

Integrated Care Pilot Programme

Prospectus for potential pilots



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Integrated Care Pilot Programme

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1. Foreword

Better integrated care is a pre-requisite for a world class health system. It has the potential to lead to better outcomes for patients, carers and users, and can improve people's experience of services. However, it is clear that we often fall short of this mark. The Integrated Care Pilot Programme presents a distinctive leadership opportunity for clinicians, working in a mature relationship with colleagues from other sectors, to shape and test new models of integrated care and achieve a sustainable step change in the quality of patient care and outcomes for service users and carers.

It is clear that in a locally led and focused NHS, different barriers stand in the way of better integration. We want to support partnerships of clinicians, care professionals and managers who are prepared to find new ways of working together in order to achieve a better deal for patients, service users and carers. We recognise that innovation is not free from risk. This programme will enable appropriate risk-taking, in order to achieve a step-change in quality and improved outcomes.

The successful pilots will develop a variety of models for better integrating care at the level of the individual and their pathway, and at the level of the healthcare system as a whole and beyond. The programme will also provide evidence of which combination of incentives, relationships and measures can most powerfully deliver improved integration in a health and care and support system as complex as ours, and demonstrate what outcomes can be achieved as a result.

We hope that you will use this pilot programme locally as an opportunity to overcome the barriers to integration and achieve a demonstrable improvement in outcomes. A test of our success will be that the results achieved by these innovators inspire others to follow rapidly, learning from and implementing new approaches at a speed our patients and service users have every right to expect.

Mark Britnell

Director General for Commissioning and System Management

David Behan

Director General, Social Care, Local Government and Care Partnerships

2. A vision for integrated care

2.1 Introduction

The imperative for improved integration was underlined in the recently published *NHS Next Stage Review and Primary and Community Care Strategy (PCCS)*, and in the concordat *Putting People First*. The PCCS announced that DH would pilot new clinically-led models of integrated care. This prospectus outlines the vision for delivering this, embracing opportunities for a true partnership approach to deliver the best possible outcomes for patients and service users.

The pilots will test and evaluate new ways in which PCTs can commission more integrated services from innovative groups of clinicians, working closely with local partners. Pilots may take the form of an 'integrated care organisation', but they will not be limited to a structural model.

This prospectus invites innovative applications from prospective integrated care pilot sites and sets out the scope of the programme, and the process for selection.

2.2 The vision

Our vision is to add life to years and years to life. This requires a relentless focus on improving quality, improving outcomes and reducing inequalities. We are seeking to deliver a step change in performance, achieved through local innovation, strong leadership from clinicians and other health and care professionals, and integration of services across organisational and professional boundaries. The Integrated Care Pilot Programme will empower clinicians, working closely with their local partners, including patients, service users and carers, to test new models of integration in order to deliver this ambition.

Clinicians are already able to integrate some services more effectively, using tools such as practice based commissioning. However, this pilot programme will support the most innovative proposals for achieving better integration and real improvements in outcomes.

2.3 The hypothesis

Better integration has the potential to deliver some of our key objectives for improving health and care services, including greater personalisation and a shift towards health promotion and prevention in its widest sense. There is a promising body of evidence – national and international – that integration can deliver better quality of care to individual patients and service users and more economic care to communities. Better integration has the potential to improve health and care outcomes through improving collaboration and breaking down professional boundaries. A summary of some of the key evidence has been published alongside this prospectus.

There are a number of different approaches to achieving better integration, and it will be up to pilot sites to determine the best fit for the needs of their local population. Integration could involve bringing together different kinds of expertise and interventions, for example by creating teams of primary and secondary care clinicians, or health and social care professionals. This kind of integration could be achieved through several means, including, but not exclusively, through co-location or employment in a single organisation. Integration could also involve bringing together resources in order to create a locus of accountability close to the patient/service user to enable better care. This could be achieved through several means, including delegation to providers of a risk adjusted capitation sum for a group of registered patients.

The rationale for these pilots is to support new forms of locally-led integration. The programme will support local innovation and redesign, whilst also helping us to understand the impact that better integration can have on improved outcomes and reduced inequalities, and the combination of levers and incentives that are needed to deliver this change. That is why rigorous evaluation is critical if we are to understand what works. The creation of an information base to support the diffusion of innovation and learning is therefore a central plank of the pilot programme.

3. Objectives and outcomes

3.1 Objectives of the pilot programme

The specific objectives of the pilot programme are to:

- Establish a number of clinically-led pilots spanning health or health and social care and beyond
- Create an effective learning and support network for the pilot sites in order to accelerate their development
- Establish a rigorous evaluation of the programme as a whole, which adds to the current evidence base and identifies what benefits can be achieved by integrated working
- Disseminate and share widely the emerging learning from the pilot sites so as to encourage spread and adoption of benefits in the wider health and care community
- Establish a knowledge base to support PCTs and Local Authorities in their commissioning and performance management of integrated care models, and to inform individuals in their choice of providers where appropriate

3.2 Outcomes of the pilot programme

There are a number of desired outcomes for the pilot programme, not all of which could be fully realised in the pilot period itself.

At a **local** level within the pilot sites, the desired outcomes are to achieve (for a specified target population):

1. Improved quality of care, health, equity and economy, at a faster rate than in comparable populations
2. Improved patient and user satisfaction, reported outcomes and quality of life
3. Improved partnerships in care provision
4. Better use of scarce resources and more effective and economic delivery systems
5. Improved relationships, governance, risk management and innovation in specific delivery systems

At a **national** level, the desired outcomes are:

1. A compelling addition to the evidence base about what improvements in quality and outcomes can be achieved through integration, through an evaluation of the whole programme
2. An appetite and process for sharing and implementing improvements widely across health and social care and beyond

4. Evaluation and measures

4.1 Purpose of evaluation

In addition to supporting local partnerships to test new models of integration, we will put in place a three-year independent evaluation of the pilot programme. The evaluation will build on the current evidence, and develop a clearer empirically based picture of what works and what improvements in outcomes can be achieved through effective integration.

It will be important for the results achieved during the life of the programme and the outcomes achieved over longer timescales, to be collected and analysed in a consistent format that will enable rigorous evaluation. Transparency about these results, and successes and failures will help everyone learn from the pilot programme. It will also enable PCTs and Local Authorities to hold providers to account and make informed commissioning decisions when considering commissioning integrated care models.

4.2 National and local measures

The design of measures of care, and the collection and open reporting of a robust data set by each pilot site will play a pivotal role in enabling the independent evaluation of the national pilots. A set of measures will be established at both a local and national level. All pilots will be expected to collect and submit data on the set of national measures. The local measures will be specific to individual pilots and will therefore vary locally.

Measures will be split into two categories:

- Process indicators
- Outcome measures

In Year 1, pilots will be expected to demonstrate prospective/process indicators that will reflect the processes that need to be in place to ensure achievement of outcome measures in Year 2.

Both the national and the local measures will fall into four measurement domains. The specific metrics within the four domains will be agreed prior to the start of the pilots. The domains are still under development, but are likely to cover:

- Improved care
- Improved care co-ordination and system responsiveness
- Productivity and effective use of resources
- Innovation and sustainable change

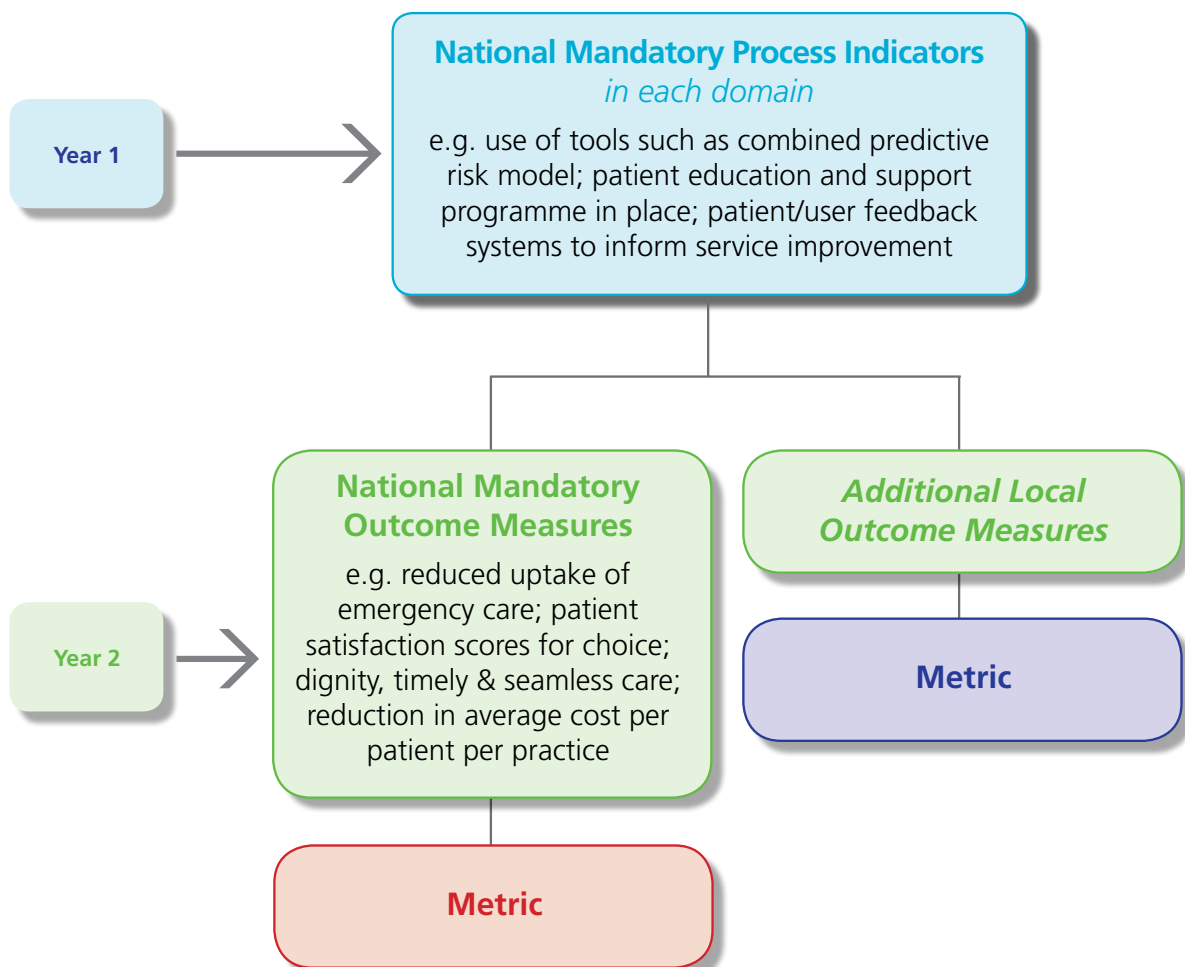
In addition to the set of national measures, pilots will be required to propose specific local metrics for the interventions they propose for their pilot. As a minimum, pilots will be expected to draw on existing national metrics and quality indicators when choosing their pilot specific local measures.

Pilots are required to achieve all process measures in Year 1 and all the national outcome measures, and at least one local measure, in Year 2 (see diagram on page 7 and Annex A for further details of the proposed metrics).

Data will need to be submitted throughout the three year evaluation period. The collection, validation, governance and security of this data will be an essential condition for inclusion in the national programme. Equally important will be an agreement between parties on matters of data access and sharing. Pilot sites will need to report and share results, as an integral part of the learning and dissemination process.

National Mandatory Domains

- Improved Care
- Improved Care Coordination & System Responsiveness
 - Productivity & Effective Use of Resources
 - Innovation & Sustainable Change



The Shakeston Measurement Hierarchy, 2008

5. Details of the pilots

5.1 Scope of the pilots

The pilots will test a number of diverse models of integration. Successful pilots will need to demonstrate a focus on innovation and integration, leading to improvements in outcomes, reductions in health inequalities, and improvements in quality and levels of satisfaction.

The approaches that pilots will take to integration are likely to vary and include different contractual forms, care designs, financial incentives and developmental inputs. We are keen to see a range of different approaches across the pilot sites.

Pilots could choose to work with various other parts of the health and care system (for example mental health, social care, local government and the third sector) in order to achieve more personal, responsive care and better outcomes for a local population. Pilot sites can also choose to work with private sector providers. Any pilot site wishing to procure the services of a commercial organisation as part of its application should do so within its own procurement framework and good procurement practice.

5.2 Essential components

There are certain essential components that all successful pilot applicants will need to demonstrate in order to be supported as part of this programme. These include:

- Clinically-led
- A partnership across providers in health, social care and beyond according to local needs
- Based on list(s) of patients registered for Medical Services – any contract type
- Supported by the PCT and where appropriate the Local Authority as the commissioner of services and confirmed as being in line with the strategic plan for their local community
- Confirmation that the pilot will co-operate fully with a three-year national evaluation programme, which will include collection of data against local and national measures

- Collaboration and commitment to data collection and sharing of data across the system to support care delivery, measurement and evaluation
- Robust project management and good governance
- Within the current legislative framework
- Confirmation that the pilot will give all patients the choice of provider they are entitled to when they are referred to secondary care, as set out in the NHS Constitution, and – for patients with long-term conditions – choice of provider, treatment and setting, linked to the agreement of their care plans
- Clarification if any of the principles and rules of co-operation and competition would need to be waived in order for the pilot to be successful – this will only be agreed in some circumstances (see below)

5.3 Number and scale of pilots

The number of sites will be dependent on the quality of proposals received, but is likely to be in the region of 20 pilots. There will be no upper or lower limits on the population or patient size of the pilots, as there is no clear evidence to suggest integration works best within a certain population size.

Some pilots may present particular issues for system management and competition. In order to encourage innovation we are prepared to consider waiving or amending the application of some aspects of the principles and rules for co-operation and competition, but only if the scheme is truly innovative and radical and demonstrates real potential to improve outcomes. Any relaxation of these rules or principles will need to be requested and agreed in advance with the Department of Health and the Co-operation and Competition Panel.

5.4 Possible participants in pilot sites

This list is not exhaustive and the pilot participants and their combination will be determined locally and could, for example, include all players in a geographical patch:

- A group of General Medical Services Providers (howsoever contracted) possibly constituting a single PBC consortium or a combination of more than one
- A group of clinicians and care professionals and/or managers
- An NHS or Foundation Trust offering acute hospital or community services
- A PCT including a Provider Services arm offering domiciliary, ambulatory and or bed-based community health services
- An NHS or Foundation Trust offering mental health services
- A Children's Trust
- A Care Trust
- A Social Enterprise
- A Local Authority offering social care, housing or other services contributing to lifestyle improvement
- An Independent or Third sector provider of care or supporting services, including pharmaceuticals
- Patients and patient groups
- An Ambulance Trust

5.5 Mainstreaming

Mainstreaming or adoption in a contractual agreement after the pilot programme has been completed will be a matter for PCTs (and, where relevant, their strategic partners) to consider and decide in their role as leaders of the local health and care community.

6. Selection process and key criteria

6.1 Selection process

There will be a competitive process in order to select the successful pilot sites. Each application will be assessed against a consistent set of criteria. In order to obtain a sufficient range of pilots to address a number of geographic locations, models and interventions, there may be some additional moderation to ensure appropriate spread and variation.

Due to the high level of interest in the pilot programme, pilot selection will involve a two-stage selection process. Stage one will include an initial desk-based filter of pilot applications. This will be followed by a more in-depth second stage assessment involving potential visits to shortlisted sites as well as an analysis of written applications.

There will be a phased approach to selecting pilot sites. This will mean that where prospective pilots have well-developed proposals and a clear and robust approach for data collection and measurement, they will be encouraged to start at an earlier stage.

Stage one

The stage one application form is included as an attachment to this prospectus. The application form should be completed with particular attention to the word limits attached to each question. Application forms which are incomplete or in which word limits are exceeded may be discounted.

Application forms must be submitted by 5pm on **Friday 14 November**. Forms should be submitted electronically to **integratedcare@dh.gsi.gov.uk**. The stage one evaluation process will be completed by early December.

Stage two

Following this shortlisting process, there will be a phased approach to selecting successful pilot sites. The second stage of the selection process will involve site visits, and may require a further written application. Prospective pilots that have more complex or less well-developed proposals will be given some additional time and support to work up their applications, with a cut off date of 31 March. The second stage of the selection process will run from January, with all pilot sites selected by the end of March 09. Further details will be available after the shortlisting phase.

Key criteria

Applications will be assessed against a number of criteria. The key areas that prospective pilots sites will need to demonstrate at this stage are:

- **Clear support from the PCT (and if relevant the Local Authority)**

- **Strong clinical leadership working alongside other professionals**

- **An innovative and radical approach to integration that will develop future ways of working**

- **Track record of effective partnership working**

- **Clear articulation of the outcomes to be achieved**

- **Good data systems and proposals for how outcomes will be measured**

- **Clear project management and governance arrangements**

7. Care integration and its characteristics

7.1 Dimensions of integration

References to some of the thinking in the integration literature are contained in *The Evidence Base for Integrated Care*, published alongside this prospectus. Two dimensions of integration are of principal interest in this pilot programme, although any might be manifested in a pilot design. One concerns the relationship between expertise and interventions that can be considered on a continuum from prevention and promotion, community and primary to specialist or secondary care, along which patients travel and return. In fact, the separation of these interventions and the expertise associated with them, often for professional or organisational reasons, does not always serve the interests of the patient. One approach to integration is therefore to bring the different kinds of expertise and interventions more closely together, for example by creating teams of primary and secondary care clinicians working together or creating teams of health and care professionals. This kind of integration can be achieved through several means, including, but not exclusively, co-location or employment in a single organisation. The objective is a change in practices and relationships between the somewhat separate communities, in the service of the care recipient.

Another dimension of integration concerns the extent to which resources are integrated to enable better care. Funding streams and the responsibilities to commit them can be complex and fragmented and this can result in an absence of stewardship. By creating a locus of accountability for a range of resources, close to the patient or service user, those delivering care can exercise new freedoms to shape and purchase the majority or whole of the care needed. This could be achieved through several means, including for example delegation of a capitation sum for a group of registered patients to providers.

The pilot programme will concern itself with innovation within, and evaluation of, both dimensions of integration, with the purpose of driving step changes in clinical results, patient satisfaction and more effective outcomes.

7.2 Characteristics of integration

A number of characteristics tend to be cited as associated with integrated care:

- Clinicians and care professionals can demonstrate systems that support close working and best use of their skills in support of the patient. As a minimum there is a multi-disciplinary patient care team
- Patient satisfaction and reported outcomes are used to improve care and systems
- Health and care professionals and managers work from documented common goals and design and use incentives, systems and processes to achieve them
- Accountability for the use of resources and quality of care is explicit
- Information systems and shared reporting readily support co-ordinated assessment and delivery of care, and enable measurement, evaluation and sharing
- Self management support and patient education resources are in place
- There is a systematic evidence-based approach to care, including the use of multidisciplinary care pathways
- A culture of quality improvement

7.3 Composition of integrated care systems

A number of entities across the world have received substantial UK attention, because of their seeming ability to deliver better quality of care for long-term conditions, including less reliance on secondary care admission. For example, US managed care organisations such as Kaiser Permanente and the Veterans' Health Administration are often quoted.

A number of UK initiatives have explored care integration and related issues, examples include:

- Demonstration sites of the Kaiser Permanente model initiated in Birmingham, Northumberland and Torbay. Key supports of the system include leadership training and a strong focus on IT and communications systems.¹
- The specific care management approach of US company United Healthcare's Evercare model, has been tested in nine PCTs.²
- UK sites have now been established in the Triple Aim Campaign of the Institute of Healthcare Improvement, focussing on the achievement of improvement goals in population health outcomes, economy and quality of care.
- Three Whole System Demonstrator sites in long terms conditions have just begun their work, focussing on the added benefit of technology in improving integrated health and social care working³.

- Three local systems are involved in the Year of Diabetes Care Project, which focuses on the components that need to be in place for someone with diabetes to receive high quality care over a year.
- A number of patient centred initiatives, supporting patients in self-management of whole system care in Norfolk, Surrey, Cheshire, and Birmingham.

There is therefore a wealth of learning and an emerging evidence base, on which local systems can pull, in order to find a solution that delivers better outcomes in their particular context.

There are a range of potential players, from whom any number could combine to create a delivery vehicle to integrate care, as well as a number of possible mechanisms to deliver integration. Some are financial and contractual and others are developmental and behavioural. Provided that solutions are deliverable within current legislation, and that the national patient choice policy is honoured, proposals for any combination of actors and mechanisms are sought. Where the pilot proposition poses specific challenges to the management of the system, the Department of Health will consider a relaxation of these rules or principles.

¹ HAM, C. (2005) Lost in Translation? Health Systems in the US and the UK. *Social Policy & Administration*, 39, 192-209

² Reviewed in the summary of the evidence base, published alongside this prospectus

³ www.wsdactionnetwork.org.uk

8. Roles and responsibilities

8.1 Pilot sites

Successful pilot sites will determine the precise model of integration that they wish to adopt and the specific interventions they wish to measure. Pilots will be responsible for the implementation of their schemes as set out in their application, including:

- All aspects of pilot governance
- Effective project management and risk management, including co-operation with the national programme management partner KPMG LLP
- Clinical and corporate leadership
- Patient and other stakeholder engagement, liaison and communications
- Sound financial management
- Collection and reporting of the national process indicators and measures
- Attendance at and contribution to collaborative learning sessions – approximately twice per year
- Co-operation with the evaluation partner, including freeing up staff time to participate in interviews and other evaluative methods over the course of the three years
- Making available financial information required in order to evaluate costs and financial benefits of the demonstrator systems, subject to normal good practice on the sharing of commercially confidential information
- Performing Equalities Impact Assessments on proposals in line with current legislation

8.2 Evaluation partner

The Department of Health is in the process of commissioning an independent evaluation partner that will be able to span the complex quantitative and qualitative range of the evaluation requirement.

Once appointed, the evaluation partner will have access to each of the pilots. They will bring pilots together to support and accelerate their learning. The evaluation partner will manage data aggregation and reporting at the whole programme level, based on minimum data set submissions by the pilots. They will prepare material for transmission to interested stakeholders including the NHS organisations not involved in the pilot programme, Local Authorities, patient, user and carer groups, professional bodies, the academic community and others with an interest in care integration.

8.3 Programme management

The Department of Health's Commissioning and System Management Directorate will establish a Programme Management Board to oversee delivery. The Board will be chaired by the Director of Commissioning at the Department of Health, and will include representation from key stakeholders.

The Programme Board will be responsible for:

- Oversight of the programme and its implementation
- Effective risk management at national level
- Ensuring learning is connected to the policy process

KPMG LLP have been appointed to provide national programme management support, and support and advice to pilots in establishing their project management arrangements. This will be in addition to, and will not replace, the local programme management arrangements, which the pilots will direct.

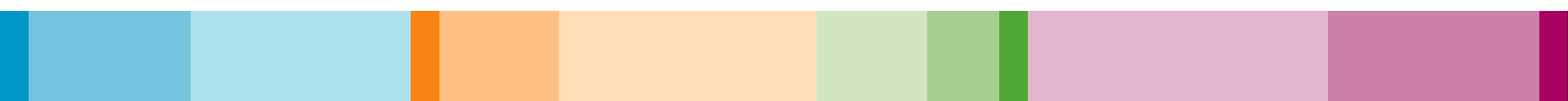
Annex A

Proposed metrics for evaluation

The following tables illustrate the proposed measurements (these are still under development and have not yet been confirmed):

Domain	Year 1 Prospective/ Process Measures <i>(all mandatory)</i>	Year 2 Outcome Measures <i>(national measures are mandatory plus one minimum local)</i>
<p>Improved Care</p>	<p>Systems in place for the routine collection and sharing of all relevant clinical information between ICP parties and across pathways</p> <p>Use of tools such as the combined predictive risk model to highlight and target at risk patients</p> <p>A systematic evidence based approach to care, including increased testing and prescribing in key areas (in accordance with best practice and national guidelines) and effective use of BCBV indicators</p> <p>System in place for monitoring patient care plan</p>	<p>National Metrics:</p> <p>Reduced uptake of emergency care (GP Out of Hours, A&E, emergency admissions, readmissions)</p> <p>Patients report having sufficient information and being involved in decisions about their care</p> <p>Measurement of change in cost of utilisation relative to the cost of the intervention</p> <p>Examples of possible local metrics (these will depend on the specific focus of the pilot):</p> <p>Improved functional health status (PROMS, SF36 etc)).</p> <p>Reductions in gaps of care for targeted patient groups (eg. Diabetic patients HBA1C)</p> <p>Reduced variations in referral and surgical rates</p> <p>Reduced years of life lost in targeted area (eg. mortality from coronary heart disease)</p>

<p>Improved Care Coordination and Health System Responsiveness</p>	<p>Joint needs assessment in place</p> <p>Multidisciplinary care teams and pathways in use</p> <p>Patient/user feedback systems to inform service improvement</p> <p>Patient education and support programme in place</p> <p>Systems in place to identify and communicate with seldom heard groups</p>	<p>National Metrics:</p> <p>Personal care plans in place</p> <p>Increased uptake of services from targeted hard to reach groups</p> <p>Patient satisfaction scores for:</p> <ul style="list-style-type: none"> • choice (what, when and where) • dignity • timely & seamless care <p>Examples of possible local metrics (these will depend on the specific focus of the pilot):</p> <p>Combined health and social care records</p> <p>One stop services</p> <p>Patient held records</p> <p>Patient satisfaction scores for:</p> <ul style="list-style-type: none"> • information & empowerment • carer support • receipt of copies of letters • information and support to make an informed decision
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<p>Productivity and Effective Use of Resources</p>	<p>Use of tools such as the NHS Combined Predictive Model to assess risk and allocate resources</p> <p>Explicit accountability for the use of resources and quality of care are documented and owned system wide / across pathways</p>	<p>National Metrics:</p> <p>Reduction in Average Cost per Patient per Practice (comparative)</p> <p>Reductions in delayed discharges</p> <p>Examples of possible local metrics (these will depend on the specific focus of the pilot):</p> <p>Reductions in unwarranted variation in referrals and utilisation of services: A&E, GP Out of Hours, emergency admissions, LOS, preference sensitive elective services (absolute and comparative)</p>
<p>Innovation and Sustainable Change</p>	<p>Dedicated resources for quality improvement</p> <p>Strategies for leadership development</p> <p>Explicit common goals between clinician and care professionals and organisations</p>	<p>National Metrics:</p> <p>Social care record containing NHS number</p> <p>Evidence of quality improvement systems</p> <p>Incentive schemes to shift care into the community and empower patients</p> <p>Examples of possible local metrics (these will depend on the specific focus of the pilot):</p> <p>Patient held budgets in place</p> <p>Joint health and social care records</p>



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