Integration of health and social care in England: integrated care ‘pilots’ and their evaluation with particular focus on the Integrated Care and Support Pioneers

Nicholas Mays

Green Templeton College Care Initiative Lecture Series Autumn 2017
23 November 2017

Improving health worldwide

www.lshtm.ac.uk
The longer term evaluation team

- LSHTM
  - Nicholas Mays, Mary Alison Durand, Nick Douglas, Bob Erens, Richard Grieve, Ties Hoomans, Tommaso Manacordia, Sandra Mounier-Jack
- PSSRU, LSE
  - Gerald Wistow
- Nuffield Trust
  - Martin Bardsley, Eilis Keeble
- HSMC, University of Birmingham
  - Judith Smith, Robin Miller
- Mary-Alison.Durand@lshtm.ac.uk (lead researcher)
- Nicholas.Mays@lshtm.ac.uk (principal investigator)
Part of this presentation summarises independent research, commissioned and funded by the NIHR Policy Research Programme (Policy Research Unit in Policy Innovation Research, PR 102/0001 and Evaluation of the Integrated Care and Support Pioneers Programme in the Context of New Funding Arrangements for Integrated Care in England, PR-R10-1014-25001). The views expressed are those of the authors and not necessarily those of the NHS, the NIHR, the Department of Health, its arm’s length bodies or other government departments.
Outline

• Policy background
• The Integrated Care & Support Pioneer programme and its national evaluation
• Early evaluation, 2013-15
• Evaluation 2016-17: interviews and key informant surveys
• Reflections on recent history of health and care integration, and its evaluation in England
• Some questions for discussion
Policy background
Health and social care: separate structures and responsibilities

- NHS is ‘central’ and social care is ‘local’ government responsibility
- Single purpose Service, managed vertically through a national hierarchy (NHS) alongside multi purpose agency operating horizontally across a place (LA)
- Different planning, funding and accountability regimes/cultures
  - NHS universal service, largely free at the point of use, funded from national taxation
  - Social care targeted, means tested, funded from mix of general & local tax
- Health and social care responsibilities explicitly defined according to skills of providers not needs of service recipients
- Relative emphases on: services over place; vertical integration over local whole systems; professional boundaries over whole person needs
- NHS and local government designed to be separate and different since 1948
The enduring policy paradigm for HSC collaboration

- First formalised in 1973 and most recently re-set in 2013
- Exhortations to work together reinforced by statutory duties
- Aspiration towards shared geographical boundaries for NHS and local government
- Local forums for coordination of commissioning plans but minimal decision-making powers or accountabilities
- Some financial incentives to support plans and planning
- Efforts to build bridges between ‘parallel’ organisations and overcome barriers rather than integrating mainstream processes
- No single agency with responsibility for systems leadership, budgets and performance
The current aspiration

Better Integrated Care

**Why?**
To redesign health and care systems to provide universal, equitable, high-quality and financially sustainable care

**How?**
Five interdependent strategies: (1) empowering and engaging people and communities; (2) strengthening governance and accountability; (3) reorienting the model of care; (4) coordinating services within and across sectors; and (5) creating an enabling environment

**What?**
To manage and deliver health and care services so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation, palliative care and support services, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the life course
Hope that care integration will help people manage their multiple chronic conditions better *and* at lower cost

- Better coordination between parts of NHS, and between NHS and social care
  - e.g. to reduce 3000 beds occupied daily by people fit to leave
- Aim for more care outside hospitals, ‘closer to home’
  - requires 15% reduction in unplanned hospital admissions to be affordable and reversing the falling share of spending on primary care
  - hampered by local government funding cuts in social care (e.g. 26% fall in numbers receiving publicly funded social care, 2009-13)
  - Better Care Fund taken from NHS to help fill the funding gap
Popular methods to realise the aspiration of ‘integrated care’ across health and care


http://journals.plos.org/plosone/article?id=info:doi/10.1371/journal.pone.0132340
The Integrated Care and Support Pioneer Programme and national evaluation
The Pioneer programme

• *Integrated care: our shared commitment* (2013)
  • DH & 12 national partners committed to ‘urgent and sustained action’ with the ‘ambition to make joined up and coordinated health and care the norm by 2018’

• DH called for the ‘most ambitious and visionary’ local areas to become integration Pioneers to drive change ‘at scale and pace, from which the rest of the country can benefit’ (DH, May 2013)
  • 14 successful out of >100, November 2013
  • 11 successful, January 2015

• To be given access to expertise, support and constructive challenge from a range of experts over a 5-year period
Pioneer programme definition of integrated care

*My care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes.*” (National Voices 2013)

- A user experience-focused definition that does not prescribe *how* this result is to be achieved at local level
Pioneers to focus on realising the National Voices ‘I statements’ in ‘*Integrated care: our shared commitment*’

- I tell my story only once
- I am listened to about what works for me, in my life
- I am always kept informed about what the next steps will be
- The professionals involved with my care talk to each other. We all work as a team
- I always know who is coordinating my care
- I have one first point of contact. They understand both me and my condition(s). I can go to them with questions any time
The Pioneers

- Generally experienced in HSC integration
- National programme but diverse with Pioneers developing their own plans
- Operating in a context of many other initiatives
  - Proactive Care Programme, Integrated Personal Commissioning Pilots, BCF, etc. ...
- With strong initial interest from national agencies, national NGOs, Ministers
- Range of support – NHSIQ, LGA, Leadership Academy, PHE
<table>
<thead>
<tr>
<th>Wave 1</th>
<th>Wave 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnsley</td>
<td>Airedale, Wharfedale &amp; Craven *</td>
</tr>
<tr>
<td>Cheshire *</td>
<td>Camden</td>
</tr>
<tr>
<td>Cornwall &amp; the Isles of Scilly</td>
<td>Fylde Coast *</td>
</tr>
<tr>
<td>Greenwich</td>
<td>Greater Manchester *</td>
</tr>
<tr>
<td>Islington</td>
<td>Nottingham (City) *</td>
</tr>
<tr>
<td>Kent *</td>
<td>Nottinghamshire *</td>
</tr>
<tr>
<td>Leeds *</td>
<td>Sheffield</td>
</tr>
<tr>
<td>NW London</td>
<td>South Somerset *</td>
</tr>
<tr>
<td>South Devon &amp; Torbay</td>
<td>Wakefield *</td>
</tr>
<tr>
<td>South Tyneside</td>
<td>West Norfolk</td>
</tr>
<tr>
<td>Southend</td>
<td>Vale of York</td>
</tr>
<tr>
<td>Stoke and North Staffordshire</td>
<td></td>
</tr>
<tr>
<td>Waltham Forest, East London &amp; City *</td>
<td></td>
</tr>
<tr>
<td>Worcestershire</td>
<td></td>
</tr>
</tbody>
</table>

* Indicates where pioneer sites are also in a locality with Forward View New Models of Care Vanguards
Evaluation of the Pioneer Programme

• Early evaluation of first wave Pioneers (n=14), Jan 14-June/July 15
  • Exploratory
  • Documentary analysis, two rounds of qualitative interviews (n=140 & 57)

• Longer term evaluation of both waves (n=25), July 15-June 20
  • To assess extent to which Pioneers are successful in providing ‘person-centred coordinated care’, including improved outcomes and quality of care, in a cost-effective way
  • To identify what works best in delivering quality integrated care in different contexts
  1. Process and (limited) impact evaluation
     • annual interviews with leads & annual web surveys with key informants
     • longitudinal analysis of performance indicators
  2. Economic evaluation of specific integration initiatives
  3. Working with sites to test findings & conclusions, consolidate learning from the evaluation
Early evaluation, 2013-15
What is a Pioneer? What does it bring to a place, population or ‘system’?

- A badge (a prize?)
- An enabler
- An informal governance arrangement
- Discrete work streams
- Specific initiatives, services
- An ethos

Multiple meanings made it difficult for respondents to specify what was in and out of scope of their Pioneer and difficult for researchers to evaluate
What were their aspirations and activities?

- **Primary prevention and alternatives to statutory services**, e.g. developing community assets and fostering self-care

- **Getting professionals to work together better**, e.g. multi-disciplinary teams (MDTs), often based around general practice, with forms of care ‘navigation’

- **Improving patient experience**, e.g. single point of contact

- **Moving from reactive to proactive care**, e.g. stratifying patients at risk of admission, care planning

- **Reducing hospital dependence**, e.g. shifting care to primary & community sector, reducing avoidable hospital admissions
Target groups

- Older people in nearly all Pioneers
- People with mental health problems/learning disabilities
- Long-term conditions, end of life care
- Carers, children, cancer
- Whole community
Cornwall & the Isles of Scilly - Shaping services around people’s needs by offering a holistic range of care

- ‘Newquay Pathfinder’ - rolling out a programme that has worked in a small area
- Focus on older people at high risk of a hospital admission or dependency on formal care
- Integrated team approach led by the voluntary sector (12 volunteers embedded in the district nursing team)
- Already shown improvements in people’s reported quality of life and a reduction in cost to the system
  - Make it personal – focus on what a person actually wants rather than assumption of what they need
  - Shared belief strategic sign up/leadership commitment and then translated to frontline staff; shared management plans
  - Robust frameworks for information-sharing and performance management - information-sharing agreement across all organisations; focus on key metrics
- Anticipating delivering cashable net savings across the whole system (e.g. cost of acute admissions, community admissions, cost of mental health services per user)

Who’s involved?
- Cornwall Partnership FT
- South Western Ambulance Service NHS FT
- Royal Cornwall Hospitals NHST
- Kernow CCG
- Cornwall Council
- Isles of Scilly Council
- Peninsula Medical School
- Peninsula Community Health
- Healthwatch Cornwall and Isles of Scilly
- local Age UK
- Carers
- Volunteers organisations
Cheshire - Connecting Care across Cheshire by joining up local health and social care around local peoples’ needs, irrespective of organisational boundaries

- Focus on 1,100 families with complex needs – c.£83.3million cost annually. Early and integrated support services covering mental health, physical health, public health, social care, housing and other key agencies.
  - **Integrated communities**: Live healthier and happier lives in their communities with minimal support; tackle social isolation; extend personalisation and assistive technology; address disadvantage.
  - **Integrated case management**: Access services through a single point, with benefit of a care co-ordinator, single assessment and care plan and multi-disciplinary working.
  - **Integrated commissioning**: Access to services with a track record of reducing the need for longer-term care, e.g. intermediate care, reablement, drug and alcohol support etc.
  - **Integrated enablers**: Joint approach to information sharing, a new funding and contracting model that shifts resources from acute and residential care to community based support, a joint performance framework and joint approach to workforce development.

Who’s involved?
- Countess of Chester NHS FT
- Mid Cheshire NHS FT
- Cheshire West and Chester Council
- Cheshire East Council
- NHS Eastern Cheshire CCG
- South Cheshire CCG
- Vale Royal CCG
- West Cheshire CCG
- East Cheshire NHS Trust
Self-reports of implementation of plans, 2013-15

• National support offer included removal of national barriers to integration but little progress reported
• Continuing impact of barriers which required national resolution as much as local action
• Examples: information sharing; funding and payment systems; procurement regime; FT pipeline requirements; provider viability; workforce development
Self-reports of implementation of plans, 2013-15

• Pioneer bids often included vision of whole system change including focus on health determinants but little ‘hard’ evidence of major service change likely to be visible to users and their informal carers

• Indeed, signs of initial ambitions being scaled back and activities increasingly focused on a narrower range of initiatives
Self-reports of implementation of plans, 2013-15

• Convergence on interventions for older people with substantial needs via MDTs organised around primary care, using, e.g.
  • care navigators and coordinators, risk stratification (e.g. of 2% most at risk) and single points of access

• Signs of more ‘top-down’ pressure on the programme to contribute to reducing financial pressures on NHS
  • deteriorating financial position impelling change of focus
  • national policy to manage rising demand by reducing unplanned admissions & delayed transfers of care
  • concerns that this would lead to less Pioneer innovation and risk taking in future
Person-centred co-ordinated care ‘I-statements’

LA/H&WB
Bottom up

Focus on user experience consistent with evidence of previous integrated care initiatives

Top down
NHS England

Reducing emergency admissions/hospital spending BCF targets

Little prior evidence that integrated care can reduce hospital use
Evaluation 2016-17: interviews and key informant surveys
Key informant surveys

- Participants’ views & experiences over time
- First survey, mid-April to mid-June 2016
- Completed questionnaires: 98/360
- Response rate: 29.1%, 1-9 respondents per Pioneer
- Respondents:
  - CCG: 26
  - LA: 24
  - Other NHS provider: 23
  - Other (e.g. patient reps): 25

- Second survey, June-July 2017 (not yet reported)
Main findings of first survey, summer 2016 (1)

• Pioneers very much CCG/LA led
  • <50% CCG respondents thought acute or community trusts or GPs were very involved

• Top 3 barriers to integrated care
  1. Financial constraints
  2. Incompatible IT/IG systems
  3. Conflicting central government/national policies and priorities
Main findings of first survey, summer 2016 (2)

• New Care Models and BCF seen as very/fairly helpful by 74% & 61%, respectively

• Respondents much more likely to report progress subjectively than against routinely measurable indicators, e.g. unplanned admissions, savings
  • most important achievements reported tended to be in terms of planning & early implementation rather than measurable impacts
  • ‘leads’ more positive than most others
| patients/service users are now able to experience services that are more joined up. | 91 |
| The quality of care for patients/service users has improved. | 91 |
| Services are now more accessible to patients/service users. | 91 |
| The quality of life for patients/service users has improved. | 86 |
| Patients/service users are now able to continue living independently for longer. | 82 |
| The experience of carers has improved. | 82 |
| Patients/service users now have a greater say in the care they receive. | 82 |
| Patients/service users are now better able to manage their own care & health. | 77 |
| Patients/services users now have a greater awareness of the services available. | 77 |
| GPs are now at the centre of organising and co-ordinating patients'/service users' care. | 77 |
| Service providers are now able to respond more quickly to patients'/ service users' (changing) needs. | 73 |
| The number of readmissions to hospital have reduced. | 68 |
| Unplanned admissions have reduced. | 64 |
| Job satisfaction among frontline staff involved in the Pioneer programme has increased. | 59 |
| On average, per patient/service user health & social care costs have decreased. | 27 |
| Most important Pioneer achievements to date by organisation, summer 2016 |
|-------------------------------------------------|------------|-------------|
| Planned/agreed vision/strategy                  | CCG (%)    | LA (%)      |
| Improved working relationships; provider alliance| 31         | 33          |
| Integrated teams; MDTs; joined-up services       | 23         | 46          |
| Joint commissioning; joined-up budgets           | 19         | 29          |
| Specific named programme                         | 15         | 17          |
| New roles introduced/piloted                     | 15         | 4           |
| Involved patients/service users/voluntary groups in co-design | 15       | 0           |
| New models of care/pathways implemented (unnamed) | 12        | 17          |
| Self-care; greater independence for patients/service users | 12   | 4           |
| Improved patient/user experience/quality of care | 12        | 0           |
| Promoting/championing new initiatives; engaging staff | 12       | 0           |
| Integrated IT; shared care records               | 8          | 17          |
| GP involvement                                   | 8          | 13          |
| Reduced hospital admissions/transfers of care    | 0          | 13          |
| Obtaining feedback; evaluation plans developed   | 0          | 13          |
Biggest challenge in next 12 months by organisation, summer 2016

<table>
<thead>
<tr>
<th>Challenge</th>
<th>CCG (%)</th>
<th>LA (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting/keeping all partners on board/working together</td>
<td>19</td>
<td>8</td>
</tr>
<tr>
<td>Workforce planning/recruitment; staff shortages</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Budget pressures/reduced funding</td>
<td>8</td>
<td>42</td>
</tr>
<tr>
<td>Competing priorities/initiatives; focus on short-term targets</td>
<td>8</td>
<td>17</td>
</tr>
<tr>
<td>Integrated commissioning; budget pooling</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Integrated IT; shared records</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Changing staff culture; changing practice/mind-sets</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Demonstrating value of initiatives</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>15</td>
<td>0</td>
</tr>
</tbody>
</table>
Interim conclusions on the Pioneers

• Pioneers remain somewhat distinctive because of avowed health & social care emphasis

• Difficult to make rapid, demonstrable progress
  • reported achievements still tend to relate to ‘vision’, plans, less tangible changes
  • difficult to involve providers
  • context is becoming less favourable with similar barriers & fewer facilitators

• Activities increasingly focused on narrower range of similar, ‘medical model’ initiatives, especially community MDTs

• Findings very similar to previous evaluations, perhaps because many of the initiatives in the Pioneers are similar
Previous evidence on integrated care and its most common manifestations in the NHS

• ‘There is ‘no conclusive evidence that joint working or integrated services either improves clinical or organizational outcomes or that it can ‘unlock efficiencies’”. A review measuring the economic impacts of integrated care suggests that we should change our expectation of integrated care being ‘inherently cost-effective and supportive of financial sustainability’ in light of the evidence. Integrated services, however, can lead to improvements in the experiences of patients and their carers.’

• Few, if any, examples of rigorously evaluated integrated care initiatives reducing emergency admissions

• ‘The evidence suggests that the [MDT] case management approach [especially of ‘high risk’ patients] is a poor choice for achieving significant cost reduction or health benefits.’

• Implementing broader, more systemic approaches may have greater potential (though evidence is sparse) but encounters legal and organisational difficulties

The ‘integration paradox’

- Growing demand and declining budgets strengthen rationale and increase urgency for IC
- However, the same pressures could make integration more difficult if organisations:
  - become more protective of their budgets/staff
  - become less open to change
  - find their staff stretched too thinly covering internal agendas
- Twin pressures likely to continue
- Balance between barriers and facilitators appears to be becoming more difficult for Pioneers to manage
  - Will other parallel policy developments help?
Reflections on recent history of health and care integration, and its evaluation in England
Implementation weaknesses or systemic failure?

• Pioneers apparently defaulting to a predominantly medical model
• Less focus on determinants of health and wellbeing and little evidence of involvement of local public health department (though early days of transfer of the PH function to local government)
• Pioneers not yet delivering integration at scale and pace
• Now risk being eclipsed by other initiatives just as they succeeded previous schemes
1999: Health Act 1999: Enabled local authorities and NHS bodies to pool budgets and enter into lead commissioning arrangements which allow the delegation of services procurement.

2001: Health and Social Care Act 2001: Gave local authorities and NHS bodies the opportunity to consider integrating social care, mental health or primary care services into single organisations called care trusts.

2008: Next stage review: Introduced the concept of ‘integrated care organisations’ in which provider or commissioner organisations could merge or operate under single budgets to deliver integrated care.

2010: Spending Review 2010: Announced the transfer of £2.7 billion from the NHS to local authorities over the four years to 2014-15, to promote better joined-up working.

2012: Health and Social Care Act 2012: Established local health and wellbeing boards in each local authority area, with a duty to encourage the integrated commissioning of health and social care services. Requires NHS England and individual clinical commissioning groups to promote integration where this would improve quality or reduce inequalities. NHS Improvement, as the sector regulator, has a duty to remove any barriers and consider how to enable integrated care provision where this is in the interests of patients.

2009: Integrated Care Pilots: Between 2009 and 2012, the Department of Health supported local health and social care organisations to explore ways to integrate care at 16 sites around England. The pilots integrated services within and across organisations, mainly for older patients with multiple, long-term conditions.

2013: Integrated Care: Our Shared Commitment: The Department of Health and 12 national partners made a commitment for “urgent and sustained action” with an “aspiration to make joined-up and coordinated health and care the norm by 2015.”

2013: Spending Review 2013: Announced the transfer of £1.9 billion of NHS funding from clinical commissioning group allocations into the Better Care Fund.

2013: Integrated Care and Support Pioneers: In November 2013 the Department of Health and national partners selected and launched 14 Integrated Care and Support Pioneers, with a second wave of 11 in April 2015. They are designed to improve the quality and cost-effectiveness of care for people whose needs are met from both NHS and local authority services.

Spending Review 2013: Introduced the Better Care Fund requiring clinical commissioning groups and local authorities to pool a minimum of £3.8 billion to promote integrated working, overseen by local health and wellbeing boards.
2014
Care Act 2014: Requires local authorities to promote integration where this would promote wellbeing, improve quality, or prevent care needs from developing

2014
Five Year Forward View: Called for a ‘radical upgrade’ in prevention and public health; models of care which shift care from hospitals to settings closer to people’s homes

2014
New models of care programme: Introduced seven new models of care based around the Five Year Forward View to be piloted at 50 ‘vanguard’ sites

2015
Spending Review and Autumn Statement 2015: Introduced a commitment to integrate health and social care services across England by 2020 and required local areas to submit plans by April 2017 demonstrating how they will achieve this

2015
Spending Review and Autumn Statement 2015: Announced:
- additional £3.5 billion for social care by 2019-20 through more money for the Better Care Fund, the social care precept which allows local authorities to raise council tax by 2% to fund adult social care; and
- Sustainability and Transformation Fund worth £2.1 billion in 2016-17 to fund sustainable transformation in patient experience and outcomes

2015
NHS Planning guidance 2016-17 to 2020-21: Introduced 44 sustainability and transformation plan ‘footprints’ requiring local health bodies to draw up plans to improve services and finances over the five years to March 2021

2016
Cities and Local Government Devolution Act 2016: Allows combined authorities such as Greater Manchester to take on any functions of a local authority or other public authorities if it is likely to improve the exercise of statutory functions

2016
The provisional local government 2017-18 finance settlement: The Department for Communities and Local Government introduced freedoms for local authorities to increase the social care precept to 3% in 2017-18 and 2018-19, provided their increases do not exceed 6% in total over the three-year period to 2019-20. The Department also announced a new Adult Social Care Support Grant, worth £240 million in 2017-18
Is a new integration paradigm needed?

• Consistently doing similar things with similar results raises questions about how far systemic failure has repeatedly been interpreted simply as weak implementation

• Is the history since 1973 a case of repeatedly trying ‘to do the wrong thing right’ (Wistow, 2017), increasingly frequently?
Intervals between launches of national integration initiatives are shortening

- Partnership for Older People Projects (POPPs), 2005
- Integrated Care Pilots, 2009
- Integrated Care and Support Pioneers, 2013
- Better Care Fund, 2014
- Care Act, 2014
- New Models of Care (Vanguards) Programme, 2015
- Integrated Personal Commissioning Pilots, 2015
- Sustainability and Transformation Plans/Partnerships, 2015
- Primary Care Home Model, 2015
- Devolution of responsibility for health care funding (Devo Manc), 2015
- Accountable care systems, 2017
Primary care home model

Key characteristics

1. integrated workforce with partnerships spanning primary, secondary and social care
2. combined focus on personalisation of care with improvements in population health outcomes
3. aligned clinical and financial drivers via unified, capitated budget with shared risks & rewards
4. provision of care to a defined, registered population of between 30,000 and 50,000

- Growth from 15 rapid test sites in Oct 2015 to > 200 across England in Oct 2017, serving eight million patients and 14% of the population

Vanguards

- 50 vanguards selected in 2015 “to take a lead on the development of new care models”
  - Integrated primary and acute care systems: joining up GP, hospital, community and mental health services (9)
  - Multispecialty community providers: moving specialist care out of hospitals into the community (14)
  - Enhanced health in care homes: joined up health, care and rehabilitation services for older people (6)
  - Urgent and emergency care: improve coordination of services and reduce pressure on A&E (8)
  - Acute care collaborations: linking hospitals to improve clinical and financial viability (13)

Integrated Care Pioneers

25 sites announced between 2013 and 2015

- Pioneers are developing and testing new and different ways of joining up health and social care services across England
- Utilise the expertise of the voluntary and community sector
- Aim of improving care, quality and effectiveness of services provided
Integration today?

• the system, as it stands, often does not deliver the integrated package of care that people (with complex problems) need. It doesn’t deliver their desired outcomes either.........There are often wide gaps between services.... The often inefficient and unreliable transitions between services result in duplication, delays, missed opportunities and safety risks...........(Future Forum 2012)

• the document frankly expressed the rising tensions with local government over what the (NHS) claimed was ‘bed blocking’ and the ambiguous status of.............‘large numbers of relatively active patients’ (who) were occupying beds ‘which are needed for the admission of urgent cases’ due to failure to provide suitable accommodation elsewhere. .. ..(Gorsky 2012)
So, it’s not much to boast about?

- ‘Despite repeated attempts to “bridge” the gap between the NHS and social care........little by way of integration has been achieved over this 40 year period’ (Health Committee 2012)
- Some successes: closing long stay hospitals; and ‘isolated pockets of excellence’ at community/hospital interfaces.
- Overall, integration initiatives have tended to focus on means and structures more than on ends and cultures
- Integration has to compete with many other often conflicting policies: e.g. frequent reorganisations; local government funding; NHS provider stability; data protection; competition and markets; silo-based regulation
Is rising demand for hospital services inevitable? Chris Ham, Chief Executive of The King’s Fund, celebrates the work of new care models that are successfully bending the demand curve.

Last week I had the privilege of visiting new care models in Dorset, Hampshire, Surrey and Buckinghamshire in the company of Don Berwick, international visiting fellow at the Fund. We met clinical and managerial leaders working to improve patient care by providing same-day access to GP appointments, integrating community services in localities, aligning these services with general practices, redesigning mental health services in association with service users, and strengthening specialist care by concentrating services on fewer sites where this will deliver better outcomes – to name but a few of the examples we saw.

We also learnt of plans to develop accountable care systems (ACSs) to take forward the work of the new care models and develop integrated care at scale. One of the lasting impressions for me was the time we spent in The Frimley Health and Care System where Andrew Morris is chief executive of Frimley Health NHS Foundation Trust and lead chief executive of the sustainability and transformation partnership (STP) and ACS. Andrew spoke passionately about the improvements in care that have been achieved by the new care models and other initiatives and the impact they are having on local hospitals.

Most importantly as a result of this work, for the first time in the 29 years Andrew has served as a chief executive, demand for hospital care has fallen. This is evident in flat A&E attendances, and falling emergency admissions and GP referrals. To be sure, local hospitals are still busy but unlike in previous years their workload is manageable and staff are working under less pressure. The downside for the foundation trust is that it is losing income by not treating as many patients as planned but this is a nice problem to have as the Frimley system looks ahead to becoming a fully-fledged ACS with a system financial control total.
Why these differences of perspective?

- Depend on what you look at, where you look, who you talk to, what you take to be evidence of change and impact, and how you interpret what you find
  - we do know that unintegrated care has large negative human impacts (Glasby, 2017)
- Also relates to how you define care integration, as Nolte & Pitchforth (2014, vi) argue:
  - ‘Fundamentally, it is important to understand whether integrated care is to be considered an intervention that, by implication, ought to be cost-effective and support financial sustainability, or whether it is to be interpreted and evaluated as a complex strategy to innovate and implement long-lasting change in the way services in the health and social-care sectors are being delivered and that involve multiple changes at multiple levels. Evidence ... strongly points to the latter, and initiatives and strategies underway will require continuous evaluation over extended periods of time enabling assessment of their impacts both economic and on health outcomes if we are to generate appropriate conclusions about programme effectiveness and the application of findings to inform decision making.’
- This exposes the limitations of conventional evaluation designs acceptable in health
  - focused on assessing the impact of discrete ‘interventions’
  - evaluations have tended to focus on specific mechanisms such as care coordination rather than system change
Conventional evaluation struggles where...

- There is no single or unambiguous ‘intervention’
- The change desired is in and of the system itself, rather than the result of something done to the system or targeted at individuals
- There is no ‘primary outcome’
- There is no obvious comparator
- The system is constantly changing
- The effects of actions on system properties are non-linear
- There are many feedback loops, dampening effects, etc. on the impacts of attempts to change the system
Some questions for discussion

1. What is the purpose of each successive initiative?
2. Is it clear how each successive initiative differs from its predecessors?
3. Why is it expected that each will fare better than is predecessors?
4. Why is it presumed that local actors will be able to bring about changes that have eluded their predecessors and national policy makers for 40 years?
5. What is expected of the evaluations of successive initiatives?
6. Should evaluations try to find out whether the HSC ‘system’ is exhibiting more/fewer of the pre-conditions for successful integrated care rather than trying to assess the costs and benefits of different approaches to integration?
Findings of the early evaluation

Published April 2016:


Also:
Report of the first annual panel survey of Pioneer participants


http://www.piru.ac.uk/assets/files/First%20key%20informant%20survey%20report.pdf