Developing a Model of Integrated Care in Croydon

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Croydon shadow Health and Wellbeing board
12 September 2012
• Case for change – “Transformation”

• Introduction to Integrated Care

• How will it work?

• What will make change stick?
Case for “TRANSFORMATION”
Expectations, Limitations, Complexity, Confusion and Cost

- Increasing demand & expectations
- Rising **costs** of care
- Increasing **population** with **complex needs** e.g. elderly & children and families
- Diversity effects e.g. Diabetes
- **Dependency culture**
- Multiplicity of services, professionals and delivery settings – *silhouette working*

- System not coordinated –duplication / inefficiencies
- Unacceptable variation – **quality**
- Ignorance among professionals – public confusion
- Workforce limitations e.g. specialists / care staff
- **Service affordability** – e.g. QIPP (NHS £20 billion savings)
- **Croydon’s Financial Deficit**
Case for “TRANSFORMATION”
Expectations, Limitations, Complexity, Confusion and Cost

• NOT ENOUGH:
  • Just more of the same
  • Tinkering on the edges with service redesign
  • Wishful thinking

• For Sustainability need for service “Transformation”
  • Shift care appropriately to the community – right care, right time, right place at right cost
  • Efficient and coordinated services
  • Increase Self Care, Self-management and personal responsibility
  • Increase early intervention & PREVENTION
Reactive vs Pro-active

- Health efforts focus much more on treatment than on the causes of poor health.

- **Wellbeing** – a positive physical, social and mental state – is an important part of our health – leading to reduced mortality, improved educational outcomes and increased productivity.

Callum, C. (2008) *The Cost of Smoking to the NHS.*
[www.ic.nhs.uk/pubs/SSS0910](http://www.ic.nhs.uk/pubs/SSS0910)

*Healthy lives, healthy people: our strategy for public health in England*
WORK IN PROGRESS

- TRANSFORMATION BOARD established
- Priorities:
  - Frail Elderly
  - Children & Families
- Project initiation Funding
• Case for change – “Transformation”

• What would “good” mean for patients

• Introduction to integrated care

• How will it work?

• What will make change stick?
Integrated Care – feedback from the Listening Exercise

“while many encounters between individual patients and professionals are patient centred, the system as a whole is not. Too many patients and carers feel that they are required to fit their needs and lives around the services on offer”

- People want co-ordination; not necessarily (organisational) integration.
- People want care; where it comes from is secondary.

http://www.dh.gov.uk/health/2012/04/care-funding-model/
Integration A report from the NHS Future Forum, 2011
11.pdf
Opportunity to design services around the needs of patients

Case Studies
Rose

• 11 years old

• Asthma diagnosed at 6 years old

• Frequent exacerbations (attacks)

• Frequent A/E visits

• Family income is very low – mother works part time.

• School absences/below average academic performance

• Father has an alcohol dependency

• Instances of domestic violence
People and Services involved in Rose’s Care

- Rose Age 11
- GP
- Asthma Nurse
- Consultant
- Physiotherapist
- School and Educational Support
- Dentist
- Pharmacist
- Social Services
- Family
What Good would look like for Rose?
Mr D

- **75 year old retired teacher**
- Has Vascular Dementia
- History of high blood pressure and high cholesterol
- Significantly reduced mobility
- Limited language and swallowing difficulties and continence issues
- Cared for by Daughter-in-law and daily carers
- In receipt of a personal budget
- Lives with son, daughter-in-law and 2 teenage grandchildren
- Impact on the emotional wellbeing of grandchildren
- Daughter-in-law has complete list of professionals participating in Mr D’s care
People and Services involved in Mr D’s Care
What Good would look like for Mr D

Mr D
Age 75

- Co-ordinated overview of his care
- Emotional Support for his family
- Focus on his whole history
- Remove Duplication
- Single entry point/contact number
- Joined up working amongst care providers
What patients want

• Services that are efficient, with no duplication of work
• Professionals who have the information they need to work with me effectively
• Services that can be accessed at a time and place and in a language and format that suit me
• Access to a range of services to meet my individual needs and preferences
• Full understanding of the services available to me and how to use them – including who to call if/when my condition worsens
• Confidence that I know what to do to maximise my own health and well-being
• To decide together with the professionals I deal with what should happen to maximise my well-being
• An ongoing and trusting relationship with the professionals I deal with
Integrated care can deliver benefits for patients, clinicians and the wider health system

- Provides proactive care, closer to people’s homes, that improves clinical effectiveness and patient experience
- Removes frustrations of the patient journey that too often causes patients to fall in the gaps between services
- Prevents patients from having to repeat their story multiple times and means those delivering care to them know what is happening

- Eliminates day-to-day frustrations from care delivery e.g., discharge communications, lack of access to full patient information
- Delivers improved clinical reasoning – from didactic to dialectical decision-making
- Brings new mutual accountability to the patient pathway, not merely the episode of care

Actual reduction in short stay beds (with lower growth levels/net reductions for the CUH acute contract in these areas), to enable re-provision in a community model of care, with increased productivity and growth levels in the CSS community contract.

This collaborative QIPP model will provide efficiency savings to the CCG, with reduced overall levels of investment across both contracts, based upon:

- Greater acuity in patient contacts (i.e. patients receiving the appropriate level of clinical-care) and use of innovation to reduce operating costs (e.g. telehealth/telecare) which means more patients are treated in lower cost settings.
- The reduced operating costs (per patient contact) and changed activity levels (i.e. reduction in admissions/higher cost settings, increased support in people’s homes), coupled with less duplication of services, should provide a collaborative QIPP to the CCG (changed pattern of investment), CUH and social care (reduced overall cost base).

Integrated care will deliver benefits for the Local Authority including:

- More effective use of resources and greater impact
- Reduced pressure on specialist services
- Reduced operating costs and efficiency savings
- Improved life chances and prevention of longer term dependency on statutory services
- Changing the balance of care provided through traditional health care to a greater reliance upon domiciliary care and social care will increase the charging for individuals – social care is not free at the point of use – may disincentivise the change programme.
Towards System Transformation
(Frail Elderly)

The proposed model of care will initiate system transformation, which will enable the overall system of health and social care to transform, with an emphasis on a mixed economy of out-of-hospital care. The change process should be led by practitioners/clinicians, bottom up, with excellent project support and direction and a network of healthy stakeholder relationships based on trust, with a clear framework for change and robust governance structures.
Scope of the project: The proposed model of care will drive system transformation to improve outcomes and reduce costs, with an emphasis on a mixed economy of out-of-hospital care (ie all the services in blue). The change management process should be led by practitioners/clinicians, bottom up, with excellent project support, direction, strong stakeholder engagement and partnership working, with a clear framework for change and robust governance structures.
Benefits Wheel – Integrated model of care for people with Long term Conditions
Based on conversations with Croydon stakeholders

Collaborative QIPP

- System wide approach
- Enhance quality of life for people with LTCs
- Improved relationships
- Efficiency/improved outcomes of care
- Resources in the right place at the right time

- Driver for service redesign
- Clinical leadership

- Care organised around person, not institutions
- Home or community settings (such as CCs) considered to be the hub for care and support
- Focus for health and social care partnership working
- Holistic outcomes

- Driver to reconfigure service and workforce redesign.

- Improved outcomes of care
- Personalised care
- Joined up care closer to home or community settings

- Identification of most vulnerable and hard to reach patients
- Possibility to increase capacity/opportunities by moving resources e.g. advocacy

- Inclusive for people with mental illness as the primary illness or as a co-morbidity
- Holistic approach
- Upstream intervention to prevent crisis occurring

- Joint commissioning.

- Improved continuity of care
- Improved preventative and self care

- Focus right resources on patients who need acute care

- Focus on patients who need acute care

- Driver for service redesign
- Clinical leadership

- Improved outcomes of care
- Personalised care
- Joined up care closer to home or community settings

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- Joint commissioning.
Strategic Overview

Croydon’s multi-agency Transformation Board will oversee the implementation and partnership sign-up to the principles of system transformation and an operational model of integrated health and social care.

Priorities:
- Roll-out of risk stratification across participating practices.
- Engagement of providers in case management system.
- Development of multi-disciplinary team meetings for case reviews.
- Establish and agree inter-provider clinical governance framework.
- Development of health and social care performance dashboard.

Link-up
- The model of care needs to link up to early intervention, reablement, rehabilitation, telehealth-care, voluntary sector services and other support/care networks to enable complete system transformation.

Enablers:
- Pump-priming resources will be available to contribute to increased operational costs, above existing service investments.
- Contract mechanisms will be introduced through LES, community/acute contracts and QoF.
- All partners face cost pressures and income reduction in real terms in the immediate future.
- The model is only sustainable if existing services adopt new ways of working and use existing resources differently.

Outcomes:
- Improved outcomes of care at lower cost
- Improved patient satisfaction and quality of life
- Reduction in bed days
- Reduction in emergency admissions and readmissions
- People getting the right joined up care at the right time in the right place.
- Acute sector able to focus on resources for patients who need acute care
- Improved identification of need, early intervention and preventative or self care
- Safeguarding strengthened so children kept safe
- Improved family resilience, independence and prevention of the escalation of need
- Improved school readiness demonstrated through improved EYFS achievement
- Healthier children and more resilient families
Provider Impact

Primary Care
- Up-take of case management, with a progressive roll-out of the model in up to 6 provider localities.
- Participation in risk stratification and case management.
- On-going improvements in screening and detection.

Croydon University Hospital (CUH)
- Reduction of unnecessary admissions to hospital, particularly for ambulatory care sensitive conditions.

Croydon Community Services (CSS):
- More responsive and productive community services piloting a new model of care.
- The model of care will require new ways of working for acute and community services
- The CCG will require evidence from CUH that workforce development needs and skill-mix are supported through CPD.

Local Authority Services and Community Partners (e.g. schools):
- Sharing of data to identify needs earlier to more effectively target resource and support to those in need
- Alignment of staged interventions
- Prevention of escalation of needs to specialist services e.g. Children’s Social Care
- More effective coordination of care at a case by case level
- Participation in multi-disciplinary case management for those with the most complex needs
- Greater impact and improved outcomes

All – development of and adherence to inter-provider clinical governance frameworks
SERVICE DELIVERY LOCALITIES
POPULATION BASED

- General Practice
- Dental Practice
- Optometric Practice
- Pharmacy
The Mission (Adults with long term conditions)

Improve the quality of care for adult patients with long term conditions

Local Multi-Disciplinary Groups...

Group

Sub-Group

Practice

- District nurse
- Community matron
- Social care worker
- Community Mental Health
- Practice nurse
- Social care Specialist
- Mental Health Specialist
- Acute Specialist

Practice

...working in a Multi-Disciplinary System

- Patient registry
- Care delivery
- Care plans
- Risk stratification
- Case conference
- Clinical protocols & care packages
- Performance review

Patient, user and carer engagement and involvement

Joint Governance through Croydon Transformation Board (shared performance/evaluation framework)

Aligned Incentives through an innovative financial model and clarity about local and national KPIs for the organisations involved.

Information sharing to timely access and analyse data

Organisational development and culture

23
The Mission: Children aged -9mths to 5 years

Improve the lives and life chances of Croydon’s children and families

Local Family Engagement Partnerships…

Group

Sub-Group

Practice

 GP

 Practice nurse

Community Paediatrician

Social care worker

Community Mental Health

Health Visitor

Children Centre Early Years Specialist

Family Key Worker

…working in a Multi-Disciplinary System

Patient registry

Risk stratification

Clinical & professional protocols

FEP Case Tracking

Performance review

Family Plan

Family centred planning, consent based

Joint Governance through Croydon Transformation Board and FEP Partnership Boards

Aligned Incentives through an innovative financial model (inc. Payment By Results model)

Information sharing to timely access and analyse data

Organisational development and culture
Target adult populations

The learning from Kings Fund evaluations of virtual wards and discussions with clinical leads suggests we should target the support needs of people at medium risk with long-term conditions.

Rationale:

- Patients more likely to benefit from case management
- Prevention of future complex service behaviours i.e. frequent access of a range of services
- Opportunity to promote self-care and prevent their conditions from becoming more complex in the future.
- (i.e. longer term health benefits / lower cost)
- High risk patients will regress to the mean i.e. after a complex episode of care with multiple admissions

Who are people with medium level of risk?
As a guide this could include:
- Co-morbidities including mental health issues (anxiety/depression)
The risk stratification tool will enable GPs to further identify patients who will most benefit from case management.
- Other areas have established thresholds based on prescribing levels (Leeds) and admission levels i.e. >3 per patient per year (Merseyside)
Targeted children and families

National research* and policy evidences the case for early intervention and preventative support in early childhood, to improve life chances and outcomes (* e.g. Allen Review 2010)

There are 25,200 under 5s in Croydon (N.B. 2011 Census data will shortly be available ) and this is predicted to increase.

The proportion of children in poverty in Croydon has been increasing over the past 3 years, and is significantly higher than the England average.

With 27% of children in Croydon living in poverty, the borough is amongst the lowest 25% of local authorities.

We estimate there are 800 families with a level of need and vulnerability requiring co-ordinated care and preventative support from services provided across the Children’s partnership.
Case for change – “Transformation”
What would “good” mean for patients
Introduction to integrated care in Croydon

How will it work?

- Adult Services
- Children’s Services

What will make change stick?
Principles of the model of care

1. Early identification of people with long term conditions/risk stratification
2. Prevention programmes (falls, medicine management)
3. Pro-active care planning and delivery by community team
4. Appropriate emergency responses
5. Pro-active case management of complex patients
6. Improved information flows
Multi-Disciplinary Model of Care

1. Each MDT holds a register of all patients who are at high risk of readmission to hospital.

2. The MDT uses information from the risk stratification tool to identify these patients by risk of emergency admission.

3. Shared clinical protocols:
   - All providers in the MDT agree to provide high quality care as laid out in the inter provider governance frameworks.

4. Care planning:
   - Each patient is then given an individual integrated care plan that varies according to risk and need.

5. Care delivery:
   - Patients receive care from a range of providers across settings, with primary care playing the crucial co-ordinating role and all care providers working collaboratively to coordinate delivery of care.

6. Case conference:
   - A small number of the most complex patients will be discussed at a multi-disciplinary case conference, which will help plan and coordinate care.

7. Performance review:
   - The MDT meets regularly to review its performance and decide how it can improve its ways of working to improve outcomes of care.

1 Icons are illustrative only: any number of other professionals may be involved in a patient’s care, a case conference or performance review.
The purpose of the risk stratification dashboard is to identify patients who require case and disease management.

The top chart represents the distribution of patients by risk score. Users can click a given risk score interval to filter the chart below.

The bottom chart displays when and where patient events have occurred or a user defined period. The colours of the Gantt chart represent the care setting where the event occurred.
How might the MDT work in practice for long term conditions patients?

Local practice activity

Stage of pathway | Patient registry | Patient identification | Care planning | Care delivery | Care co-ordination | Case conference

1. Each practice reviews its list of patients and adds high priority patients as required.

2. Any high risk patients who present who are not on the high priority list will also be offered a care planning session. Patients identified as needing social care support will be referred to reablement. If the carer of a patient is identified as being under stress, the carer will be referred to Social care for assessment.

3. Basic care planning is done by the practice nurse in with the patient and patient navigator present in a 45 minute appointment. As part of care planning, a review date is set and a care co-ordinator named (usually the nurse who leads the session).

4. Care delivered across setting as described in care plan. Complex cases needing full GP review are referred to a GP session.

5. Named care co-ordinator regularly reviews overdue care plan flags, schedules follow-ups as needed, communicates regularly with each patient’s GP and alerts the GP if complications arise.

- GPs refer most complex patients to MDT case conference, where they are discussed by multi-disciplinary team of professionals.
What does that mean for clinicians?

Low risk of hospital readmission (~2.7%)
- Most patients will continue to receive care in their local GP practice with their GP as their primary point of contact and input from practice nurses

Medium risk of hospital readmission (~1.7%)
- A small number of patients who receive care from multiple services will be discussed at practice-based conferences that bring in all the practice’s GPs and other providers as required
- Small practices may have to partner with larger ones to make this resource effective

High risk of hospital readmission (~0.7%)
- A very small number of the most complex patients will be discussed at multi-disciplinary case conferences that include input from an acute consultant and other providers
- These will happen at the full Group level to ensure sufficient scale
Contents

- Introduction to integrated care in Croydon
- How will it work?
  - Children’s Services
- What are the financial arrangements?
- What will make change stick?
An integrated model of care for children aged -9mths to 5 years: Family Engagement Partnerships

Will improve early identification, engagement of and support for vulnerable young families (-9mths – 5 yrs) by …

• co-ordinating planning and support where a response from more than one agency is required through…

• locality partnership arrangements with each children’s centre as the hub of a community network leading integrated delivery with health visitors, GPs and other health services …

• enabling multi-agency teams to be put in place around the most vulnerable families (5-10%) to consider their needs and collaborate to deliver a plan of evidence based support and interventions (the Family Plan)…

• underpinned by strong joint commissioning arrangements and outcome focused contracts to ensure resources are allocated to need and drive maximum impact.
Principles of the model of integrated care for vulnerable children and families

1. Early identification of children and families with additional needs and vulnerabilities (Stage 2 or step down from Stage 3)
2. Multi-disciplinary, locality based, family centred care
3. Family Plan agreed with family putting a programme of parenting support and early interventions in place
4. Regular reviews and tracking of outcomes via CAF or Family Outcomes Star
5. Exit once outcomes achieved with transition to universal services
6. Improved information flows and joined up care
Early Years Foundation Stage
(funded early learning)

**STAGE 1**
Universal personalised services

**STAGE 2**
Single and multi-agency help
Common Assessment Framework
Lead Professional
Team Around the Family (TAF) resolutions

**STAGE 3**
Higher level intervention
Referral to specialist assessments & services
Team Around the Family (TAF) resolutions

**STAGE 4**
Statutory intervention to promote and protect the welfare of children/young people

**LEVEL 1**
Universal
Children, young people & families requiring personalised universal services

**LEVEL 2**
Low Vulnerable
Children, young people & families with low level additional needs requiring single agency support or an integrated response using a common assessment

**LEVEL 3**
Complex
Children, young people & families with high level needs. These children/young people include ‘Children in Need’ (Section 17) who require integrated, targeted support.

**LEVEL 4**
Acute
Children, young people & families with complex additional needs requiring specialist/statutory integrated response; includes child protection (Section 42) and children whose needs/safety cannot be managed in the community

**Universal**
Health and Development Reviews
Screening & physical examinations
Immunisations
Promotion of health and wellbeing
Promotion of sensitive parenting and child development
Involvement of fathers
Mental health needs assessed
Preparation and support with transition to parenthood and family relationships
Signposting to information and services

**Universal plus**
Emotional & psychological problems addressed
Promotion and extra support with breastfeeding
Support with behaviour change (smoking, diet, keeping safe, SIDS, dental health)
Parenting support programmes, including assessment and promotion of parent – baby interaction
Promoting child development, including language
Additional support and monitoring for infants with health or developmental problems
Common Assessment Framework completed

**Higher risk**
High intensity based intervention
Intensive structured home visiting programmes by skilled practitioners
Referral for specialist input
Action to safeguard the child
Contribution to care package led by specialist service
How will the FEP work in practice?

1. **Stage of pathway**
   - **Patient registry**
     - GP Practice reviews its list of patients and adds high priority patients as required.

2. **Patient identification**
   - Children’s Centres will identify families with additional needs.
   - Social Care will identify families with appropriate level of vulnerability, from initial contacts or cases stepping down from Stage 3.
   - GPs, Health Visitors, Midwives and other community health services will identify families with appropriate level of vulnerability (Stage 2 needs) through core activity.

3. **Care planning**
   - CC will engage with referred families and obtain consent.
   - A multi-agency FEP meeting will allocate resources and support to engage with family and provide interventions (such as parenting classes, family support services, outreach activity).

4. **Care delivery**
   - Support provided to family as agreed in Family Plan.
     - FEP team regularly reviews progress of Plan.
     - CAF or Family Outcomes Star in place to identify progress.
     - Referral to other services if needs change.

5. **Care co-ordination**
   - Exit plan in place.
     - Two year old funded nursery provision with family support plan or
     - Family to access universal offer (in line with Family Outcomes Star).
     - Notify referrer.
▪ Case for change – “Transformation”
▪ Introduction to integrated care in Croydon
▪ How will it work?
▪ What will make change stick?
What will make change stick?

Aligned incentives

Outcomes incentives will be aligned across providers, and providers will share a pool of funding.

Joint governance

Representatives from each provider organisation will be part of a joint governing, decision-making body that monitors and acts on issues.

Information sharing

A mechanism for sharing that aggregates patient-level data so that it can be analysed and accessed in a timely, seamless way.

Organisational development and culture

Leaders and clinical teams spanning provider organisations will undertake joint training and development, and will begin to develop their own team cultures.

Ownership by the public
Two crucial steps need to be taken and one agreement needs to be made to support the delivery of cost effectiveness before incentives to be paid out.

**Step 1: What savings have been made?**

- To release the funds for incentive payments, providers need to be able to demonstrate savings have been made through reduced emergency admissions and UCC/A&E attendances.

**Step 2: What is the impact on quality?**

- Quality of care must be maintained or improved on four dimensions:
  - Safety
  - Effectiveness and outcomes
  - Experience
  - Individual/Family/Carer satisfaction

**Agreement: How do you spend?**

- Allow the providers to invest any incentive payments into improving services which impact directly on NHS patients within their provider organisation with specific guidelines for GPs.
Performance management approach

… There is a clear view of **what success look like** – across all the relevant provider organisations

**1. Set direction & context**

**2. Establish clear accountabilities and metrics**

**3. Create realistic budgets, plans & targets**

**4. Track performance effectively**

**5. Robust case management performance reviews**

**6. Ensure actions, rewards and consequences**

Improved health/care outcomes, affordability and sustainability

**… Accountabilities** are clear, metrics and scorecards cover **relevant and specific areas** and cascade from the CCG/LA to Practice level

**… Targets are realistic yet stretching and fully owned** by providers and the CCG/LA, and supported by appropriate resource

**… Reporting gives a timely view of performance at appropriate detail**, without burdening providers and specifically MDTs or FEPs

**… Actions** are taken to improve performance; there are **incentives** for good and procedures to eliminate bad performance

**… Case management and Performance reviews** are both challenging and supportive, focused, fact-based, and action-oriented

= Today’s focus
Some metrics will be extracted from the information tool whereas others will come from a quarterly audit.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Operations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of emergency admissions</td>
<td>Patients on care plan</td>
</tr>
<tr>
<td>Total number of A&amp;E attendances</td>
<td>Adherence to care plan</td>
</tr>
<tr>
<td>Total number of UCC attendances</td>
<td>Average length of stay</td>
</tr>
<tr>
<td>Total number of emergency inpatient days</td>
<td>Quality of care planning</td>
</tr>
<tr>
<td>Total number of prescriptions</td>
<td>Community nursing hours per patient</td>
</tr>
<tr>
<td></td>
<td>Community social support per patient</td>
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<td></td>
<td>Bed occupancy rate</td>
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<table>
<thead>
<tr>
<th>Quality</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of acute re-admissions</td>
<td>Attendance at MDTs and robust case management</td>
</tr>
<tr>
<td>Reduction in long-term care</td>
<td>Staff-satisfaction of IC.</td>
</tr>
<tr>
<td>Waiting lists for non-acute care</td>
<td>Quality of MDT interaction</td>
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<tr>
<td>Patient experience metrics</td>
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Metrics will be reviewed to ensure the value of the information is proportionate to the time taken to collect.
Outcomes for children/families and service efficacy will be measured from service data and through tools such as CAF or Family Outcomes Star

<table>
<thead>
<tr>
<th>Activity</th>
<th>Outcomes</th>
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<tbody>
<tr>
<td>▪ Number of contacts by service</td>
<td>▪ Narrowing the gap between pupils achieving a good level of development (EYFS Profile) between FSM and non-FSM pupils</td>
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<tr>
<td>▪ Caseload</td>
<td>▪ Increase the proportion of disadvantaged 2 year old children taking up free early education</td>
</tr>
<tr>
<td>▪ Proportion of F2F contact time</td>
<td>▪ Increase in breastfeeding prevalence at 6-8 weeks</td>
</tr>
<tr>
<td>▪ % of outcomes achieved</td>
<td>▪ Percentage of families in greatest need (20% lowest SOAs) having sustained contact with children’s centres</td>
</tr>
<tr>
<td>▪ Duration of support</td>
<td>▪ Increase the proportion of parents with young children completing evidenced based parenting programmes</td>
</tr>
<tr>
<td>▪ Waiting lists for interventions</td>
<td>▪ Increased take up of early education for disadvantaged 3 year olds</td>
</tr>
<tr>
<td>▪ Time to respond to referral</td>
<td></td>
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<tr>
<td>▪ Time to engage with family</td>
<td></td>
</tr>
<tr>
<td>▪ Attendance at FEP meetings and robust case management</td>
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</tbody>
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| Quality                                                                  |                                                                         |
| ▪ Number of emergency admissions                                         |                                                                         |
| ▪ Family/Child satisfaction metrics                                      |                                                                         |
| ▪ Staff satisfaction                                                     |                                                                         |
| ▪ Volume of referrals to Stage 3 services                                |                                                                         |
| ▪ Volume of cases transitioned to universal services                     |                                                                         |

| Sustainability                                                           |                                                                         |

Indicative Evaluation Metrics for Children’s Integrated Care
The Dashboard will enable integrated care planning, tracking of care delivery and information sharing across settings
Conclusions and key messages

- We are **transforming a system of care**, not just redesign pathways

- All service users must benefit from improved outcomes of care which is provided closer to home.

- All service providers must benefit from reduced duplication, operating costs and delivery of care in lower cost settings.

- What is different about this effort is the focus on putting in place the critical enablers
  - Information
  - Shared working
  - Incentives
  - Governance
  - Culture

- The potential longer-term benefits are exciting but unquantifiable at this point. Benefits are likely to be preventative, enabling patients to be more independent and able to manage their conditions better, with an improved quality of life.

- **BETTER USE OF AVAILABLE RESOURCES**