Developing an integration scorecard: A model for understanding and measuring progress towards health and social care integration
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• supporting people who plan, commission, deliver and use services to put that knowledge into practice
• informing, influencing and inspiring the direction of future practice and policy.
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Executive summary

A national policy objective over many years has been the integration of health, social care and related services. Expected to deliver improvements in care and support, along with better experiences and outcomes, in recent times this objective has been pursued through initiatives such as integration pilot schemes, the New Models of Care Programme and the Better Care Fund. Underpinned by a government intention that by 2020 integration should be achieved across the country, discussions began on how progress could be best measured, monitored and shared to help encourage and embed integrated approaches in very different local environments.

Research and consultation carried out in 2016 by the Social Care Institute for Excellence (SCIE) for the Department of Health (DH) concluded that an Integration Standard and associated metrics should be driven by people’s experiences and outcomes, and that it should include a focus on leadership and partnership approaches as well as the processes leading to integration of services and care. In its Integration and Better Care Fund Policy Framework (March 2017), the Government confirmed its plans to develop a wider integration scorecard incorporating these points. Other recent developments in respect of the integration agenda have been the use of a performance dashboard with metrics centred on the health/social care interface (July 2017), and the start of DH commissioned Care Quality Commission system reviews in areas defined as having particular issues around Delayed Transfers of Care (September 2017).

In April 2017 SCIE was asked to carry out further research. Comprising additional desk and case study-based research and engagement with service users, carers and other stakeholders through interviews and workshops, the aims were to:

- develop an overarching framework, building on the original Integration Standard, that would help local areas understand what good integration looks like
- test and build a draft set of integration metrics that would underpin this framework, and help local areas measure whole system performance towards the ambition of full integration.

Creating a framework for integration: Use of a logic model

We created an overarching framework for integration by building a ‘logic model’, an approach adapted from social science evaluation methodologies. Our resulting model would be a visual depiction for how a fully integrated health and care system might be structured and function, and the outcomes and benefits it should deliver for those who use services and their carers. By presenting the whole system in this way, the logic model seeks to describe ‘what good looks like’ and moves firmly away from the limitations of the original Integration Standard, which focused more on structural changes. After agreeing the model’s content, we could then select a set of metrics; particularly those linked to the integration outcomes. These metrics would help to measure local progress towards integration and to support improvement ambitions.
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The draft logic model was tested and refined through the research and stakeholder engagement. Some key feedback on the first and second iterations of the logic model, gathered in stakeholder workshops and other mechanisms, was:

- Ensuring that the overall vision of ‘Right care, right place, right time’ would drive the content of the model.
- How the model could incorporate a mix of national ‘must do’s’ as well as local priorities, and be helpful at levels from national to Health and Wellbeing Board.
- How the model could be adaptable to change, including the advent of new care models, variation in local health and care delivery systems, and policy emphasis on, for example, more personalised and assets-based approaches to the planning and delivery of care.
- The benefits of clearer delineation of the enablers of integration, the components of integration, and its outcomes and impacts.

Further refinements to the model in response to feedback included a greater focus on the integrated care workforce, system relationships, technology-enabled care, and the transparency of budgets across the system. Overall, the stakeholders saw the model as providing a helpful ‘on a page’ visualisation of what good system-wide integration arrangements should look like and what they should help achieve. Stakeholders also commented that the model should not be linked to any specific deadline, such as Integration by 2020. The achievement of fully joined-up care was viewed as a journey, one best judged by better care outcomes rather than a fixed end point. The model could serve as a useful framework for local planning, performance monitoring and improvement activity. In recognition of this positive response to using the model, we suggest it is ready for publication and dissemination, as set out on page 11.

Developing the supporting metrics

In creating an initial shortlist of metrics to support the emerging logic model, we were especially mindful of the need to avoid the burden of new data collection. We took into account the range of detailed work already completed or ongoing regarding integration measurement. In addition, we worked to a set of criteria including ease of gathering and collation, whole systems focus, a balance of qualitative and quantitative, reliability, validity, avoidance of perverse incentives, and how far the metric would align with and support decision-making processes.

The range of feedback set out in this report demonstrates the complexity of establishing a set of system-wide metrics acceptable and useful to different audiences, and of providing a real sense of progress toward integration objectives in very different environments. However, there was a considerable amount of support for an approach that balances pragmatism (i.e. focusing on what’s currently collected) with the need for ambition (i.e. thinking about possible future metrics and mechanisms for gathering). We also found perceived benefits to be derived from bringing together data from disparate parts of the system into a single place to support more transparent and focused ways of working. Discussions were motivated by how best to gather important data, for example on:
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- people’s experiences of/satisfaction with transfers of care
- experiences and outcomes of self-directed support
- delivery and effectiveness of preventive care in communities
- the difference integrated services make in terms of experiences and outcomes.

This report includes a list of currently proposed metrics, identifying their source, the outcome they relate to, and perceived strengths and weaknesses. They are, however, best viewed as work in progress, with the more developed integration logic model remaining the starting point and framework for continuing work. We believe the next step should be pilot testing draft metrics in a sample of local areas, and focusing on how metrics align with what is known about performance, how they complement other means of measurement, and how they support improvement action, ongoing self-assessment, and well-informed comparison with other localities.

Recommendations

In summary, our key recommendations are therefore:

- In recognition of its positive reception to date, to publish and disseminate the integration logic model as a tool for supporting health and social care integration efforts in local areas.
- To conduct further research, testing and evaluation of the metrics before they are used nationally.
- To position the logic model and supporting metrics (further developed) as a recognised framework for supporting improvement and signposting people to useful resources.

We are, finally, grateful to the wide range of service users, carers and wider stakeholders for the range of insights, perspectives and advice we have received during this project.
1. Introduction: The policy context for the Integration Scorecard

The integration of health and social care services has been a policy goal for years, not least for the present Government, which continues to be committed to bringing health, social care, housing and other public services together to deliver better quality care and support, believing that: ‘More joined-up services help improve the health and care of local populations and may make more efficient use of available resources.’ With the ambition laudable, the purpose and principles of integration have received support from across the political parties.

Making integration a reality continues to be a challenge, however, even with the recent investment in pilot schemes (the Pioneers), the New Models of Care Programme and through the Better Care Fund (BCF). Competing national policies, disparate funding sources, local priorities and other factors have delayed progress in some local areas. The recent report by the National Audit Office on the Government’s strategy on integrated care described in detail the challenges being faced by local areas in making progress. Nonetheless, good practice is emerging, and evidence suggests many localities are indeed making considerable progress.

National policymakers are eager to measure and monitor this progress in order to help encourage and embed integrated approaches, over and above how such progress is currently measured through the BCF. In spring 2016, on the back of a Spending Review which set out a plan ‘that by 2020 health and social care are integrated across the country’, the Government developed an Integration Standard with associated metrics with the aim of enabling each area to measure its progress toward integration. The Integration Standard focused on a small number of interventions intended to facilitate integration.

Following the announcement of this ambition, in June 2016 the Department of Health (DH) asked the Social Care Institute for Excellence (SCIE) to undertake scoping research and engagement to better understand what excellent integrated health and social care should look like in 2020; to test out the Integration Standard with national stakeholders and local areas; and to provide feedback and support for further development of the Standard. See the report for the DH, Integration 2020: Scoping research.

SCIE’s research concluded that while there was strong support for some kind of national framework that helped people understand what good integration looks like, the Integration Standard in its current form inadequately serves this purpose. In particular,

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3 Department for Communities and Local Government and Department of Health (2017) Integration and Better Care Fund Policy Framework 2017–19.

4 The Integration Standard set out to measure the following: 1) Digital interoperability; 2) Resources targeted at a high-risk cohort to prevent crises and maintain wellbeing; 3) Value for money; 4) Single
we found that while the Standard identified helpful integration activities such as risk stratification, multi-disciplinary community teams and data sharing across providers, overall it was considered too process-orientated and failed to capture a vision of the ‘whole system’, i.e. what a good integrated system should look like and be aiming for:

[The Integration Standard] is too focused on health and the acute sector in particular – it needs to focus on “the whole system” including primary, community and social care.

In particular, outcomes for service users and carers were missing, and the Integration Standard also overlooked the significance of strong local leadership and partnership working as key drivers of local integration efforts. Most important, clear links needed to be established between what good integration looks like and how progress should be measured.

In its Integration and Better Care Fund Policy Framework, published in March 2017, the Government confirmed its plans to develop a wider integration scorecard – which would now combine outcome metrics, user experience and process measures – to help areas understand whether they are meeting its integration ambition, especially at the interface between health and social care. Policymakers have not yet agreed decisions about how the scorecard will be used to judge or inform system performance.

In a separate but related development, in July 2017 the DH published a new performance dashboard showing how health and social care partners in every local authority area in England are performing at this interface. The dashboard focuses on acute sector-related metrics, including Delayed Transfers of Care, emergency admissions, length of stay in hospital, and the number of people still at home 90 days after being discharged from hospital. This dashboard is expected to be incorporated into the integration scorecard, but is not intended to measure how well local areas are progressing with full integration.

At the same time as the new performance dashboard was published, the CQC was asked by the Secretaries of State for Health and for Communities and Local Government to undertake a programme of local system reviews of health and social care in 12 local authority areas. These reviews, exercised under the Secretaries of State's Section 48 powers, will include a review of commissioning across the interface of health and social care and an assessment of the governance in place for the management of resources. They will look specifically at how people move between health and social care, including Delayed Transfers of Care, with a particular focus on people over 65 years old. The first review report is now published with more to follow, and the review process as a whole is likely to provide powerful learning about how local services are working together and how improvement can be measured across the system.

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2. Methodology

In April 2017 SCIE was asked to carry out further research and stakeholder engagement:

- to develop an overarching framework, building on the original Integration Standard, that would help local areas understand what good integration looks like
- to test and build a draft set of integration metrics that would underpin this framework, and help local areas measure whole system performance towards the ambition of full integration.

This work has involved a combination of desk research, in-depth case study work in three local areas, interviews with experts in integrated care and a workshop with policy stakeholders, and two national and regional workshops with stakeholders from across health, social care and housing, and patients, service users and carers.

Early in this second phase of work (building on the Scoping Research), a logic model was developed to create a picture of how a fully integrated health and care system is structured, the changes it will create and how it will function, and the outcomes and benefits it is expected to deliver for service users, health and care services, and the wider health and care system itself. More information about the logic model and its development process is provided in Section 3 below. Underpinned by the research evidence, the logic model would be tested and refined with stakeholder input.

The integration metrics would be developed directly from the logic model, particularly the desired outcomes, and these would also be tested and refined with stakeholder feedback. A long list of available metrics was compiled and then shortlisted with a set of criteria, looking at both the technical quality of the data and its robustness in measuring factors associated with integration. For instance, we reviewed the strength of existing evidence underpinning each metric, and data validity and reliability, availability and feasibility of collection through existing datasets. We also sought to avoid metrics that would encourage perverse incentives. Critically, the metrics needed to align with the outcomes described in the logic model. Combined, the final set of proposed metrics would provide sufficient information to understand the progress of local areas towards integration and support efforts for improvement. More information about the process of identifying and deciding the metrics is provided in Section 3 below.
3. Understanding and measuring integration

Creating the logic model

Our rationale for choosing a logic model was to create an understandable framework for what good looks like and to propose a set of metrics for measuring progress towards integration. It was also suggested that a logic model would help us capture some of the additional complexity of how an integrated system works and how it undergoes change, something not adequately captured by the original Integration Standard, which emphasised structural changes. Adapted from social science evaluation methods, the logic model is a useful tool for constructing a ‘theory of change’ for development programmes, enabling programme managers, researchers and evaluators to understand the purpose of their interventions and how those interventions will produce desired outputs and outcomes. The structure of a logic model is simple: it neatly lays out inputs and activities, as well as outputs and outcomes. From the logic model, it is possible to determine what can be measured and how. Logic models are now commonplace across health and social care and are used, for instance, as part of the New Models of Care Programme and Integrated Personal Commissioning. Indeed SCIE recommends they are used in social care to inform how progress on transforming care and support is planned and measured.⁶

Experience from other large-scale programmes suggests that having a clear logic model is one of the active components for successful change. Logic models can also be used as a planning tool, helping to clarify thinking and reduce the scope for programme failure owing to poor design and untested assumptions. (NHS England, 2015)⁷

The first draft of the logic model resulted in re-conceptualising integration not as a standard with a set of objectives but as a ‘whole system’ undergoing change. Similar logic models used in other initiatives, like the New Models of Care Programme, provided helpful templates and steer about our model’s content. From the emerging evidence about good practice, including the Think Local Act Personal and National Voices ‘I’ Statements⁸, ⁹, ¹⁰, research by the Kings Fund, Nuffield and other academics, we were able to set out in the resulting logic model how the different features of a good

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Integrated systems contribute to improved services and outcomes for service users, patients, and carers. The initial logic model articulated:

- the key enablers of integration
- the core interventions (each evidence-based, and reflecting the variation in approaches by local areas)
- the service user outcomes (short term) and impacts
- the impact on the health and social care system.

Obtaining feedback on the initial logic model: In July we held a workshop with policy stakeholders to refine the logic model, seeking detailed feedback particularly about the metrics associated with the model. Attendees included experts in integrated care from central government departments, regulators, the NHS, local government, and think tanks/research organisations. The workshop’s participants provided comments as well as specific responses to the model’s different components in four broad areas: 1) the model’s underlying logic, its scope and premises; 2) the utility of the model and its measures; 3) the model's versatility, adaptability and flexibility; and 4) the balance of metrics and how these might be used. The use of a logic model was welcomed and positively received by the policy stakeholders, although suggestions for how it could be improved were provided, including the following:

- The policy stakeholders thought the initial model’s trajectory suggested the purpose of integrating health and care is to reduce demand and limit expenditures in the acute care. Defining the system this way, however, was seen as too narrowly stipulated. Instead, there was a strong suggestion that the overall purpose is ‘Right care, right place, right time’, starting with the patient/service user, and that this should drive the underlying logic within the model.

- There was a need to clarify who the tool is for and its purpose, how it will be used and by whom, e.g. as a local self-assessment tool and/or as one for system monitoring, oversight and accountability. Could the model incorporate a mix of national ‘must do’s’ as well as local priorities? Could it work at different levels of the system (national, STP, CCG, or Health and Wellbeing Board area)?

- In what ways does the model incentivise progress towards integration? For instance, how can using this model help local health and care systems move towards joint accountability?

- The model should not be fixed but adaptable in recognition of a changing external and policy environment, especially with the advent of new care models and growing variation in local health and care delivery systems. Future adaptations are likely to be needed over time. Some asked how the model could accommodate the broad personalisation agenda, incorporating such initiatives as Integrated Personal Commissioning and asset-based approaches to providing health, care, and support.
Feedback on a second iteration of the logic model was received at two stakeholder events in September attended by professionals from across the health and social care system, the voluntary and community sector and central government, as well as service users. As presented at the workshops, the logic model now more clearly described:

- **Enablers of integration**: contextual factors that create the pre-conditions for integrated care. This includes 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. The list describes a menu of evidence-based options in recognition of the variation in local approaches.

- **Outcomes divided into three groupings**: for service users (people’s experience of care), 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: reflected the convention of the Triple Aim\(^\text{11}\) – improving health and wellbeing, enhancing quality and providing best value care.

Once again, stakeholders were largely very positive about the logic model, agreeing that it captured the main enablers, components and outcomes of integration. They appreciated the approach and could see how local areas would benefit from using it. The service user outcomes were regarded as an essential reminder of the importance of measuring the experience people have of integration; the stakeholders also welcomed the inclusion of an outcome relating specifically to carers. Many felt that the logic model provided a helpful ‘on a page’ visualisation of how the different components of integration fit together. Overall, the stakeholders welcomed the logic model as a useful tool and framework, suggesting it was a useful roadmap for local planning and performance monitoring and could easily be linked to a developing suite of support materials and resources.

A repeated theme at the workshops was the need for the logic model to be locally useful, and stakeholders proposed a range of ideas about how they might put it into practice. Stakeholders emphasised that integration activity necessarily varies from area to area and that there had to be some flexibility in how the logic model was applied. They highlighted a risk that the logic model could be used, mistakenly, to standardise practice to such a degree that it stifles innovation, although they recognised that this was not its intention.

Stakeholders also suggested that the logic model should not be linked to any specific timescale or end point date, such as Integration 2020. They argued that integration should be viewed as a journey, which can be achieved through a broad range of means,

\(^{11}\) NHS England (2014) *Five Year Forward View*. London: NHS England. With system sustainability aiming to address: 1) the health and wellbeing gap; 2) the care and quality gap; and 3) the funding and efficiency gap.
and not an end point in time. They certainly felt that we should not measure the achievement of integration by assessing the extent of structural change but rather by considering the achievement of outcomes.

Stakeholders commented that they would welcome greater clarity about the logic model in relation to the following themes:

- The logic and evidence underpinning the model, recognising that the evidence base is emergent. This will help in attributing the achievement of outcomes and impacts to integration activity.
- The intended footprint of the model, i.e. sustainability and transformation planning area, Health and Wellbeing Board area, etc.
- The intended populations to be covered by the logic model, summed up by the question ‘integrated care for whom?’ (Many people acknowledged that the model focused on older people, but they were keen for it to be useful for mental health users, people with learning disabilities, other chronic conditions, and so forth.)
- The timeframe around the model – does it reflect where local areas should be by 2020 or is it a longer-term vision?
- How the logic model and metrics will be future proofed – how often will the model and metrics be reviewed and revised?
- How the national challenges and barriers to achieving local integration are being, or will be, addressed.

Regarding improvements, the stakeholders identified a number of themes and/or groups which they felt could feature more prominently in the logic model, notably a focus on the integrated care workforce, system relationships, technology-enabled care, and the transparency of budgets across the system, with the idea of the ‘public pound’ driving integration efforts.

**The final logic model** incorporates the feedback from these two workshops. In addition to refining the outcomes, the content now includes a placeholder column for outputs, which would allow local areas to define, measure and track the products of local integration activities, such as the proportion of eligible people being supported for self-care, the number of people receiving personal budgets, etc. The stakeholder feedback confirmed that the logic model provides a helpful visualisation of a system-wide approach to integration, and that it has the potential to add real practical value in terms of a planning and improvement tool locally. It improves upon and moves firmly away from the original Integration Standard. In recognition of this positive response to using the model, we suggest it is ready for publication and dissemination.
Developing the metrics

Creating an initial shortlist of metrics: Following our desk research, and using the Integration Standard and our logic model as a framework, we pulled together a long list of possible metrics. In developing the metrics, we were especially mindful of avoiding creating a new burden of data collection for local areas. We took into consideration: existing datasets for measuring outcomes in health and social care; the considerable work already done by DH; metrics currently used or recently experimentally tested by the Better Care Fund and the New Models of Care (the Vanguards); and recent work by McKinsey’s looking at health and social care interface metrics on behalf of the Cabinet Office. Specific sources included:

- ‘Stepping Up To the Place’, produced in collaboration by the LGA, NHS Confederation, ADASS and NHS Clinical Commissioners
- PIRU indicators for measuring the quality of integrated care
- CQC’s work around the feasibility of tracking the user experience of integration
- the work of National Voices, TLAP and their partners on ‘I’ statements expressing user experiences
- DH local area performance metrics
- CQC local system reviews methodology
- Adult Social Care Outcome Framework (ASCOF), NHS Outcomes Framework (NHSOF), Public Health Outcomes Framework (PHOF), CCG Improvement & Assessment Framework

Appendix 1 includes a list of the integration metrics currently in use, along with their sources. In light of our earlier engagement for the Integration Standard, we were particularly keen to include metrics about user experience. This is an emerging but undeveloped field and not currently captured by these sources.

‘Neither the NHS nor adult social care can demonstrate, from people’s reports of their experience, that they are coordinating care around the person.’

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13 Local Government Association et al. (2016) Stepping up to the Place: The Key to Successful Health and Care Integration. London: NHS Confederation.
Our goal was to identify metrics that linked specifically to the outcomes of the logic model, while recognising that not all outcomes could presently be measured, and, at best, some could be measured by proxy. A set of criteria\(^\text{19}\) broadly informed the shortlisting choices that produced a manageable number. The metrics were individually assessed for:

- how well they reflected whole system performance or important aspects of the system
- relevance to delivering integrated health and social care
- validity (the data measure what they are intended to measure)
- accuracy (the quality of data)
- reliability (the consistency of data)
- feasibility (ease of data collection and reporting)
- meaningfulness (level of insights and ability to action on insights)
- implications for action (they support decision-makers to make better decisions)
- avoidance of perverse incentives (measures cannot easily be manipulated and they produce no adverse effects).

**Feedback on the initial set of metrics** at the July policymakers’ workshop was mixed. Although there was agreement that the metrics should include both quantitative and qualitative measures, there was no consensus on the right mix or number of measures. Ideally the model should enable measurement of progress over time. The feedback strongly recommended that the metrics align with other assurance systems, rather than require unique data collection. Having a manageable number of metrics was suggested, along with striking a good balance between:

- quantitative and qualitative measures
- core national and local measures
- measures that show progress and those that demonstrate attainment of specific outcomes or standards.

Participants further commented that it is difficult to measure certain desirable outcomes and impacts, such as reduced demand or admissions avoided. Some suggested that the metrics selected should focus on positive interventions and behaviours because the act of measurement shines a spotlight on these as priorities.

The group recognised that there are challenges to measuring ‘soft’ metrics like leadership and culture, as well as service user experiences. For instance, qualitative measures for service user outcomes require additional research and testing. Qualitative workforce measures also need further development, such as how well staff are working together on joint care planning and delivery. Moreover, in recognition of the variability of integrated systems, the core interventions and enablers are more likely to be locally determined and will have local measures and targets. In developing the metrics and

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collecting data, several workshop participants pointed out that knowledge continues to emerge and other agencies and research organisations are undertaking relevant work, such as re-designing patient and staff surveys, or ongoing research to develop robust measures about user and carer experiences.

**Refining the metrics with stakeholder feedback:** As we refined the logic model, we also refined the metrics. The metrics were selected and placed into three groups, reflecting the revised outcomes in the logic model: people’s experience of care, health and care services, and whole system performance. We explicitly identified where there were gaps in our ability to measure selected outcomes. We also identified a handful of metrics to develop in the short and long term. A copy of the workshop discussion paper is attached at Appendix 2.

In refining the list of metrics, it was apparent that the available metrics were predominantly health or NHS-centric, reflecting the existing data collection methods and preferences of the current system. In addition, the existing measures varied greatly in terms of their timing and rigour, and tended to measure what has happening within services and locational silos, rather than measuring how services are working together. Other important caveats include:

- Many metrics are proxy measures for the desired outcomes in the logic model.
- Metrics are not uniformly collected; some are reported with regular frequency but with different timescales, while others are from periodic surveys; the closest to real-time information is from hospital episode statistics.
- Attribution is indirect for a number of the metrics; multifactorial causes lead to many of the outcomes, rather than a single measure.
- Many of the metrics are measuring failure to achieve outcomes, rather than the more positive, desired outcomes themselves; this is especially apparent for the hospital metrics.
- The bias towards hospital metrics is real and limits our ability to monitor and measure a whole system of changes.
- Experience data for service users and carers is of limited value and should also be regarded as proxy because direct user experience with integrated services is not captured.

Feedback from September’s stakeholder workshops was insightful and invaluable in suggesting a number of further refinements. The stakeholders recognised the sizeable challenge in compiling a list of existing metrics that would say something meaningful about integration. There was general support for an approach that balances pragmatism (i.e. focusing on what’s currently collected) with ambition (i.e. thinking about possible future metrics, revising current national surveys to better capture integration, and/or creating new metrics if needed).

In addition to the caveats cited above, the stakeholders made a number of general points about the limitations of the metrics:
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- Most of the metrics are collected and reported too infrequently to be useful for local planning and improvement activity. Collecting real-time feedback from patients/service users and having data at a sufficiently detailed level (by age group, hospital, type of service received, locality, etc.) are essential to understanding where problems lie and how they should be proactively addressed. On their own, each metric has limitations, for example source, frequency of collection and sampling concerns. In revising the metrics, we need to be more specific about identifying the populations and/or services to which each metric refers.

- Movement in metrics could be caused by a variety of factors, some of which are outside the control of the local system. Some of the attribution problems in the logic model could be compounded by the metrics selected, particularly proxy metrics.

- Outcome and impact metrics should be interpreted with reference to how a local area is doing in relation to the enablers and key components of integration.

Despite the perceived limitations of the metrics, some felt that there was significant value in bringing together data from disparate parts of the system into a single place to support a more transparent way of working. There was also a groundswell of support for the view that, due to the limitations described previously, some metrics may need to be derived locally to get a true picture of what was happening in an area. As one stakeholder put it:

> If these metrics are the best we can do, then we need to be really honest about what each can and can’t tell us about integration…and use qualitative evidence and locally relevant data to plug gaps.

Detailed comments were received about each of the three sets of metrics. This feedback and additional research led us to refine the metrics further. Specific gaps were identified in the feedback, such as the absence of a way to measure people’s experience of care in a systematic and standardised way, despite the existence of ‘I’ statements for several years. Stakeholders generally welcomed the inclusion of quality of life metrics and a carer-related metric, but commented on the limitations of the data collection methods, in particular the GP survey, which is limited to a self-selecting group of people.

They identified a number of gaps and/or themes that could feature more prominently, namely:

- people’s experiences of/satisfaction with transfers of care
- self-management
- delivery of integrated preventative care in communities
• how different services are sharing/using each other’s care plans to provide an integrated service in the absence of integrated IT
• patient choice over their care.

For the integrated services metrics, stakeholders understood why they had been chosen, but felt that they were insufficient on their own. They welcomed the suggested possible future metrics relating to amendments to the staff survey, and the effectiveness of reablement. Workforce capacity as well as capability should be measured. How we measure the quality of integrated services is also not well established.

Stakeholders remained concerned that the metrics are biased towards the healthcare system. Integration with community services and an asset-based approach need to feature more prominently. A greater emphasis on prevention and early intervention was also suggested, i.e. metrics that focus on what is happening early in the pathway rather than at the end. The gaps in terms of other services, such as mental health and intermediate care, were also noted.

• The system metrics were familiar to many stakeholders. A repeated comment related to the feasibility of identifying metrics that measured a system’s successes rather than its perceived failures. Some stakeholders also observed that many of the metrics relate to the 65+ age group, and that it would be helpful to extract this data for higher risk patients, e.g. 75+ and/or 85+ age groups.
• Stakeholders were generally supportive of the other potential metrics suggested: the effectiveness of working relationships in the system, length of stay for emergency admissions and capacity metrics relating to different sectors. They made their own suggestions, although there was debate about how useful/feasible some of these would be:
  • Total and/or proportion of spend on hospitals compared to community services, tracked over time.
  • Workforce capacity such as vacancy and turnover rates, or community nurses per capita, as a proxy for staff satisfaction.
  • Proportion of inpatient discharges before midday.
  • Public health measures such as life expectancy or early mortality.
  • Admissions to long-term residential care and length of stay.

Finally, the stakeholders welcomed further research and testing of the metrics to better understand their usefulness as both a performance and improvement tool. For instance, they asked for clarity from the DH about whether some of the metrics would be weighted more heavily than others. They wondered whether any of the metrics could be used to incentivise integration. Since local areas are asked to collect a whole range of metrics for different purposes, they also wondered if progress towards integration might

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20 Future metric around revisions to the staff survey to address: (1) care coordination and joint working; (2) access to shared records and joint resources; and (3) support for personalisation.
enable them to collect only those metrics that mattered the most, dropping others that were found to be less meaningful for integration.

The proposed set of metrics

The list of metrics for the balanced scorecard should be viewed as a work in progress because of the caveats and feedback described above. **Fundamentally, our starting point is the logic model itself.** Using this, we have identified which outcomes each metric relates to, along with its source and relative strengths and weaknesses. Where metrics are proxy measures, these are noted, and important gaps are identified. In addition, we are aware that some of the metrics are highly sensitive and high profile, especially Delayed Transfers of Care but also emergency admissions and readmissions. There is a suggestion that continuing to emphasise these hospital-centric metrics over the whole set could raise doubts about the purpose of the scorecard and limit its acceptance by local areas as a tool for understanding how services are integrating and how local systems are changing.

The next step ought to be pilot testing these metrics with existing performance data. We suggest taking a sample of local areas, selecting a range of areas considered good, average or performing less well and evaluating questions such as: Do the metrics align with or confirm what we know about each area? Or, do they present a different picture, and if so what does this tell us about measuring progress towards integration? In addition, we suggest holding discussions with stakeholders in local areas to confirm whether the metrics enable them to self-assess their progress, to identify what’s working and to ascertain where attention and support are required. In this way, local areas can help us assess whether a blended approach to metrics is possible, namely combining local metrics with the proposed set to provide a well-rounded picture of local progress. We would be keen to discover which local metrics areas find useful, and whether these could be replicated for use more widely.

The proposed metrics follow, grouped by theme and with their specific strengths and weaknesses identified. A glossary of source abbreviations can be found in Appendix 4.
People’s experiences of integrated care

Importantly, we note that all of the metrics are collected for other purposes, and do not directly measure people’s experience of integrated care. Therefore, the proposed metrics are considered proxies, and each has limitations. Most significant, there are real gaps in what we can measure, and these too are noted. At present, six metrics are proposed:

<table>
<thead>
<tr>
<th>Metric and its source</th>
<th>Outcome it relates to</th>
<th>Strengths and weaknesses</th>
</tr>
</thead>
</table>
| Proportion of patients with care plans in place who helped to design them, find them helpful, and are helped regularly to review them (Proxy measure) | I am involved in discussions and decisions throughout about my own care, support and treatment. | Strengths  
Metric captures degree to which people are directly involved in the planning of their person-centred care.  
Weaknesses  
Data reflects experience within health care setting only.  
Survey questions do not probe experience of single, holistic care plans across settings. Population sampled may not consist of people receiving integrated health and social care.  
Data collection and frequency inadequate. Ideally, survey should be administered at point of service delivery and data published on a monthly or quarterly basis. |
<table>
<thead>
<tr>
<th>Metric and its source</th>
<th>Outcome it relates to</th>
<th>Strengths and weaknesses</th>
</tr>
</thead>
</table>
| **Proportion of people feeling supported to manage their long-term conditions**  
(Proxy measure)  
Data used for NHSOF 2.1  
Data source: GP Patient Survey (Qs32–33)  
Frequency: Annual | I am able to access the right resources and networks in my community to keep me well. | **Strengths**  
People with LTCs are more likely to benefit from a coordinated approach – high scoring to these questions could provide an indication of level of integrated care.  
Questions explicitly probe experience across settings, not just health services.  
**Weaknesses**  
Population sampled may not consist of people receiving integrated health and social care.  
Data collection and frequency inadequate. Ideally, survey should be administered at point of service delivery and data published on a monthly or quarterly basis. |
| **Patient experience of GP out-of-hours services**  
(Proxy measure)  
[NHSOF 4a.ii]  
Data source: GP Patient Survey  
Frequency: Annual | I am able to access the right resources and networks in my community to keep me well. | **Strengths**  
Measures provision of urgent care and people’s ability to access community-based services.  
**Weaknesses**  
Only measures primary care input; although a critical aspect of care in the community, does not capture timely provision of social care services and how the settings interface.  
Population sampled may not consist of people receiving integrated health and social care. |
## Developing an integration scorecard

<table>
<thead>
<tr>
<th>Metric and its source</th>
<th>Outcome it relates to</th>
<th>Strengths and weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social care-related quality of life</strong>&lt;br&gt;(Proxy measure)&lt;br&gt;[ASCOF 1A] Data source: Adult Social Care Survey (Q3a, Q4a, Q5a, Q6a, Q7a, Q8a, Q9a, Q11) Frequency: Annual</td>
<td><strong>Taken together, my care and support help me live the life I want to the best of my ability.</strong></td>
<td><strong>Strengths</strong> Metrics captures the critical impact integrated care aims to make – high scoring would show integration is making a difference to people’s wellbeing. <strong>Weaknesses</strong> Issues with attribution – improved quality of life could be the results of a number of variables and approaches. Data collection and frequency inadequate. Ideally, survey should be administered at point of service delivery and data published on a monthly or quarterly basis. Does not include opinions of people not eligible for publicly funded social care or not in receipt of support services managed by social services.</td>
</tr>
<tr>
<td>Metric and its source</td>
<td>Outcome it relates to</td>
<td>Strengths and weaknesses</td>
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</tr>
<tr>
<td>Health-related quality of life for people with long-term conditions (Proxy measure) [NHSOF 2] Data source: GP Patient Survey (Q34 (EQ-5D™)) Frequency: Annual</td>
<td>Taken together, my care and support help me live the life I want to the best of my ability.</td>
<td><strong>Strengths</strong> Metrics captures the critical impact integrated care aims to make – high scoring would show integration is making a difference to people’s lives. <strong>Weaknesses</strong> Issues with attribution – improved quality of life could be the results of a number of variables and approaches. Population sampled may not consist of people receiving integrated health and social care. Data collection and frequency inadequate. Ideally, survey should be administered at point of service delivery and data published on a monthly or quarterly basis.</td>
</tr>
<tr>
<td>Carer reported quality of life (Proxy measure) [ASCOF 1D] Data source: Carers’ Survey (Qs7–12) Frequency: Biennial</td>
<td>Carers report they feel supported and have a good quality of life.</td>
<td><strong>Strengths</strong> Carers are instrumental to the delivery of good integrated care and their wellbeing a priority for integration – measuring the changes in their QoL may provide an indication of how well the system as a whole is working for them. <strong>Weaknesses</strong> Issues with attribution – improved quality of life could be the results of a number of variables and approaches. Data collection and frequency inadequate. Ideally, survey should be administered at point of service delivery and data published on a monthly or quarterly basis.</td>
</tr>
</tbody>
</table>
Future metrics (to be developed):

Existing datasets are currently not collecting data related to the following outcomes in the logic model:

- *I have the information, and support to use it, that I need to make decisions and choices about my care and support.*
- *When I move between services or care settings, there is a plan in place for what happens next.*

Future metrics will need to be developed to plug these gaps. In particular, we suggest research and development prioritise measuring a person’s experience of integrated care, such as addressing experiences of moving between services and other well-known ‘I’ statements. Understanding and measuring access to out-of-hours social care may also be important as a proxy measure. Bearing in mind advancing policies for personalisation and person-centred care, new metrics may also be required to understand user experiences with personal budgets, direct payments and Integrated Personal Commissioning.

**Integration of services metrics**

The six metrics proposed below mostly measure access to services, especially out of hours. Other than for some reablement services, they do not directly measure the quality of integrated care, which is an important gap that needs to be addressed. Another important gap that will need addressing is measuring transfers of care between different types of services, and not just at discharge from hospital.

<table>
<thead>
<tr>
<th>Metric and its source</th>
<th>Outcome it relates to</th>
<th>Strengths and weaknesses</th>
</tr>
</thead>
</table>
| **Proportion of discharges (following emergency admissions) that occur at the weekend** | The integrated care delivery model is available 24/7 for all service users, providing timely access to care in the right place. | **Strengths** Measures how well the services work at the interface between health and social care, 24/7.  
**Weaknesses** May not provide the full picture, and may need to be used in combination with other metrics (e.g. discharges by midday). |
<p>| [LAPMs 6] Data source: NHS Digital analysis of HES | | |</p>
<table>
<thead>
<tr>
<th>Metric and its source</th>
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<th>Strengths and weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient experience of GP out-of-hours services</strong>&lt;br&gt;[NHSOF 4a.ii]&lt;br&gt;Data source: GP Patient Survey&lt;br&gt;Frequency: Annual</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><strong>Strengths</strong>&lt;br&gt;Measures provision of urgent care and people’s ability to access community-based services.&lt;br&gt;<strong>Weaknesses</strong>&lt;br&gt;Only measures primary care input; although a critical aspect of care in the community, does not capture timely provision of social care services and how the settings interface. Population sampled may not consist of people receiving integrated health and social care.</td>
</tr>
<tr>
<td><strong>Unplanned hospital admissions for chronic ambulatory care sensitive conditions</strong>&lt;br&gt;[NHSOF 2.3.i]&lt;br&gt;Data sources: HES/ONS&lt;br&gt;Frequency: Annual</td>
<td>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.</td>
<td><strong>Strengths</strong>&lt;br&gt;Measures the degree to which integrated, and easy to navigate, access to community-based care reduces or delays hospitalisation (right care in the right place).</td>
</tr>
<tr>
<td><strong>Proportion of older people aged 65 and over offered reablement services following discharge from hospital</strong>&lt;br&gt;[ASCOF 2B part 2]&lt;br&gt;Data sources: SALT/HES&lt;br&gt;Frequency: Annual</td>
<td>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.</td>
<td><strong>Strengths</strong>&lt;br&gt;Short-term rehabilitation services allow for smooth transition across settings and better outcomes for people (maximising independence).&lt;br&gt;<strong>Weaknesses</strong>&lt;br&gt;Local cohorts may be too small in size to provide meaningful insights.&lt;br&gt;This only measures reablement as a step-down service.</td>
</tr>
<tr>
<td>Metric and its source</td>
<td>Outcome it relates to</td>
<td>Strengths and weaknesses</td>
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| **Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services** [ASCOF 2B part 1] | 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.                                      | **Strengths**  
Short-term rehabilitation services allow for smooth transition across settings and better outcomes for people (maximising independence). Measures the quality of reablement by how well it keeps people out of hospital and at home.  
**Weaknesses**  
Local cohorts may be too small in size to provide meaningful insights.  
Potentially creates a perverse incentive to exclude very frail people.  
This only measures reablement as a step-down service. |
| Data sources: SALT/HES  
Frequency: Annual                                                                 |                                                                                                                                                                                                                       |                                                                                                                                                                                                                         |
| **Delayed Transfers of Care (DToCs), overall and those due to social care, NHS or both**  
(Proxy measure – as it only measures transfer delays from hospital)                      | Transfers of care between care settings are readily managed without delays.                                                                                                                                             | **Strengths**  
Indicates whether the whole system works effectively together, measuring the smooth transition from acute to community and social care and how well settings interface. High or rising numbers are problematic and indicative of a stressed system.  
**Weaknesses**  
Issues around consistency in data collection and attribution.  
Measure needs to be contextualised against the local context and the many variables. |
| Data sources: NHSE  
Monthly Situation Reports/ONS  
Frequency: Monthly                                                                         |                                                                                                                                                                                                                       |                                                                                                                                                                                                                         |
Future metrics (to be developed):

Existing datasets are currently not collecting data related to the following outcomes in the logic model:

- **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.**

To plug these gaps, the staff survey could be revised to address: (1) care coordination and joint working; (2) access to shared records and joint resources; and (3) support for personalisation. Careful sampling of front-line staff working to deliver integrated care could be an ongoing challenge. Rather than use the annual staff survey, local approaches collecting real-time data should be investigated and assessed for wider use.

Integrated care models seek to keep people out of hospital, but the quality and outcomes of these services are not being measured. Current data collection focuses on the hospital, rather than on community and social care services. That limits our ability to measure the quality of integrated care services and their outcomes. In particular, developing a metric for the effectiveness of reablement (or intermediate care) as a step-up service is important.

**Health and care system metrics**

The four metrics proposed are consistent with metrics used by NHS England, the Departments of Health and Communities and Local Government (Better Care Fund) and CQC. They capture points of interface between acute and social care, as well as attempt to measure how well community services and post-discharge services are keeping people out of hospital. As our stakeholder feedback reinforced, the metrics tend to describe system failure, and not achievement of the logic model’s outcomes per se (keeping people out of hospital is not the main objective of integrated care). The metrics also overlap with the set proposed for measuring integrated services; this acknowledges the limitations of existing data sources.

Aspects of system performance are also dependent on system capacity and funding, and we have noted suggestions about potential metrics for measuring these – or a combination of metrics.

As above, there are existing gaps between the outcomes we seek to measure and what is currently collected. Future metrics are proposed.
<table>
<thead>
<tr>
<th>Metric and its source</th>
<th>Outcome it relates to</th>
<th>Strengths and weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Delayed Transfers of Care (DToCs), overall and those due to social care, NHS or both</strong></td>
<td>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.</td>
<td><em>Strengths</em> Indicates whether the whole system works effectively together, measuring the smooth transition from acute to community and social care. High or rising numbers are problematic and indicative of a stressed system.</td>
</tr>
<tr>
<td>(Proxy measure – as it only measures transfer delays from hospital)</td>
<td></td>
<td><em>Weaknesses</em> Issues around consistency in data collection and attribution.</td>
</tr>
<tr>
<td>Data sources: NHSE Monthly Situation Reports/ONS Frequency: Monthly</td>
<td></td>
<td>Measure need to be contextualised against the local context and many variables.</td>
</tr>
<tr>
<td><strong>Emergency Admissions (65+) per 100,000 65+ population</strong></td>
<td>Effective provision of integrated care helps to manage demand for higher cost hospital care and to control growth in spending.</td>
<td><em>Strengths</em> A measure of how well LTCs are managed in the community, reducing the need for emergency admissions – collaboration across health and care settings should result in fewer emergency admissions. High numbers of emergency admissions suggest problems with care management in primary and community services.</td>
</tr>
<tr>
<td>(Proxy measure because multiple factors can influence growth in emergency admissions)</td>
<td></td>
<td><em>Weaknesses</em> Rates of emergency admissions are susceptible to seasonability.</td>
</tr>
<tr>
<td>Data source: HES Frequency: Annual</td>
<td></td>
<td>Measures for other population profiles (e.g. adults, 75+, people with mental health problems, people with learning disabilities) would provide additional insights.</td>
</tr>
<tr>
<td>Metric and its source</td>
<td>Outcome it relates to</td>
<td>Strengths and weaknesses</td>
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</table>
| **Emergency readmissions (for people 65+) per 100,000 emergency admissions**       | Effective provision of integrated care helps to manage demand for higher cost hospital care and to control growth in spending. | *Strengths* Measures whether adequate out of hospital support (potentially including social care and coordinated care) is available. High numbers of emergency admissions suggest problems with post-discharge care management in primary and community services; discharge without adequate support in place; or early discharge of medically unstable patients.  
*Weaknesses* Rates of emergency admissions are susceptible to seasonability. Measures for other population profiles (e.g. adults, 75+, people with mental health problems, people with learning disabilities) would provide additional insights. |
| (Proxy measure because multiple factors can influence growth in emergency re-admissions) |                                                                                      |                                                                                          |
| Data source: HES                                                                    | Frequency: Annual                                                                    |                                                                                          |

| Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services | Effective provision of integrated care helps to manage demand for higher cost hospital care and to control growth in spending. | *Strengths* Short-term rehabilitation services allow for smooth transition across settings and better outcomes for people (maximising independence). Measures the quality of reablement by how well it keeps people out of hospital and at home.  
*Weaknesses* Local cohorts may be too small in size to provide meaningful insights. Measures effectiveness of reablement as a step-down service only. Potentially creates a perverse incentive to exclude very frail people. |
| [ASCOF 2B part 1]                                                                   |                                                                                      |                                                                                          |
| Data sources: SALT/HES                                                               | Frequency: Annual                                                                    |                                                                                          |
Future metrics (to be developed):

Using existing datasets, we cannot measure all of the outcomes in the logic model, including:

- **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. (Note: We can only measure delays transfers of care from hospital, not improvements in efficiency.)**
- **Integrated care shifts service capacity and resources from higher cost hospital settings to community settings.**
- **The system enables personalisation by supporting personal budgets and Integrated Personal Commissioning, where appropriate.**

Consequently, the list of metrics could be greatly improved if it included ways of measuring and monitoring system capacity. These potential metrics can be measured now: (1) social care capacity such as social care spend/capita for 65+, and capacity of social care services/100,000; (2) workforce capacity such as vacancy and turnover rates, or community nurses/capita; (3) primary care capacity such as patients/GP; (4) community care capacity such as intermediate care beds/person 65+; (5) hospital occupancy rates for hospital capacity. Local areas may be interested in piloting approaches to understanding capacity and its effects.

Further research and development is required to design metrics related to demand management, spending controls and efficiencies, and the shifting of resources from hospital and community settings. All of these metrics would enable policymakers and local leaders to assess the sustainability of their care models as well as their cost-effectiveness and value for money.

Metrics for assessing how well a system supports personalisation are also under-developed and needed. Advancing NHS research and policies on Integrated Personal Commissioning and personal budgets pilots could contribute to this learning in the development of the metrics.
4: Conclusions and Recommendations

This research has shown that despite the enormous challenges local areas face in integrating health and social care, a strong appetite exists for tools that help local areas think about how they deliver and measure better integrated care and support.

This research sought feedback on a framework for understanding what good integrated care looks like, in the form of a logic model, and a set of aligned metrics for measuring progress on integration. We received positive and encouraging feedback about the logic model. Stakeholders commented that the model presents an understandable visualisation of what enables and supports good integrated services, and that it would enable local areas to develop plans that are supported by evidence. By presenting the whole system in this way, the logic model moves firmly away from the limitations of the original Integration Standard, which emphasised structural changes. The grouping of outcomes into three sets – people’s experience of care, service integration and whole system – also received stakeholder support. Logic models, by their very nature of being a concise visual aid, can never be fully comprehensive and reflect the huge variations of approaches in different local areas; but most stakeholders felt that this model provided a useful starting point for discussions on local plans. There are many ways in which this model could be used, including as a planning tool to help local areas prioritise where they need to focus efforts.

The proposed metrics received much more mixed feedback. The measurement of progress on integration has been a goal for many years, and there is some frustration in the sector that greater progress has not been made, especially in developing measures that work with the Think Local Act Personal and National Voices ‘I’ Statements. Because of the limitations associated with current datasets, the metrics seem overly focused on acute care, and they inadequately capture the quality or outcomes of integrated services in primary and community settings. The greatest gap that needs to be filled is measuring how people experience integrated care. Policymakers’ plans for using the proposed metrics – as an integration scorecard for judging progress towards integration or supporting improvement or for both – need to be clarified and resolved, as this will facilitate their acceptance and create support for further research and development.

Sector feedback also confirmed widespread support for the goals of integration. However, the achievement of fully joined-up care was viewed as a lengthy journey, characterised by a process of complex changes and best judged by better care outcomes rather than a fixed end point, such as that expressed in the ambition of Integration 2020.

Three sets of recommendations and next steps are proposed:

1. In recognition of its positive reception to date, **publish and disseminate the integration logic model** as a tool for supporting health and social care integration efforts in local areas. Policymakers should no longer use the previous Integration Standard as a reference point, although it was a useful starting point for discussions about integration. A welcome clarification includes recognising that the model focuses...
on older people, but that it can be adapted to fit for other groups of service users and local circumstances. Additional actions are suggested:

- Policymakers need to clarify how the logic model (and metrics) will be used – for performance measurement or improvement or both.
- Policymakers need to clarify the geographic footprint for a local area to support accountability for delivery of whole system integration, e.g. the footprint of a Health and Wellbeing Board.
- Further work on the logic model is suggested, allowing adaptations and modifications to ‘future proof’ it and for its use with different population groups, from people with learning disabilities to mental health users, etc., to including different sectors, such as housing.
- The logic model, and indeed the metrics, might be revised further to take account of relevant learning from the current CQC reviews.

2. **Further research, testing and evaluation of the metrics** are recommended before the metrics are used nationally.

- Using existing performance data, we recommend the metrics be piloted with a sample of local areas, selecting a range of areas considered good, average or performing less well. We would suggest the following evaluation questions: Do the metrics align with or confirm what we know about each area? Or do they present a different picture and, if so, what does this tell us about measuring progress towards integration?
- Additionally, it would be helpful to hold discussions with a small set of local area leaders, probing both the utility and acceptability of the metrics: Do the metrics enable local leaders to self-assess their progress and to identify what’s working and where attention and support are required?
- Similarly, it would be helpful to establish: In what ways can the proposed metrics be combined with local metrics to provide a more rounded picture of local progress? Are local metrics better able to capture the complexity of integration? Are there consistent sets of local metrics being used?
- Other metrics need developing. For instance, should there be metrics for other parts of the logic model, such as measuring the quality of service provision, and not just the outcomes? How could some of the enablers or components of care be measured?
- National investment is necessary for the development of user experience metrics, which measure the experiences of integrated care.

3. The logic model and metrics should be used as a **framework for improvement support and resources**.

- At the stakeholder events in particular, we asked for feedback on how the logic model and integration metrics could be used to support improvement.
Participants commented on how the model could be used as a prioritisation tool; a signposting tool; a self-assessment and planning tool; and even a benchmarking tool. To advance the model as a roadmap, the following actions are suggested:

- The development of guidelines or a checklist that sits alongside the model to help people apply and use it appropriately.
- Embedding hyperlinks in an interactive version of the logic model, e.g. to research evidence, good practice case studies, available support, checklists, next steps, and so forth.
- Offering guidance and support on how to link health and social care data, as well as data from allied sectors, to understand how well a system is integrating over time.
### Appendix 1: Sets of integration related metrics currently in use

<table>
<thead>
<tr>
<th>Metric</th>
<th>Description</th>
<th>Relevance</th>
<th>Data source</th>
<th>Used by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delayed Transfers of Care</td>
<td>Delayed transfers of care from hospital per 100,000 population</td>
<td>• Reduced pressure on acute care&lt;br&gt;• Good provision of adult social care</td>
<td>NHS England&lt;br&gt;DToC + ONS Population Statistics</td>
<td>BCF 2017–19</td>
</tr>
<tr>
<td>Non-elective admissions (General and Acute)</td>
<td>Total number of specific acute (replaces G&amp;A) non-elective spells in a month</td>
<td>• Reduced pressure on acute care&lt;br&gt;• Good provision of adult social care</td>
<td>NHS Performance &amp; Activity E.M.11</td>
<td>BCF 201–19</td>
</tr>
<tr>
<td>Admissions to residential and care homes</td>
<td>Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population</td>
<td>• Good provision of adult social care</td>
<td>ASCOF 2A(2)</td>
<td>BCF 2017–19</td>
</tr>
<tr>
<td>Effectiveness of reablement – Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services</td>
<td>Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services</td>
<td>• Good provision of adult social care</td>
<td>ACOF 2B</td>
<td>BCF 2017–19</td>
</tr>
</tbody>
</table>
Developing an integration scorecard

<table>
<thead>
<tr>
<th>Metric</th>
<th>Description</th>
<th>Relevance</th>
<th>Data source</th>
<th>Used by</th>
</tr>
</thead>
</table>
| Emergency Admissions (65+) per 100,000 65+ population | Emergency admissions for those with identified age (65+) resident in a local authority) divided by; (Local authority population 65+/100,000 | • Reduced pressure on acute care  
• Good provision of adult social care | Hospital Episode Statistics, NHS Digital ONS 2016 Mid-Year Population Estimates | DH – Local Area Performance Metrics |
| 90th percentile of length of stay for emergency admissions (65+) | The 90th percentile length of stay following emergency admission, e.g. 10% of patients within a local area have a length of stay longer than X days. | • Reduced pressure on acute care | Hospital Episode Statistics, NHS Digital | DH – Local Area Performance Metrics |
| TOTAL Delayed Days per day per 100,000 18+ population | Average number of monthly delayed days (ALL) per day Divided by; Local authority population 18+/100,000 | • Reduced pressure on acute care  
• Good provision of adult social care | NHS England – Delayed Transfers of Care ONS 2016 Mid-Year Population Estimates | DH – Local Area Performance Metrics |
| Effectiveness of reablement – Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services | Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services | • Good provision of adult social care | ACOF 2B Part 1 | DH – Local Area Performance Metrics |
| Effectiveness of reablement – Proportion of older people (65 and over) who are discharged from hospital who receive reablement/ rehabilitation services | The proportion of older people aged 65 and over offered reablement services following discharge from hospital | • Good provision of adult social care | ACOF 2B Part 2 | DH – Local Area Performance Metrics |
| **Proportion of discharges (following emergency admissions) which occur at the weekend** | Percentage of discharges (following emergency admission) at the weekend | • Reduced pressure on acute care  
• Good provision of adult social care | NHS Digital analysis of HES | DH – Local Area Performance Metrics |
|---|---|---|---|---|
| **Social Care Delayed Days per day per 100,000 18+ population** (for context only – does not form part of the combined national ranking) | Average number of monthly delayed days attributable to Social Care per day Divided by; (Local authority population 18+/100,000) | • Reduced pressure on acute care  
• Good provision of adult social care | NHS England – Delayed Transfers of Care ONS 2016 Mid Year Population Estimates | DH – Local Area Performance Metrics |
| **NHS Delayed Days per day per 100,000 18+ population** (for context only – does not form part of the combined national ranking) | Average number of monthly delayed days attributable to NHS per day Divided by; Local authority population 18+/100,000 | • Reduced pressure on acute care  
• Good provision of adult social care | NHS England – Delayed Transfers of Care ONS 2016 Mid Year Population Estimates | DH – Local Area Performance Metrics |
<table>
<thead>
<tr>
<th>Metric</th>
<th>Description</th>
<th>Relevance</th>
<th>Data source</th>
<th>Used by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency admissions</td>
<td>All new care model vanguards are ultimately looking, as part of their drive to improve efficiency, to reduce hospital emergency admissions and to shift care from hospitals to the community</td>
<td>Efficiency metric</td>
<td>Derived from secondary user service (SUS)/hospital episode statistic (HES) data</td>
<td>New care models evaluation: core metrics</td>
</tr>
<tr>
<td>Total bed days</td>
<td>All new care model vanguards are ultimately looking, as part of their drive to improve efficiency, to reduce hospital emergency admissions and to shift care from hospitals to the community</td>
<td>Efficiency metric</td>
<td>Derived from SUS/HES data</td>
<td>New care models evaluation: core metrics</td>
</tr>
<tr>
<td>Patient involvement in care (GP – Q21 part d)</td>
<td>Q21: Last time you saw or spoke to a GP from your GP surgery, how good was that GP at [...] involving you in the decisions about your care</td>
<td>Care and quality metric</td>
<td>GP patient survey – Q21 part d</td>
<td>New care models evaluation: core metrics</td>
</tr>
<tr>
<td>Patient involvement in care (Nurse – Q23 part d)</td>
<td>Q23: Last time you saw or spoke to a nurse from your GP surgery, how good was that nurse at [...] involving you in the decisions about your care</td>
<td>Care and quality metric</td>
<td>GP patient survey – Q23 part d</td>
<td>New care models evaluation: core metrics</td>
</tr>
<tr>
<td>Care plan (Q37)</td>
<td>Q37: Did you help put your written care plan together?</td>
<td>Care and quality metric</td>
<td>GP patient survey – Q37</td>
<td>New care models evaluation: core metrics</td>
</tr>
<tr>
<td>Quality of life (Q34)</td>
<td>Average of the EQ5D score, measuring people’s view on the state of their health today in relation to: mobility, self-care, usual activities, pain/discomfort, anxiety/depression</td>
<td>Health and wellbeing metric</td>
<td>GP patient survey – Q34</td>
<td>New care models evaluation: core metrics</td>
</tr>
<tr>
<td>Metric</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NEL admissions (65+) per 1,000 65+</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Description</strong></td>
<td>Unplanned admissions to hospitals as the results of attendances at A&amp;E, MIU (minor injury unit) or directly from clinics / GPs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Relevance** | • Reduced pressure on acute care  
• Good provision of adult social care |
| **Data source** | HES |
| **Proposed by** | McKinsey |
| **NEL admissions (65+) with length of stay >30 days per 1,000 65+** |
| **Description** | Unplanned admissions to hospitals as the results of attendances at A&E, MIU (minor injury unit) or directly from clinics / GPs, resulting in staying in hospital for over 30 days |
| **Relevance** | • Reduced pressure on acute care  
• Good provision of adult social care |
| **Data source** | HES |
| **Proposed by** | McKinsey |
| **Emergency readmission (65+) per 1,000 emergency admissions 65+** |
| **Description** | Percentage of hospital admissions which returned to hospital as emergency admissions within 30 days of being discharged from their last stays at the hospital |
| **Relevance** | • Reduced pressure on acute care  
• Good provision of adult social care |
| **Data source** | HES/ NHSOF 3b |
| **Proposed by** | McKinsey |
| **Institutionalisation bed days (65+) per 1,000 65+** |
| **Description** | A sum of ‘institution’ bed days, i.e. total number of days a patient/user spent at any institution (acute, community, care homes) instead of own home, which is assumed to be the best place for people to be |
| **Relevance** | • Reduced pressure on acute care  
• Good provision of adult social care |
| **Data source** | HES/ PSSEUC/ new |
| **Proposed by** | McKinsey |
| **DTOC – overall and due to social care placement or package per 1,000 65+** |
| **Description** | A sum of bed days that a patient spends in a hospital after getting a Medically Fit for Discharge (MSFD) status due to delays in arranging of social care placement or package |
| **Relevance** | • Reduced pressure on acute care  
• Good provision of adult social care |
| **Data source** | NHSE |
| **Proposed by** | McKinsey |
| **Index of ‘User reported quality of life’ and ‘Proportion of people feeling supported to manage their LTC’** |
| **Description** | Supporting overarching indicator |
| **Relevance** | • People’s experience of care |
| **Data source** | ASCOF/ NHSOF |
| **Proposed by** | McKinsey |
| **Index of multiple deprivation (IMD)** |
| **Description** | Contextual indicator |
| **Data source** | N/A |
| **Proposed by** | McKinsey |
## Developing an integration scorecard

<table>
<thead>
<tr>
<th>Metric</th>
<th>Description</th>
<th>Relevance</th>
<th>Data source</th>
<th>Used by</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASC gross current expenditure per 10,000 capita</td>
<td>Contextual indicator</td>
<td>• Good provision of adult social care (contextual) • Cost-effectiveness</td>
<td>GM baseline core measures</td>
<td></td>
</tr>
<tr>
<td>ASC percentage of total LA expenditure</td>
<td>Contextual indicator</td>
<td>• Good provision of adult social care (contextual) • Cost-effectiveness</td>
<td>GM baseline core measures</td>
<td></td>
</tr>
<tr>
<td>ASC expenditure per capita by deprivation rank</td>
<td>Contextual indicator</td>
<td>• Good provision of adult social care (contextual) • Cost-effectiveness</td>
<td>GM baseline core measures</td>
<td></td>
</tr>
<tr>
<td>Overall satisfaction of service users with care and support</td>
<td></td>
<td>• People’s experience of care</td>
<td>ASCOF 3A</td>
<td>GM baseline core measures</td>
</tr>
<tr>
<td>Adult social care complaints per 10,000 population</td>
<td></td>
<td>• People’s experience of care</td>
<td>GM baseline core measures</td>
<td></td>
</tr>
<tr>
<td>CQC overall rating of care homes</td>
<td>Inadequate, requires improvement, good, outstanding</td>
<td>• Good provision of adult social care</td>
<td>GM baseline core measures</td>
<td></td>
</tr>
<tr>
<td>Emergency admissions (all ages) per 1,000 capita</td>
<td></td>
<td>• Reduced pressure on acute care • Good provision of adult social care</td>
<td>GM baseline core measures</td>
<td></td>
</tr>
<tr>
<td>Population by age group</td>
<td><em>Under 18s, 18–64, 65+ – contextual indicator, to assess whether age profile is driving expenditure</em></td>
<td>N/A</td>
<td>GM baseline core measures</td>
<td></td>
</tr>
<tr>
<td>DTocC days per 100,000 population</td>
<td></td>
<td>• Reduced pressure on acute care • Good provision of adult social care</td>
<td>GM baseline core measures</td>
<td></td>
</tr>
<tr>
<td>People supported by long-term care</td>
<td>Includes: learning disabilities, mental health, physical support, sensory support, memory and cognition, and non-SALT</td>
<td>• Good provision of adult social care (contextual)</td>
<td>GM baseline core measures</td>
<td></td>
</tr>
<tr>
<td>Metric</td>
<td>Description</td>
<td>Relevance</td>
<td>Data source</td>
<td>Proposed by</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>NEL admissions (65+) per 1,000 65+ (McKinsey)</td>
<td>Unplanned admissions to hospitals as the results of attendances at A&amp;E, MIU (minor injury unit) or directly from clinics / GPs</td>
<td>• Reduced pressure on acute care • Good provision of adult social care</td>
<td>See McKinsey</td>
<td>SCIE proposed metrics</td>
</tr>
<tr>
<td>Emergency readmission (65+) per 1,000 emergency admissions 65+ (McKinsey)</td>
<td>Percentage of hospital admissions which returned to hospital as emergency admissions within 30 days of being discharged from their last stays at the hospital</td>
<td>• Reduced pressure on acute care • Good provision of adult social care</td>
<td>See McKinsey</td>
<td>SCIE proposed metrics</td>
</tr>
<tr>
<td>Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services</td>
<td>Measures effectiveness of reablement</td>
<td>• Reduced pressure on acute care • Good provision of adult social care/community-based care</td>
<td>See BCF metrics / (ASCOF 2B/NHSOF 3.6i)</td>
<td>SCIE proposed metrics</td>
</tr>
<tr>
<td>Permanent admissions of adults aged 65+ to residential and nursing care homes per 100,000 population (BCF metric)</td>
<td>Measures effectiveness of community-based services in preventing institutional accommodation</td>
<td>• Good provision of adult social care/community-based care</td>
<td>See BCF metrics</td>
<td>SCIE proposed metrics</td>
</tr>
<tr>
<td>DToC – overall and due to social care placement or package per 1,000 65+ (McKinsey)</td>
<td>A sum of bed days that a patient spends in a hospital after getting a Medically Fit for Discharge (MSFD) status due to delays in arranging of social care placement or package</td>
<td>• Reduced pressure on acute care • Good provision of adult social care</td>
<td>See McKinsey</td>
<td>SCIE proposed metrics</td>
</tr>
<tr>
<td>Institutionalisation bed days (65+) per 1,000 65+ (McKinsey)</td>
<td>A sum of ‘institution’ bed days, i.e. total number of days a patient/user spent at any institution (acute, community, care homes) instead of own home, which is assumed to be the best place for people to be</td>
<td>• Reduced pressure on acute care • Good provision of adult social care</td>
<td>See McKinsey</td>
<td>SCIE proposed metrics</td>
</tr>
</tbody>
</table>
## Developing an integration scorecard

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Area of Improvement</th>
<th>Metric Code</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of people using social care who receive self-directed support, and those receiving direct payments</td>
<td>• Good provision of adult social care</td>
<td>ASCOF 1C</td>
<td>SCIE proposed metrics</td>
</tr>
<tr>
<td></td>
<td>• People’s experience of care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of patients with care plans in place who helped to design them, find them useful, and are helped regularly to review them</td>
<td>• People’s experience of care</td>
<td>GP Patient Survey</td>
<td>SCIE proposed metrics</td>
</tr>
<tr>
<td>Proportion of people feeling supported to manage their (long-term) condition</td>
<td>• People’s experience of care</td>
<td>NHSOF 2.1</td>
<td>SCIE proposed metrics</td>
</tr>
<tr>
<td>Overall satisfaction of people who use services with their care and support</td>
<td>• People’s experience of care</td>
<td>ASCOF 3A</td>
<td>SCIE proposed metrics</td>
</tr>
<tr>
<td>Proportion of discharges from hospital that take ongoing needs into account</td>
<td>• People’s experience of care</td>
<td>NHS Inpatient Survey</td>
<td>SCIE proposed metrics</td>
</tr>
<tr>
<td>Patient experience of GP out-of-hours services</td>
<td>• People’s experience of care</td>
<td>GP patient survey</td>
<td>SCIE proposed metrics</td>
</tr>
<tr>
<td>Staff engagement index</td>
<td>• Leadership and workforce</td>
<td>Illustrative example: CCG I&amp;AF 163a</td>
<td>SCIE proposed metrics</td>
</tr>
<tr>
<td>Effectiveness of working relationships in the local system</td>
<td>• Leadership and workforce</td>
<td>Illustrative example: CCG I&amp;AF 164a</td>
<td>SCIE proposed metrics</td>
</tr>
</tbody>
</table>
Developing an integration scorecard

<table>
<thead>
<tr>
<th>Metric</th>
<th>Description</th>
<th>Relevance</th>
<th>Data source</th>
<th>Proposed by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average cost of care across all care settings for top 2% high-risk population</td>
<td>• Cost-effectiveness</td>
<td>Placeholder, DH shortlisted metric</td>
<td>Additional metric for consideration</td>
<td></td>
</tr>
<tr>
<td>Unplanned hospitalisation for chronic ambulatory care sensitive conditions</td>
<td>• Reduced pressure on acute care</td>
<td>NHSOF 2.3i</td>
<td>Additional metric for consideration</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Good provision of adult social care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency admissions for acute conditions that should not usually require hospital admission</td>
<td>• Reduced pressure on acute care</td>
<td>NHOF 3a</td>
<td>Additional metric for consideration</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Good provision of adult social care/community-based care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of bed days spent in acute care</td>
<td>• Reduced pressure on acute care</td>
<td></td>
<td>Additional metric for consideration</td>
<td></td>
</tr>
<tr>
<td>Carer-reported quality of life</td>
<td>• People’s experience of care</td>
<td>ASCOF 1D</td>
<td>Additional metric for consideration</td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 2: Workshop Discussion Paper (Metrics)

### 1. People’s experiences of integrated care – Draft metrics

<table>
<thead>
<tr>
<th>Draft metric</th>
<th>Outcome it relates to</th>
<th>How and where it is collected nationally</th>
</tr>
</thead>
</table>
| Proportion of patients with care plans in place who helped to design them, find them useful, and are helped regularly to review them. | I am involved in discussions and decisions throughout about my own care, support and treatment. | Data Source: GP Patient Survey (Qs36–39)  
Frequency: Annual                                                                                           |
| [Gap: Future metric]                                                         | When I move between services or care settings, there is a plan in place for what happens next. |                                                                                                         |
| Proportion of people feeling supported to manage their long-term conditions. | I am able to access the right resources and networks in my community to keep me well.    | [NHSOF 2.1]  
Data source: GP Patient Survey  
Frequency: Annual                                                                                           |
| Patient experience of GP out-of-hours services.                              | I am able to access the right resources and networks in my community to keep me well.    | [NHSOF 4a.ii]  
Data source: GP Patient Survey  
Frequency: Annual                                                                                           |
| Access to out-of-hours social care [Gap: Future metric]                       |                                                                                         |                                                                                                         |
| Social care-related quality of life.                                         | Taken together, my care and support help me live the life I want to the best of my ability. | [ASCOF 1A]  
Data source: Adult Social Care Survey  
Frequency: Annual                                                                                           |
Developing an integration scorecard

<table>
<thead>
<tr>
<th>Draft metric</th>
<th>Outcome it relates to</th>
<th>How and where it is collected nationally</th>
</tr>
</thead>
</table>
| Health-related quality of life for people with long-term conditions. | Taken together, my care and support help me live the life I want to the best of my ability. | [NHSOF 2]
Data source: GP Patient Survey
Frequency: Annual |
| Carer reported quality of life. | Carers report they feel supported and have a good quality of life. | [ASCOF 1D]
Data source: Carers Survey
Frequency: Biennial |

People’s experience of care – Other potential metrics (what we can measure now):

- Overall satisfaction of people who use social care services with their care and support ([ASCOF 3A; Data source: Adult Social Care Survey; Frequency: Annual).
- Health-related quality of life for carers ([NHSOF 2.4]; Data source: GP Patient Survey; Frequency: Annual).
- Proportion of carers who say they have been supported to have a break for over 24 hours (Data source: Survey of Adult Carers in England (Q 5b); Frequency: Biennial).

Future metrics (existing gaps, or to be developed):

- New metrics for measuring a person’s experience of integrated care, such as addressing experiences of moving between services and other well-known ‘I’ statements.
- Personalisation: new metrics required to understand user experiences with personal budgets, direct payments and Integrated Personal Commissioning.
### 2. Integration of services metrics – draft metrics

<table>
<thead>
<tr>
<th>Draft metric</th>
<th>Outcome it relates to</th>
<th>How and where it is collected nationally</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of discharges (following emergency admissions) that occur at the weekend.</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>[LAPMs 6]</td>
</tr>
<tr>
<td>Patient experience of GP out-of-hours services.</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>[NHSOF 4a.ii] Data source: GP Patient Survey Frequency: Annual</td>
</tr>
<tr>
<td>Unplanned hospital admissions for chronic ambulatory care sensitive conditions.</td>
<td>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.</td>
<td>[NHSOF 2.3.i] Data sources: HES/ONS Frequency: Annual</td>
</tr>
<tr>
<td>Coverage of reablement – Proportion of older people aged 65 and over offered reablement services following discharge from hospital.</td>
<td>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.</td>
<td>[ASCOF 2B part 2] Data sources: SALT/HES Frequency: Annual</td>
</tr>
<tr>
<td>Effectiveness of reablement – Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.</td>
<td>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.</td>
<td>[ASCOF 2B part 1] Data sources: SALT/HES Frequency: Annual</td>
</tr>
</tbody>
</table>
### Developing an integration scorecard

<table>
<thead>
<tr>
<th>Draft metric</th>
<th>Outcome it relates to</th>
<th>How and where it is collected nationally</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Gap: Future metric or local metric]</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>[Gap: Future metric or local metric]</td>
<td>Integrated assessment, care and discharge teams report they are readily able to access joint resources to meet the needs of service users.</td>
<td></td>
</tr>
<tr>
<td>Delayed Transfers of Care (DToCs), overall and those due to social care, NHS or both.</td>
<td>Transfers of care between care settings are readily managed without delays.</td>
<td>Data sources: NHSE Monthly Situation Reports/ONS Frequency: Monthly</td>
</tr>
</tbody>
</table>

**Integration of services – Other potential metrics (what we can measure now):**

- Patients are discharged to home or to their usual place of care following an episode of hospital care (Data source: HES; Frequency Monthly).
- Long-term support needs of older people (aged 65+) met by admission to residential and nursing care homes, per 100,000 population ([ASCOF 2a part 2]; Data sources: SALT/ONS; Frequency: Annual).

**Future metrics (existing gaps, or to be developed):**

- Revisions to staff survey to address: (1) care coordination and joint working; (2) access to shared records and joint resources; and (3) support for personalisation.
- Metric for the effectiveness of reablement or similar as a step-up community service (not just in relation to hospital discharge).
## 3. Health and care system metrics – draft metrics

<table>
<thead>
<tr>
<th>Draft metric</th>
<th>Outcome it relates to</th>
<th>How and where it is collected nationally</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delayed Transfers of Care (DToCs), overall and those due to social care, NHS or both.</td>
<td>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.</td>
<td>Data sources: NHSE Monthly Situation Reports/ONS Frequency: Monthly</td>
</tr>
<tr>
<td>(1) Emergency admissions and (2) readmissions (for people 65+) per 100,000 emergency admissions.</td>
<td>Effective provision of integrated care helps to manage demand for higher cost hospital care and to control growth in spending.</td>
<td>Data source: HES Frequency: Annual</td>
</tr>
<tr>
<td>Effectiveness of reablement – Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.</td>
<td>Effective provision of integrated care helps to manage demand for higher cost hospital care and to control growth in spending.</td>
<td>[ASCOF 2B part 1] Data sources: SALT/HES Frequency: Annual</td>
</tr>
<tr>
<td>[Potential metrics to assess capacity of different health and social care services, including workforce capacity]</td>
<td>Integrated care shifts service capacity and resources from higher cost hospital settings to community settings.</td>
<td></td>
</tr>
<tr>
<td>[Gap: Future metric]</td>
<td>The system enables personalisation by supporting personal budgets and IPC, where appropriate.</td>
<td></td>
</tr>
</tbody>
</table>

### Health and care system – Other potential metrics (what we can measure now):
- Effectiveness of working relationships in the local system ([ICGIAF 164a]).
- 90th percentile of Length of Stay (LOS) for emergency admissions 65+ (Data source: HES).
• Capacity metrics: (1) social care capacity such as social care spend/capita for 65+, and capacity of social care services/100,000; (2) workforce capacity such as vacancy and turnover rates, or community nurses/capita; (3) primary care capacity such as patients/GP; (4) community care capacity such as intermediate care beds/person 65+; (5) hospital occupancy rates for hospital capacity.

Future metrics (existing gaps, or to be developed):
• Personalisation measures.
Appendix 3: Bibliography of research evidence


Local Government Association, NHS Confederation, ADASS, and NHS Clinical Commissioners (2016) Stepping up to the Place: The Key to Successful Health and Care Integration. London: NHS Confederation.


Appendix 4: Glossary of abbreviations

ADASS: Association of Directors of Adult Social Services
ASCOF: Adult Social Care Outcomes Framework
BCF: Better Care Fund
CCG: Clinical Commissioning Group
CCGIAF: Clinical Commissioning Groups Improvement and Assessment Framework
CQC: Care Quality Commission
DCLG: Department for Communities and Local Government
DH: Department of Health
DToC: Delayed Transfer of Care
EQ-5D™: European Quality of Life-5 Dimensions
HES: Hospital Episode Statistics
IPC: Integrated Personal Commissioning
LAPMs: Local Area Performance Metrics (DH)
LGA: Local Government Association
NHSE: NHS England
NHSOF: NHS Outcomes Framework
ONS: Office of National Statistics
PHOF: Public Health Outcomes Framework
PIRU: Policy Innovation Research Unit
SALT: Short and Long Term Support
STP: Sustainability and Transformation Plan/Partnership
TLAP: Think Local Act Personal
Developing an integration scorecard: A model for understanding and measuring progress towards health and social care integration

Delivering better and better value care and support experiences and outcomes through the integration of health, social care and related services has been a policy objective for some years.

This report includes a list of currently proposed metrics, identifying their source, the outcome they relate to, and perceived strengths and weaknesses.