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National Evaluation of the Department of Health's Integrated Care Pilots

FINAL REPORT: SUMMARY VERSION

RAND Europe, Ernst & Young LLP

Prepared for the Department of Health

March 2012

The research described in this document was prepared for the Department of Health.

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Preface to the Summary Report

This document is the abbreviated version of a longer final output of an evaluation of the 16 DH integrated care pilots (ICPs). It provides a summary of the evaluation activities conducted, the data collected and the analyses completed. This document is designed to be read as a standalone report; however we would refer all readers to the long report which can be accessed and downloaded on the Department of Health's website.

We have identified key findings and conclusions about the processes and outcomes seen within the pilots during the evaluation. The evaluation was conducted by a team from RAND Europe and Ernst & Young LLP, with additional statistical analysis provided by the RAND Corporation and The Nuffield Trust.

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Many people have kindly contributed to the production of this report; in particular we would like to thank the pilot site project teams for their input, generosity of spirit, and patience with evaluation activities over the past two years. A fuller list of individual contributors is given in the full version of this report.

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Acronyms and glossary

CCF	Congestive cardiac failure
COPD	Chronic obstructive pulmonary disease
CVD	Cardiovascular disease
DH	UK Department of Health
Deep Dives	Term for four pilots chosen for in-depth case study: Cumbria, Nene, Norfolk and Principia
Difference-in-difference analysis	A quantitative analysis designed to measure the effect of an intervention, comparing the outcome before and after the intervention, but taking into account any changes that may have occurred in a control population; sometimes abbreviated to DiD
HES	Hospital Episode Statistics
ICO	Integrated care organisation, an entity formed from previously separate care providers or an organisation created to provide integrated services (some sites use this interchangeably with ICP where their intervention involved such a partnership)
ICP	Integrated Care Pilot(s)
Living Document	A template consisting of eight questions/subject areas that all 16 sites amended, tracking their progress at six points throughout the pilot period
NRC	National Reference Costs
p-value	Throughout this report we make reference to 'p-value'. It tells us the likelihood of the statistical data being a result of chance. We use it in order to avoid making unfounded claims about the significance of our observations. Selecting a significance level is a matter of convention but usually a p-value of less than 0.05 is said to be statistically significant.

Key messages from this evaluation

Integrated care comes in many shapes and sizes

- While much of the wider literature focuses on ‘models’ of integrated care, we found that ICPs developed and implemented a loose collection of ‘integrating activities’ based on local circumstances. Despite the variations across the pilots, a number of aims were shared: bringing care closer to the service user; providing service users with a greater sense of continuity of care; identifying and supporting those with greatest needs; providing more preventive care; and reducing the amount of care provided unnecessarily in hospital settings.
- Most pilots concentrated on horizontal integration – e.g., integration between community-based services such as general practices, community nursing services and social services rather than vertical integration – e.g., between primary care and secondary care.

Staff reported improvements in care, most of which were process-related

- Integrated care led to process improvements such as an increase in the use of care plans and the development of new roles for care staff. Staff believed that these process improvements were leading to improvements in care, even if some of the improvements were not yet apparent.
- A range of other improvements in care were reported by pilots following local evaluations. We have reported these in the full ICP Evaluation Report, but they lie beyond the scope of the national evaluation.

Patients did not appear to share the sense of improvement

- This could have been because the process changes reflected the priorities and values of staff (a so-called ‘professionalisation’ of services); the benefits had not yet become apparent to service users (‘too early to tell’); poor implementation; or the interventions were an ineffective way to improve patient experience.
- We believe that the lack of improvement in patient experience was partly due to professional rather than user-driven change, partly because it was too early to identify impact within the timescale of the pilots, and partly because, despite having project management skills and effective leadership, some pilots found the complex changes they set for themselves were harder to deliver than anticipated.
- We also speculate that some service users (especially older patients) were attached to the ‘pre-pilot’ ways of delivering care, although we recognise this may change over time.

It is possible to reduce utilisation and associated costs of hospital care, but it seems to be very hard to reduce emergency admissions

- A key aim of many pilots was to reduce hospital utilisation. We found no evidence of a general reduction in emergency admissions but there were reductions in planned admissions and in outpatient attendance. We speculate that among the patients in our pilots some may have been attached to the pre-pilot ways of delivering care, although we recognise this may change over time.
- The costs of implementing change were varied and individual to each pilot. We found no overall significant changes in the costs of secondary care utilisation, but for case management sites there was a net reduction in combined inpatient and outpatient costs (reduced costs for elective admissions and outpatient attendance exceeding increased costs for emergency admissions).

- Can the approaches to integrated care found in these pilots save money? Our conclusions concur with those of Ovretveitⁱ (2011) – not in the short term and certainly not inevitably. However, we found evidence that the case management approaches used in the pilots could lead to an overall reduction in secondary care costs.
- Echoing the views of Powell Davies and colleaguesⁱⁱ (2006), the most likely improvements following integrated care activities are in healthcare processes. They are less likely to be apparent in patient experience or in reduced costs.

ⁱ Ovretveit J. *Does Clinical Coordination Improve Quality and Save Money?* London: Health Foundation, 2011.

ⁱⁱ Powell Davies G, Harris M, Perkins D, Roland M, Williams A, Larsen K, et al. *Coordination of Care within Primary Health Care and with other Sectors: A Systematic Review.* Sydney: Research Centre for Primary Health Care and Equity, School of Public Health and Community Medicine, UNSW 2006.

What do the results of this evaluation mean for decision-makers?

Do not under-estimate the challenges involved

- The scale and complexity of delivering integrated care activities can easily overwhelm even strong leadership and competent project management. While it may seem obvious in theory that integrating activities should be scaled to match local capacity, this was not always the case in practice. In some cases, enthusiastic local leadership produced expectations that were difficult to realise in practice. Changes to practice often took much longer to achieve than anticipated.
- The approach to integrated care found in these pilots can improve the quality of care if well led and managed, and tailored to local circumstances and patient needs. Improvements are not likely to be evident in the short term.
- Individual organisations looking to implement service integration initiatives should take time up front to prepare for these challenges and create back-up plans to address them.
- Similarly, although the needs of the individual ICPs were due to local circumstances, there were some very common challenges reported, similar to those of more general organisational change.
- We also recommend that the NHS as a whole should work to enable local, transitional changes (e.g., through giving organisations temporary relief from regulations restricting health or social care staff employment, or competition regulations, where strong cases are made).

Do not lose sight of the needs and preferences of patients and service users

- The focus on the needs and preferences of end users can easily be lost in the challenging task of building the organisational platform for integration and in organising new methods of delivering professional care.
- Using performance metrics focused on the end user and strengthening the user voice in the platform for integration might avoid this.

Be creative in developing approaches to integration

- When developing integrating activities there is no one approach that suits all occasions, and local circumstances and path dependencies will be crucial in shaping the pace and direction of change.
- Integration is not a matter of following pre-given steps or a particular model of delivery, but often involves finding multiple creative ways of reorganising work in new organisational settings to reduce waste and duplication, deliver more preventive care, target resources more effectively or improve the quality of care.
- Although there are no pre-given steps, we believe that there is a common set of questions that should be asked when delivering more integrated care. These questions are identified in our proposed structured approach to planning and decision-making, which is summarised in our 'route map'.

Expect the unexpected

- Of the approaches used in these 16 pilots, the case management focus adopted by six sites looked to be the most promising in terms of reducing secondary care costs. However, the reductions in costs were in elective admissions and outpatient attendance rather than in emergency admissions as had been anticipated.

Summary report

1. Background and policy context of the ICP evaluation

The 2008 NHS Next Stage Reviewⁱⁱⁱ (Darzi Review) articulated the need for previously fragmented services to be better coordinated and integrated in order to provide supportive, person-centred care that would facilitate earlier and more cost-effective intervention. This was reinforced in the White Paper *Equity and Excellence: Liberating the NHS* and has received further attention more recently with changes to the Health and Social Care Bill. These changes include the NHS Commissioning Board, economic regulator Monitor, clinical commissioning consortia, and health and wellbeing boards all being given duties to promote better integrated care.

The programme of ICPs was a two-year DH initiative that aimed to explore different ways of providing integrated care to help drive improvements in care and well-being. Organisations across England were invited to put forward approaches and interventions that reflected local needs and priorities, and 16 were chosen for participation (see Table 1).

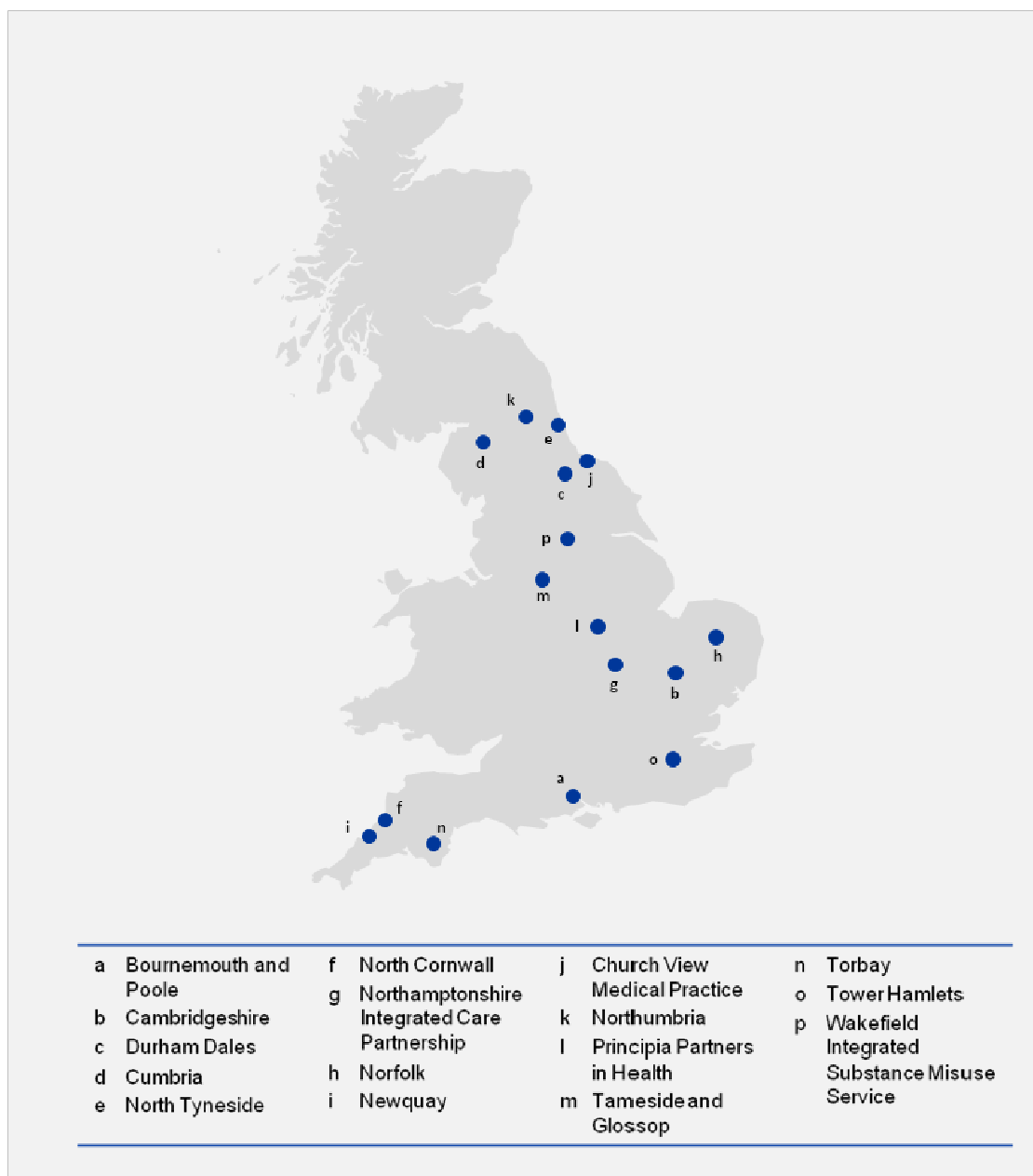
Table 1: The 16 initiatives selected to participate in the DH ICP programme

Pilot	Main integration focus / client group
Bournemouth & Poole	Structured care for dementia
Cambridge Assura	End-of-life care
Church View, Sunderland	Older people at risk of admission
North Cornwall	Mental healthcare
Cumbria	People at risk of admission (self-management)
Durham Dales	<ul style="list-style-type: none"> a) Rapid-access medical assessment clinic with reclassification of acute hospital as community hospital b) Moving services closer to home c) Fuel poverty intervention d) Improved transport to services e) Older people's mental health
Nene (Northamptonshire Integrated Care Partnership)	People at risk of admission to hospital (long-term conditions)
Newquay	Structured care for dementia
Norfolk	Long-term conditions
North Tyneside	Falls in over-60s
Northumbria	Chronic obstructive pulmonary disease (COPD)
Principia, Nottinghamshire	<ul style="list-style-type: none"> a) People at risk of admission b) COPD
Tameside & Glossop	<ul style="list-style-type: none"> a) People at risk of cardiovascular disease (CVD) b) People with CVD
Torbay	<ul style="list-style-type: none"> a) Prevention of admission of older people to hospital b) Enhanced discharge planning c) People in nursing homes with COPD/ congestive cardiac failure (CCF) d) Services for low-level dementia
Tower Hamlets	Structured care for diabetes
Wakefield	Substance misuse

ⁱⁱⁱ Darzi A. *High Quality Care for All: NHS Next Stage Review Final Report*. London: Department of Health, 2008.

Figure 1: Locations of the ICPs

Source: *Integrated Care Pilots: An Introductory Guide*. London: Department of Health September 2009.



The ICP programme was led by the DH with programme management support and pilot liaison provided by an external supplier for most of the programme's lifespan. The ICP evaluation team comprised Ernst & Young LLP (EY), RAND Europe, the University of Cambridge and the Nuffield Trust.

2. Existing evidence on integrated care

There is a lack of common definitions of concepts underlying integrated care. As a consequence, a plethora of terms have been used, including 'integrated care', 'coordinated care', 'collaborative care' and many others. Thus, integration in healthcare is not likely to follow a single path and variations will be inevitable.

Evidence suggests that the problems associated with a lack of integrated care take many forms. In particular, as the population ages, healthcare systems are ever-less well equipped to

respond to the needs of increasing numbers of older patients suffering from multiple chronic conditions and, who require a combination of regular primary care support with both predictable and unpredictable specialist care.

A review of the literature suggests three important conclusions:

- There is no single 'solution' to integrating care. Success is likely to depend on the context in which the integration is introduced, not just the initiative itself.
- Interventions designed to integrate care are likely to improve processes of care and users' experience of care.
- Such interventions are much less likely to reduce costs.

In a recent review, Ovretveit (2011) concluded that the answer to the question 'Does clinical coordination improve quality and save money?' was 'Yes, it can', but that the answer depended on the approach used, how well it was implemented and the environment in which it was introduced, including the financial environment. In our view, this conclusion holds for a broad range of approaches to providing integrated care.

Despite uncertainties revealed in the literature, the need for integrated care retains very high appeal, and much effort has been put into learning from other countries (Rosen et al., 2011^{iv}) and providing guidance to the NHS on approaches that could be used (Ham et al., 2008^v; Lewis et al., 2010^{vi}; Ham and Curry, 2011^{vii}).

3. Evaluation methods

The evaluation used a combination of quantitative and qualitative methods. Our data came from six sources: staff interviews, Living Documents, patient/service-user questionnaires, staff questionnaires, HES, including data on outpatient and inpatient utilisation, and the results of local evaluations submitted by sites.

The quantitative components included analysis of hospital utilisation data from HES, surveys of patient/service-user experience collected from 11 sites and surveys of staff collected from all 16 sites. Questionnaires were administered at two time points: for a cohort of patients/service users in autumn 2009 and autumn 2010, and for staff in summer 2010 and spring 2011. The quantitative evaluation sought to measure changes before and after an intervention had been received for patients, and early and late in the intervention period for staff. Difference-in-difference regression analyses were used to analyse hospital utilisation data for 8,691 cases and 42,206 matched controls, and McNemar's test allowing for clustering was used in the analysis of data from staff and patient/service-user surveys.

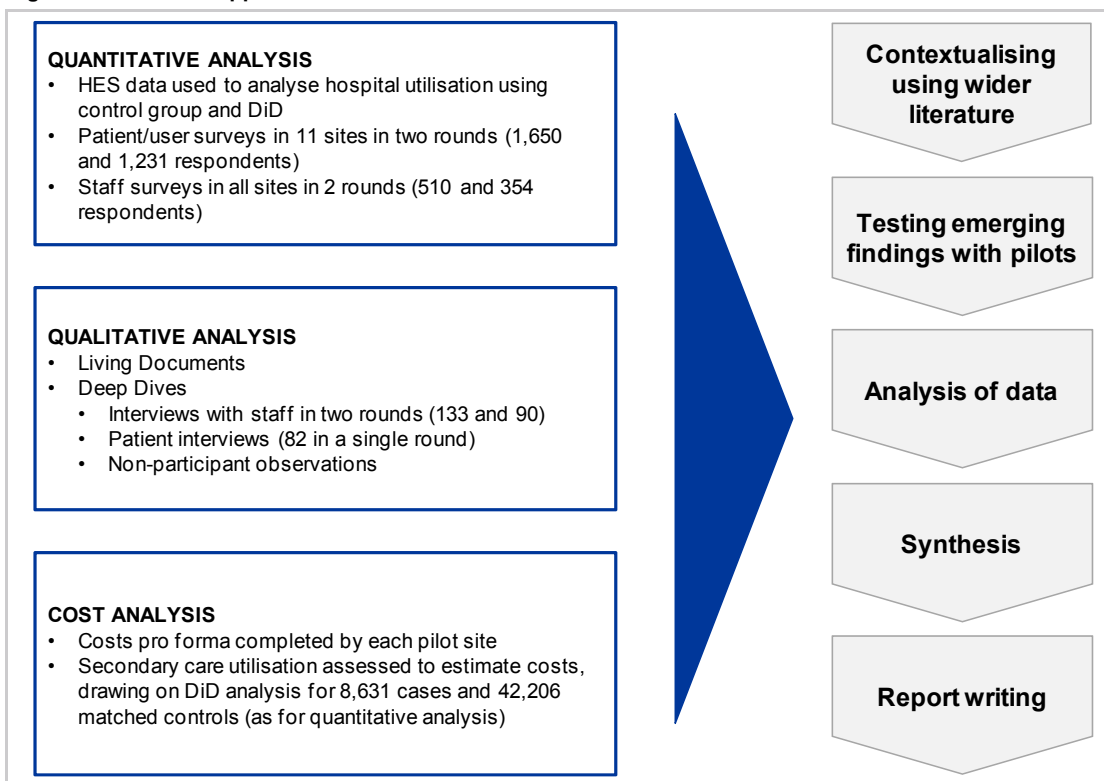
^{iv} Rosen R, Lewis G, Mountford J. *Integration in Action: Four International Case Studies*. London: Nuffield Trust, 2011.

^v Ham C, Glasby J, Parker H, Smith J. *Altogether Now? Policy Options for Integrating Care*. Birmingham: Health Services Management Centre, University of Birmingham, 2008.

^{vi} Lewis R, Rosen R, Goodwin N, Dixon J. *Where Next for Integrated Care Organisations in the English NHS?* London: Kings Fund and Nuffield Trust, 2010.

^{vii} Ham C, Curry N. *Integrated Care. What is it? Does it Work? What Does it Mean for the NHS?* London: Kings Fund, 2011.

Figure 2: Evaluation approach



Qualitative data were collected in two ways: through a structured, free-form questionnaire referred to as a ‘Living Document’, which all 16 sites completed quarterly with support from the evaluation team, and interviews and direct observation in a smaller selection of ‘Deep Dive’ sites. We carried out 133 semi-structured face-to-face interviews with staff members in six sites in autumn 2009 and 90 interviews in four sites in autumn 2010, as well as conducting 82 patient interviews across five sites in spring 2010. Changes in funding of the programme part way through the evaluation meant that a second round of patient interviews as had been originally planned was not feasible. Non-participant observations of various board meetings were carried out alongside the interviews in both rounds.

The evaluation included an analysis of costs and other resources required to develop and run the pilots. The cost estimation aimed primarily to identify categories of cost and the scale of resources required for each category for the first 12 months of pilot operation. We developed a pro forma template sent to all sites for one-time completion (January 2011), allowing us to understand their perceptions of the additional costs involved in developing and implementing the piloted activity. In addition, estimated changes in cost were based on changes in secondary care utilisation from HES data using 2008/09 Payment by Results tariffs. Activity not covered by the tariffs was costed using the NRC). If neither tariff nor NRC were available, the activity was costed as the average tariff for the specialty under which it was delivered.

4. About the pilots

Approaches to integrated care and the activities varied greatly amongst the 16 pilot sites, although most were based in primary care and most involved multiple partner organisations.

Integration as a concept was not rigidly pre-defined for the pilot sites (indeed a degree of experimentation was encouraged), and consequently there were differences in chosen approaches to integration. A few sites attempted full-scale organisational integration (macro-level integration) but this was often difficult within the confines of NHS regulations. The commonest type of activity, implemented in almost all sites, involved integration of practitioners

working in different organisations (meso-level integration). A small number of sites focused on integration within their organisation to improve coordination of patient care (micro-level integration). Most pilots concentrated on horizontal integration – e.g., integration between community-based services such as general practices, community nursing services and social services rather than vertical integration – e.g., between primary care and secondary care.

Details of the integrated care activities in each of the 16 pilot sites are outlined in the long report, including details of conditions and populations targeted, intended interventions and organisations involved.

5. Our findings

We have presented our findings against the five main areas of investigation:

- What did staff tell us?
- What did patients and services users tell us?
- What did hospital utilisation analysis tell us?
- What was the impact on costs?
- What were the facilitators and barriers to success?

a) What did staff tell us?

Outcomes included **improved teamworking**, with **improved communication** both within and between organisations. Sixty per cent of staff who were most involved with pilot interventions reported that they worked more closely with other team members. By the end of the pilot, 51 per cent of staff working closely with the pilot reported that communication within their organisation had improved and 72 per cent reported that communication had improved with other organisations, compared to 1.4 per cent who reported that either or both of these had got worse. Integration with social care remained a problem in many sites, and fewer than half of staff members surveyed thought that their patients received care that could be described as a 'seamless service' by the end of the pilot period.

Staff, especially those closely involved in pilots, reported changes to their work patterns with 62 per cent of this group reporting an increased depth and 84 per cent an increased breadth of their job. Sixty-four per cent of staff closely involved in the pilots had **taken on greater responsibility**, and 64 per cent reported that they had a **more interesting job**. There was a **need for additional training** for these new roles, but less than 30 per cent of staff felt they had increased support for training. Some were critical of the lack of formal training.

A range of improvements to care for patients were described in staff interviews, Living Documents and local evaluations. In the second staff survey, 54.3 per cent of respondents thought that the **care of their patients had improved** over the previous year, compared to 1.1 per cent who thought it had got worse. Fifty per cent of respondents to the second staff survey had seen improvements in care that they attributed to the pilot, though 37 per cent thought it was still too early to tell.

b) What did patients and service users tell us?

Responses to surveys from patients and service users were more mixed. Following the interventions, respondents across all sites reported **receiving care plans more frequently** (round 1: 26 per cent, round 2: 34 per cent, $p < 0.01$ ^{viii}) and **care that was better coordinated when they were discharged from hospital** (e.g., 'knew who to contact about your treatment after you left hospital'; round 1: 71%, round 2: 80 per cent, $p = 0.03$). However, patients and

^{viii} For those unfamiliar with the meaning of p-values, please see the Glossary.

service users also found it **significantly more difficult to see the nurse of their choice** following an intervention (9 per cent reduction in those 'always' or 'almost always' seeing their preferred nurse, $p = <0.01$), and they reported being **listened to less frequently**, with a 15 per cent reduction in patients feeling their preferences were taken into account ($p = 0.02$). They also reported being **less involved in decisions about their care** (round 1: 59 per cent, round 2: 54 per cent, $p = 0.03$). These differences were, in general, more evident in sites focusing on case management for at-risk patients.

c) What did the hospital utilisation analysis tell us?

Across all sites (8,691 cases and 42,206 matched controls), we found a significant 2 per cent **increase in emergency admissions** for pilot patients, with a **reduction in elective admissions and outpatient attendances** by 4 per cent and 20 per cent respectively. These findings were exaggerated among the case management sites (3,646 cases and 17,311 matched controls) where we found a significant increase of 9 per cent in emergency admissions in the six months following an intervention and a reduction in outpatient attendances and elective admissions by 22 per cent and 21 per cent respectively. The increase in emergency admissions was unexpected and may have been due to imperfect matching of cases and controls. Sensitivity analyses suggest that, while we cannot be sure that sites increased emergency admissions, we are confident that they did not in general achieve their aim of reducing emergency admissions.

A preliminary analysis suggests that three-quarters of the reduction in elective admissions in case management sites was associated with fewer elective admissions for cancer, and for chemotherapy in particular.

d) What was the impact on costs?

We assessed the effort that was required to establish integrated care initiatives and the consequences in terms of costs of secondary care utilisation. We identified the costs incurred in the pilots in terms of:

- set-up/one-time costs (labour)
- set-up costs (non-labour)
- costs carried over from previously existing services (non-labour)
- running costs (additional labour)
- running costs (continuing/existing labour)
- running costs (non-labour).

We estimated these costs for each of the 16 pilot sites, but noted that project and finance managers in sites had great difficulty at times estimating what were the costs associated with the introduction of integrated care. As a result, some of the estimates have a large element of uncertainty attached. Introducing new services generally requires an up-front investment and very few sites included in their original proposal an aim to make cost savings in their largely primary or community-based organisations within the time period of the pilot. However, several sites aimed to reduce the use of secondary care.

Notional secondary care costs were estimated from our analysis of HES data by applying the set of mandatory and indicative tariffs used in England for the reimbursement of inpatient and outpatient care (2008/09 Payment by Results tariffs). Activity not covered by the tariffs was costed using the NRC. If neither tariff nor NRC were available, the activity was costed as the average tariff for the speciality under which it was delivered. The difference-in-difference (DiD)

analysis for individual pilot patients across all sites (excluding Torbay^{ix}) shows **significant increases in costs for emergency admissions, balanced by significant reductions in costs for elective admissions and outpatient attendances**, leading to a non-significant reduction in overall secondary care costs (£37 per patient/service user, p = 0.36). **For case management sites, there was a significant 9 per cent reduction in overall secondary care costs in the six months following intervention** (£223 per patient/service user, p = 0.01).

e) What were the facilitators and barriers to success?

We identified facilitators and barriers to the success of the integrated care pilots in meeting their individual objectives through interviews with staff in Deep Dive sites and through review of Living Document submissions. The barriers and facilitators identified could often be seen as two sides of the same coin, e.g., good management/poor management. We did not expect to find a single and simple shared set of facilitators and barriers across the range of pilots and variety of staff consulted. Nevertheless, a number of common themes emerged, many of which would be common to any major organisational change. These are summarised in Table 2.

Table 2: Facilitators and barriers to ICP success

Facilitators	Barriers
<ul style="list-style-type: none"> • Strong leadership • Pre-existing relationships at a personal level across organisations • Shared values; collective communicated vision • Investment of effort in widespread staff engagement; staff can see clear benefits • Provision of education and training specific to service change 	<ul style="list-style-type: none"> • Large-scale, complex integrations (scale and complexity were frequently underestimated) • Roles or professional identity of staff under threat • Changes to staff employment involving TUPE (Transfer of Undertakings Protection of Employment) regulations • Unrelated organisational changes; unexpected budgetary changes • National policies, processes and legislation; NHS and local government bureaucracy (e.g., pooling budgets) • Poor IT connectivity between systems and organisations

6. Discussion and conclusions

There is a challenge involved in making judgements about heterogeneous and emergent activities in a changing environment. Not only did the ICPs themselves adapt and change, but the changing wider context, including NHS and social care reforms, introduced a range of confounding factors. Furthermore, pilot status brought with it a degree of legitimacy and national support that coincided with a palpable energy from local leaders. Care would need to be taken before assuming that any of the approaches would generate a similar sense of purpose and enthusiasm if rolled out without pilot status.

The evaluation reveals that integration is a way of managing the problems associated with specialisation and organisational differentiation. Specialisation, in particular, has driven improvement in healthcare for much of the twentieth century while organisational differentiation is an effective way of recognising the need for accountable bodies with manageable tasks. 'Integration' is not an alternative to 'specialisation'. Rather, integrating approaches should be seen as adaptable models of care combining specialisation and standardisation with personalisation and integration.

We identified a set of 'integrating activities' that broadly describe the steps that the pilots went through when trying to provide better-integrated care. These are shown in Figure 3.

^{ix} Torbay is excluded from individual patient analysis of emergency admissions and costs, as patients were not identified as being part of the pilot until actually admitted to hospital.

Figure 3: Steps to provide integrated care



Staff experiences of carrying out their projects were largely positive. Most staff members interviewed were enthusiastic about their pilot's progress and its potential for future impact, though some participants expressed disappointment that their pilot had not lived up to initial high expectations in the scope of new activities or the changes actually implemented. Indeed, it was the case that a number of major planned initiatives, sometimes critical to the pilot's plans, could not be implemented. Most often these were innovations that required major structure change or changes in financial arrangements.

A majority of staff who had direct patient contact thought that care for their patients had improved over the previous year, but we also note that over a third of staff in the second survey round thought it was too early to tell whether their pilot had improved care for patients. This emphasises the length of time that it took for several pilots to introduce their planned interventions – it is very difficult to produce rapid change in a system as complex as health and social care.

In contrast to staff experiences, patient/service-users' experience of care was mixed following interventions, with more care plans and better coordination following hospital discharge, but less continuity of care, poorer communication from professionals and less involvement in decision-making. We speculate on a number of possible explanations for this, including disruption in staffing leading to frail older people having to accustom themselves to new staff and new routines, and the process of care planning professionalising care rather than increasing the engagement of patients and service users in their own care.

We found no evidence of the anticipated reduction in emergency admissions for patients who received an intervention. We have no means of determining whether the continuing volume of admissions was appropriate or not. Balancing the unanticipated persistence of emergency admissions, we found reductions in outpatient attendances, which we suggest may have been due to moving services into primary care settings, an aim of several of the sites. Reasons for the observed reduction in elective admissions (especially in chemotherapy for cancer) are less clear. Taking these changes together, we found no significant impact of the pilots on secondary care costs.

Integrated care activity throughout 16 pilot sites has to date resulted in changes to the delivery of care that have led to improvements in staff experience and organisational culture. The interventions had high appeal to staff involved, and we hypothesise that if continued, they may bring about improvements in outcomes relating to patient care and longer-term cost savings.

	Getting started					System change		Integrated care	
BUILDING GOVERNANCE AND PERFORMANCE MANAGEMENT SYSTEMS	Who is going to do what in the new environment?	What standards will apply to new services or new ways of working?	What are the agreed measures of performance and outcomes?	Who will be held to account, for what, and how will they be held to account?	How will we communicate progress to outside stakeholders?	How will we embed new accountability and responsibilities?	How will integrated management and change services, experiences and outcomes?	How will the accountability arrangements be made to work in newly integrated services?	
MAKING AND DEVELOPING THE LOCAL BUSINESS CASE FOR INTEGRATED CARE	How can more integrated approaches be described clearly and compellingly to multiple stakeholders?	How will integrated approaches deliver more evidence based improvements to health outcomes and patient experiences?	How will more integrated approaches deliver better value for money through lower costs, improved productivity or measurable benefits?	How can data be used to demonstrate the extent of progress and keep forward momentum?		How does monitoring produce learning and adaptation?		How can continuing benefits be communicated to target groups to sustain flexibility, support and momentum?	
CHANGING ATTITUDES AND BEHAVIOURS	What style of leadership is required and how might this change with different stages of development?	Whose behaviour needs to change and how will this be brought about?	Do stakeholders have the necessary skills and capacities to deliver integrated care?	Why should stakeholders support more integrated services?	Do staff and service users know: 1. What our approach to integration is? 2. Why it might improve care? 3. Their role in delivering it?	How will new values become accepted as legitimate?	How will new behaviours and professional roles become accepted as legitimate?	How will new behaviours become part of routine normal practice?	How will the need for specialist care be combined with the need for well coordinate care?
DEVELOPING NECESSARY INFRASTRUCTURE (INCLUDING INFORMATION TECHNOLOGY)	Does the infrastructure currently existing support more integrated working?	How can current infrastructure be adapted or changed to meet the needs of more integrated working?	How can necessary changes to current infrastructure be resourced?	How can necessary changes to infrastructure be implemented?	How can current infrastructure be developed so that it drives integration rather than getting in its way?	How can infrastructure start to drive integration rather than prevent it?	How can infrastructure enable learning and adaptation in delivering integrated care?	How can infrastructure facilitate and sustain changes in the wider environment of health and social care?	How can a new approach to infrastructure support continuous improvement?
ESTABLISHING SUPPORTIVE FINANCIAL SYSTEMS AND INCENTIVES	How can resources be moved to where they are most effective?	How can financial savings be identified in real time?	How can decision makers be shown the financial consequences of their choices?	How can decision makers be shown the non-financial consequences of their choices?	How can decision makers be incentivised if savings are made elsewhere in the system?	How can decision-making move to whole lifecycles analysis for financial decision making and away from activity based funding?	How can financial decisions be integrated so resources follow priorities?	How can a lean system of provision be established where priorities match resource allocation across the whole system?	How can financial systems become resilient to external change?

Important limitations to our findings

- The ICPs stated that they enjoyed considerable support from their status as DH pilots, and, in addition, they were provided with project management support and formative feedback from the evaluation team. For these reasons, we should be careful about assuming that lessons learned from the evaluation would apply to establishing integrated care more widely.
- The pilots built on existing practices, then learned, adapted and/or abandoned some things and seized new opportunities. Any before-and-after study is limited by the emergent and changing character of the interventions.
- Much of the qualitative data used here was sourced from interviews, surveys and structured feedback from the sites. It is inevitable that such data will be subjective and, on occasion, may be designed to present the best impression, though we do not believe this was generally the case.
- The reduction in secondary care costs which we demonstrated in case management sites needs to be balanced against the cost of delivering new services in the community, which were not measured in this study.
- The quantitative evaluation was limited to survey data from staff and service users and comparison of outcomes with data from matched controls. Attribution of changes (or lack of them) to the intervention is less secure in this design than in, say, a randomised controlled trial.
- General conclusions about integration are limited by the nature of the particular interventions of these 16 ICPs, especially their focus on integrating community-based care as opposed to, for example, integration between primary and secondary care (which was the focus of only a minority of pilots).

Note

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