

Does integrated care deliver the benefits expected?

Findings from 16 integrated care pilot initiatives in England

Demands on health and social care are growing as the population ages, new treatments emerge and public expectations rise. A further challenge in England is a complex organisational structure that splits funding and care provision between 433 local authorities providing social services and 152 local health trusts commissioning care from GPs, community bodies and hospitals. In light of this, the *NHS Next Stage Review of 2008*¹ set an aspiration for services to provide better-integrated, person-centred care and earlier, more cost-effective interventions.

To explore these possibilities more fully, the English Department of Health initiated a programme of integrated care pilots (ICPs) in 2009. Some 16 projects were selected, representing a mixed range of target populations, interventions and care providers, with a particular focus on elderly care and management of complex long-term conditions.

There was no single definition of integrated care and the concept was not rigidly predefined for the pilots. Projects were encouraged to set goals and metrics based on local circumstances and to experiment with new delivery models and new ways of working. Most pilots concentrated on horizontal integration between local services rather than vertical integration between hospitals and care in the community. Six projects focused on case management of patients at high risk of emergency hospital admission.

An evaluation team was appointed to assess impact over a two-year period, comprising RAND Europe, the University of Cambridge, Ernst & Young LLP and the Nuffield Trust. The evaluation combined quantitative and qualitative methods in order to explore staff and patient views, including case control analysis of hospital admissions and costs, surveys of patients and staff before and after interventions and staff interviews.

Staff enthusiastic about pilots

Staff in pilot sites were generally positive about the exercise (see Figure 1), with over 60 per cent saying their job had become more interesting. Most felt that teamwork and communication with colleagues had improved, compared to just 1.4 per cent who thought they had worsened, and 72 per cent of staff believed they were working better with other organisations. Encouragingly, given overall aims to

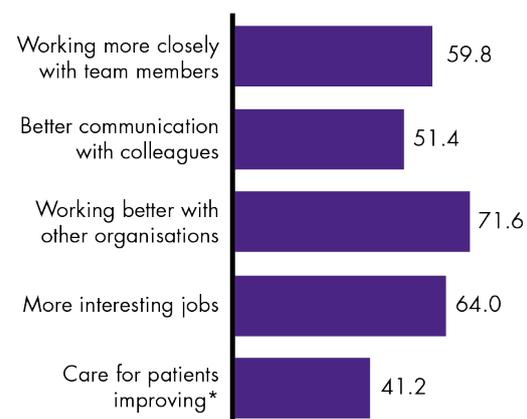
Abstract

A two-year initiative by the Department of Health explored new ways of integrating patient care from different local providers. RAND Europe co-led an evaluation of 16 varied pilot projects, using a mix of quantitative and qualitative methods. We found that no single approach suits all circumstances and change often took longer than anticipated. Overall, the results of the pilots were mixed. Staff were more positive about new ways of working than patients, who did not always feel that new approaches had improved care. Hospital utilisation changed, with fewer planned admissions and outpatient visits, but emergency admissions increased. Local decisionmakers should not underestimate the challenges involved in coordinating care across boundaries, nor lose sight of the needs and preferences of service users.

improve health and well-being, over 40 per cent of staff thought patient care had improved, compared to 1.1 per cent who thought it had worsened. However almost 40 per cent felt that it was too early to tell whether improvements had taken place, underlining the difficulty of producing rapid change in a highly complex system.

Figure 1. Staff felt integrated care improved care and job satisfaction

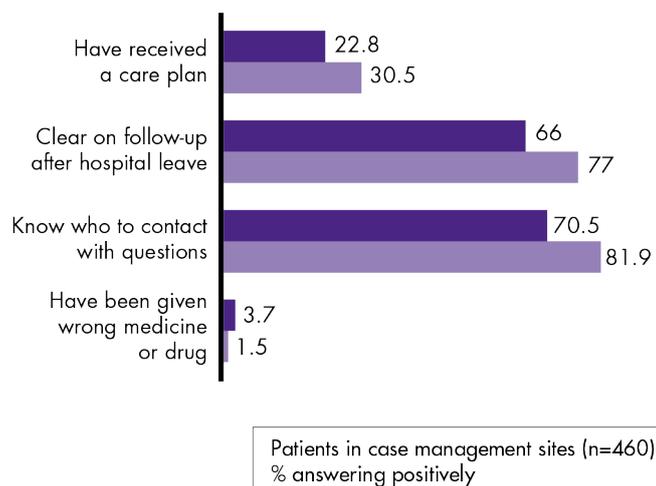
Second round staff survey results (n=350)
% of staff reporting improvement



* 39.6% believed it was "too early to tell"

¹ *High Quality Care For All: NHS Next Stage Review final report.* Department of Health, June 2008.

Figure 2. Patients reported some process improvements



Patients less positive about their experience

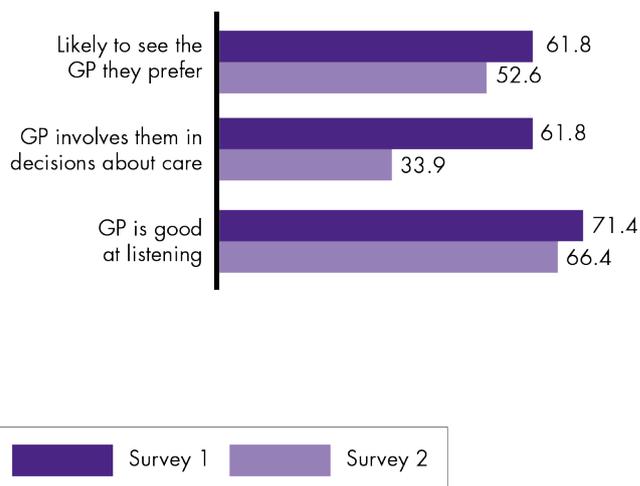
Compared to staff, patient feedback was lukewarm. Patients reported some process improvements (Figure 2), with more patients reporting they had a care plan and understood coordination arrangements. However, their perceptions of the experience were less positive (Figure 3). Patients felt they were less likely to see the GP or nurse of their choice, or to be involved in decisions about their care. There was also a drop in those who felt listened to by social services.

We can speculate on several possible explanations for this drop in patient satisfaction. The process of care planning may have become overly professionalised while failing to engage patients. Some service users, especially older people, may have been attached to pre-pilot ways of delivering care and unsettled by new staff and routines. It may also have been too soon for service users to see benefits, and some pilots certainly found complex changes harder to deliver than anticipated.

Mixed effect on hospital use and costs

A key aim of many pilots was to reduce emergency admissions. We found significant reductions in elective admissions, down by 4 per cent (21 per cent in case management sites), and outpatient visits, down by 20 per cent (22 per cent in case management sites). However, emergency admissions rose by 2 per cent (9 per cent in case management sites), an unexpected increase. This result may

Figure 3. Patients were less satisfied with their care experience



partly have been due to imperfect matching of cases and controls, but our analyses suggest it was highly unlikely that sites achieved their goal of reducing emergency admissions. For case management pilots focusing on those most at risk of hospital admission, closer scrutiny could also have led to more patients being appropriately admitted for specialist care.

The costs of implementing change were individual to each pilot. Very few sites aimed to make cost savings in community-based care, though several hoped to reduce hospital care costs. We found no significant overall reduction in costs, though in case management sites there was an overall 9 per cent reduction in hospital costs.

Challenges should not be underestimated

Efforts to integrate care were helped by clear leadership, shared values, clinician involvement, personal relationships between leaders in different organisations, clear governance and finance arrangements, good communication, support for staff in new roles and stability of both organisations and staff. Barriers commonly mentioned by staff included underestimating scope and difficulty, threats to staff roles and professional identity, national policies and processes, local bureaucracy and poor IT connectivity between systems. A detailed 'routemap' can be found in the evaluation report and further reading (Ling et al., 2012). It identifies questions for providers to consider when planning interventions to improve the integration of care.

Further reading

- *National Evaluation of the DH Integrated Care Pilots*, prepared by RAND Europe and Ernst & Young LLP for the Department of Health, March 2012; TR-1164-DH www.rand.org/pubs/technical_reports/TR1164
- Roland, M et al., "Case management for at-risk elderly patients in the English integrated care pilots: observational study of staff and patient experience and secondary care utilisation", *International Journal of Integrated Care*, Vol. 12 (2012); www.ijic.org/index.php/ijic/article/view/850/1772
- Ling, T et al., "Barriers and facilitators to integrating care: experiences from the English integrated care pilots", *International Journal of Integrated Care*, Vol. 12 (2012); www.ijic.org/index.php/ijic/article/view/982/1770

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