 20 items, and should be sufficiently brief to use in many settings. When paired with the ACIC, these tools can provide complementary consumer and provider assessments of important aspects of care for chronic illness patients. The results of our validation study of the PACIC were published in 2005.

- Patient Assessment of Care for Chronic Conditions (PACIC, 20 items)

The Patient Assessment of Care for Chronic Conditions+ (PACIC+, 26 items) includes the same 20 items as the PACIC but adds six items to the original instrument. The items are derived from the 'SAs' model (ask, advise, agree, assist, and arrange), a patient-centered model of behavioral counseling that is congruent with the CCM and has been frequently used to enhance self-management support and linkages to community resources. The PACIC+ combines these with existing PACIC items, thus permitting scoring of five-item subscales on delivery of each of the 'SAs', as well as an overall 'SAs' score.

- Patient Assessment of Care for Chronic Conditions+ (PACIC+, 26 items)
### Further Resources: Sample of Tools

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measurement tools (free)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enablers</td>
<td>Stepping up to the Plate readiness tool (LGA)</td>
</tr>
<tr>
<td></td>
<td>SCIROCCO self-assessment tool</td>
</tr>
<tr>
<td>People’s experiences</td>
<td>P3C-EQ (SW AHSN and Plymouth Univ)</td>
</tr>
<tr>
<td></td>
<td>Patient Activation Measure (through NHSE)</td>
</tr>
<tr>
<td></td>
<td>CTM-15 (caretransitions.org)</td>
</tr>
<tr>
<td></td>
<td>Carer Experience Scale</td>
</tr>
<tr>
<td>Services and processes</td>
<td>TCI-14 (team effectiveness tool – see p3c.org)</td>
</tr>
<tr>
<td></td>
<td>P3C-OCT (organisational tool - see p3c.org)</td>
</tr>
<tr>
<td></td>
<td>Development tools (eg HSMC at Birmingham)</td>
</tr>
<tr>
<td>System effects</td>
<td>Outcomes Frameworks (NHS Digital)</td>
</tr>
<tr>
<td></td>
<td>“Best Use of Resources” methodology</td>
</tr>
<tr>
<td>Overall tools – maturity levels, geared towards improvement</td>
<td>ACIC 3.5 (MacColl Inst for Healthcare Innovation)</td>
</tr>
<tr>
<td></td>
<td>Primary Care Home (MacColl Inst)</td>
</tr>
<tr>
<td></td>
<td>CHAFEA (EU) ICPA</td>
</tr>
</tbody>
</table>
Value for money

- Can we determine if local integrated care arrangements are value for money?

- Evidence from international studies suggest savings are highly dependent on providing services to people who are most likely to benefit from them (people with high chronic care needs).

- Best estimate is 6-7% savings in hospital spend (Geisinger study) after several years of their programme for chronic care.

- Admissions avoidance is hard to record; need to look at the trends for the target population group.
Potential metrics

- Some of the integrated care Vanguards demonstrated good performance in reducing emergency admissions; now looking at emergency bed days (admission +1 or +2) as better indicator.

- The care home Vanguard in East London showed a reduction of 36% in emergency admissions, and bed days following emergency admission fell 53%.

- Other hospital data: emergency admissions, unplanned care, bed days, LOS and delayed transfers of care

- Potential data: readmission rates, pharma costs
Questions to think about…

- What is our local integration ambition?
- What is our model of care? What are our interventions?
- What are the outcomes and impact we want to achieve – for service users, local services, system?
- What can we measure to know we’re improving?
- How can we use metrics to encourage or accelerate service and system changes?
- Can we create our own local scorecard to enable us to track progress?
Building your own dashboard

- Be clear about what you’re measuring and why: do your own logic model.

- Use metrics that are understood by – and meaningful to - the people responsible for leading and delivering the changes.

- Metrics should also be meaningful to service users.

- Less is more, but remember: “What gets measured gets done.”

- In addition to being meaningful, data must be easy to collect, reliable, affordable and readily available (real time, if possible).
Approaches for local metrics

- Refer to the logic model, refine over time
- Use agile approaches, continuous quality improvement cycles
  - “Small tests of change”
  - ”Do and build”
- Measure outputs, good outcomes and poor outcomes (adverse events, eg falls)
- Monitor improvements over time
What standard of data/evidence is needed?

Level 1
You can describe what you do and why it matters, logically, coherently and convincingly

Level 2
You capture data that shows positive change, but you cannot confirm you caused this

Level 3
You can demonstrate causality using a control or comparison group

Level 4
You have one or independent replication evaluations that confirms these conclusions

Level 5
You have manuals, systems and procedures to ensure consistent replication

NESTA [2015]. Using research evidence: a practice guide
# Balance hard and soft metrics (example)

<table>
<thead>
<tr>
<th>Service users, carers and their experiences</th>
<th>Quality of services and service delivery</th>
<th>System effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experiences of care planning, coordination</td>
<td>Team working experiences (MDTs) for care planning and coordination</td>
<td>Reduced rates of emergency admissions <em>for target population</em></td>
</tr>
<tr>
<td>Experiences at transfers of care</td>
<td>Smooth transfers of care</td>
<td>LOS and readmission rates are lower</td>
</tr>
<tr>
<td>Personalised – better health and quality of life</td>
<td>Quality of specific integrated services</td>
<td>Prevention (eg falls)</td>
</tr>
</tbody>
</table>

## System enablers: what is working and what might be getting in the way

- Good access to resources for assessment, care planning and at discharge
- Data interoperability and good access to integrated service user records
- Staff training for MDT and other joint working
<table>
<thead>
<tr>
<th>Measure(s)</th>
<th>Key Measures of Success</th>
<th>Possible Indicator(s)/ evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased empowerment / ability to self-manage (patients)</td>
<td>Patients describe changes in their knowledge / ability to manage their condition(s) following introduction of MDT</td>
<td>Self reporting tools such as used by #HelloOurAimIs campaign</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Personal Social Impact Action Measurement System (PSIAMs)</td>
</tr>
<tr>
<td>Improved social / care outcomes (patients)</td>
<td>Change in % of patients reporting that their desired outcomes were achieved</td>
<td>Self reporting tools such as used by #HelloOurAimIs campaign</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PSIAMs</td>
</tr>
<tr>
<td>Improved Access to Services</td>
<td>People know where to go to get advice</td>
<td>GP access survey</td>
</tr>
<tr>
<td></td>
<td>People can get an appointment to see a GP when they need to</td>
<td>Patient experience reports drawing on F&amp;F data etc.</td>
</tr>
<tr>
<td>Care and support are person-centred:</td>
<td>People feel supported to attain their own health &amp; well-being goals: what matters to them</td>
<td>Care plans</td>
</tr>
<tr>
<td>personalised, coordinated, empowering</td>
<td>People’s experiences of:</td>
<td>Living review of people in MDT</td>
</tr>
<tr>
<td></td>
<td>• involvement in decisions,</td>
<td>Self reporting tools such as used by #HelloOurAimIs campaign</td>
</tr>
<tr>
<td></td>
<td>• control &amp; independence,</td>
<td>PSIAMs</td>
</tr>
<tr>
<td></td>
<td>• wellbeing,</td>
<td>OD and shared learning process with front-line staff to empower them to engage together and with the MCP</td>
</tr>
<tr>
<td></td>
<td>• confidence to manage,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• feeling supported</td>
<td></td>
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<tr>
<td></td>
<td>People’s reported access to personalised care and support planning</td>
<td></td>
</tr>
<tr>
<td></td>
<td>People’s experience of care coordination – including discharge &amp; transitions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Access to records and personal budgets</td>
<td></td>
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<tr>
<td></td>
<td>Care professionals’ knowledge, confidence &amp; skills in person centred approaches</td>
<td></td>
</tr>
</tbody>
</table>

Dudley MCP Vanguard indicators and metrics for person-centred care
# Process Indicators

## EU Sustain and ACT@Scale Projects

<table>
<thead>
<tr>
<th>ACT@Scale</th>
<th>SELFIE</th>
<th>SUSTAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population coverage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td># Population stratified by the population tool</td>
<td>Example frail elderly: % patient with an individual care plan</td>
<td>Person centeredness</td>
</tr>
<tr>
<td># stratification levels</td>
<td>% patients discussed in a multi-disciplinary team meeting</td>
<td># users with needs assessment</td>
</tr>
<tr>
<td># Population per risk stratum</td>
<td>% patients actually present themselves during a multi-disciplinary team meeting</td>
<td># care plans with activities (being) actioned</td>
</tr>
<tr>
<td># Target population (size)</td>
<td></td>
<td># care plans shared across profs</td>
</tr>
<tr>
<td># Population served (size)</td>
<td></td>
<td># care plans shared across orgs</td>
</tr>
<tr>
<td># Population diagnosed with target disease (size)</td>
<td></td>
<td># carers with a needs assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td># carers with a care plan</td>
</tr>
<tr>
<td><strong>Prevention orientation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td># users receiving medication review</td>
<td># users receiving med adherence advice</td>
</tr>
<tr>
<td></td>
<td></td>
<td># users receiving self-man advice</td>
</tr>
<tr>
<td><strong>Safety</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td># users receiving safety advice (eg falls)</td>
<td># users with falls recorded in care plan</td>
</tr>
</tbody>
</table>

**Additional process indicators**
- Change and stakeholder management
- Service selection
- Business models and sustainability
- Citizen empowerment
## ICPA core indicators (EU – CHAFEA)

<table>
<thead>
<tr>
<th>Domain</th>
<th>Indicators</th>
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</thead>
<tbody>
<tr>
<td>Advancement of integration</td>
<td>• Personalised plans&lt;br&gt;• Shared care plans&lt;br&gt;• Alignment of resources to population needs&lt;br&gt;• Take-up of case management&lt;br&gt;• Quality of case management&lt;br&gt;• Take-up of multi-disciplinary training</td>
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<tr>
<td>Use of Care Services</td>
<td>• Home and/or community-based long-term services and support&lt;br&gt;• Coordinated transitions across continuum of care&lt;br&gt;• Medication review in patients receiving multiple and/or long term medication</td>
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<tr>
<td>Health outcomes</td>
<td>• Improved level of independence in patients with identified impairment&lt;br&gt;• Patient reported outcomes measures (PROMS)</td>
</tr>
<tr>
<td>Patient experiences of care</td>
<td>• Level of met needs among people receiving care&lt;br&gt;• Satisfaction with the level of social contact&lt;br&gt;• Carers quality of life&lt;br&gt;• Quality of life for people receiving care&lt;br&gt;• Experience of case management&lt;br&gt;• Inclusion of carers</td>
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</table>
PCHs have been successful in releasing a range of benefits for patients, staff, practices and the wider system

<table>
<thead>
<tr>
<th>Pilot Site Example Benefits</th>
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<tbody>
<tr>
<td><strong>A&amp;E Attendances</strong></td>
</tr>
<tr>
<td>▶ £27k of savings each year enabled by providing extended primary care access in Thanet</td>
</tr>
<tr>
<td><strong>A&amp;E Admissions</strong></td>
</tr>
<tr>
<td>▶ £295k of savings from reductions in A&amp;E admission driven by Thanet Health</td>
</tr>
<tr>
<td><strong>GP Referrals</strong></td>
</tr>
<tr>
<td>▶ 330 GP referrals to hospital avoided given a slowdown in the growth rate demonstrated by Beacon Medical Group</td>
</tr>
<tr>
<td><strong>Prescribing Costs</strong></td>
</tr>
<tr>
<td>▶ £220k of prescribing savings demonstrated by Larwood and Bawtry</td>
</tr>
<tr>
<td><strong>Staff Satisfaction</strong></td>
</tr>
<tr>
<td>▶ 67% of staff surveyed felt that PCH had improved their job satisfaction</td>
</tr>
<tr>
<td><strong>Utilisation</strong></td>
</tr>
<tr>
<td>▶ 78% of staff felt PCH had decreased or not added to their workload</td>
</tr>
<tr>
<td><strong>Staff Retention</strong></td>
</tr>
<tr>
<td>▶ 86% of staff regarded Beacon Medical Group as a good employer</td>
</tr>
<tr>
<td><strong>Patient Experience</strong></td>
</tr>
<tr>
<td>▶ 82% of staff felt that PCH had improved patient experience</td>
</tr>
<tr>
<td><strong>GP Waiting Time</strong></td>
</tr>
<tr>
<td>▶ 6 day reduction in the average time patients wait to see their GP</td>
</tr>
<tr>
<td><strong>Population Health</strong></td>
</tr>
<tr>
<td>▶ 13% increase in flu vaccinations for patients with COPD registered with Beacon Medical Group</td>
</tr>
<tr>
<td><strong>Length of Stay</strong></td>
</tr>
<tr>
<td>▶ 8 day reduction for admitted care home residents registered with Beacon Medical Group</td>
</tr>
</tbody>
</table>
More about the SCIE Logic Model

From SCIE’s website:


Further resources and tools: links online


- Measures for Person-Centred Coordinated Care: [http://p3c.org.uk/](http://p3c.org.uk/) (SW AHSN, Plymouth University)


QUESTIONS AND DISCUSSION
Contact for further information

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