Evaluation of the Integrated Care and Support Pioneers Programme in the Context of New Funding Arrangements for Integrated Care in England

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On behalf of the Evaluation Team
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Evaluation of the Pioneer Programme

• Early evaluation of first wave Pioneers (n=14), Jan 14-June/July 15
  • Documentary analysis, indicators & interviews

• Longer term evaluation of both waves (n=25), July 15-June 20 (with colleagues from Birmingham, Nuffield Trust and LSE)
  1. Process and (limited) impact evaluation, monitoring (inc. panel surveys)
  2. Economic evaluation of specific integration initiatives
  3. Working with sites to test findings & conclusions, consolidate learning from the evaluation
Objectives of the early evaluation

- Describe & understand vision, scope, plans, priorities of 14 first wave Pioneers
- Identify mechanisms – ‘intervention logic(s)’
- Describe financial incentives, contractual forms, budgetary arrangements
- Identify barriers & enablers to integration
- Analyse contribution of Better Care Fund to implementation
- Qualitatively analyse progress
- Set basis for longer term evaluation
Early Evaluation - Methods

• In-depth semi-structured interviews with key staff in Pioneers (mostly face-to-face)
  • Apr 14-Nov 14 (n=140)
  • Mar 15-Jun 15 (n=57)
  • LAs, NHS commissioners, NHS providers, voluntary sector providers

• Analysis of Pioneer proposals, plans & other documents

• Attendance at local & national meetings where possible
Key findings of the early evaluation (1)

• Pioneer seen as:
  • A badge; enabler; governance arrangement; discrete work streams; specific initiatives, services; an ethos.

• Aspirations and activities:
  • Focus on primary prevention and alternatives to statutory services; getting professionals to work together; improving patient experience; moving from reactive to proactive care; reducing hospital dependence. A

• 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
Key findings of the early evaluation (2)

- Pioneer bids often included vision of whole system change but little ‘hard’ evidence of major service change likely to be visible to users and their informal carers.

- Signs of initial ambitions being scaled back and activities increasingly focused on a narrower range of initiatives.

- Tending to converge on interventions for older people with substantial needs via MDTs organised around primary care employing, e.g.
  - care navigators and coordinators, risk stratification and single points of access.

- Signs of more ‘top-down’ management of the programme since NHSE became responsible, perhaps leading to less innovation & risk-taking in future.
  - deteriorating financial position impelling change.
Findings – Early Evaluation

Published 2016:


Also forthcoming in Journal of Integrated Care
Longer term evaluation (2015-20) – Aims

• Assess extent to which all 25 Pioneers are successful in providing ‘person-centred coordinated care’, including improved outcomes and quality of care, in a cost-effective way

• Help build the evidence on what works best in delivering quality integrated care in different contexts
Main strands of longer-term evaluation

Three work packages (WPs):

• WP1: Pioneer level process evaluation and (limited) impact evaluation
  • Indicators
  • Annual surveys and interviews

• WP2: Scheme/initiative level impact and economic evaluation
  • Evaluation of community based integrated MDTs

• WP3: Working with Pioneers, national policy makers and other partners, patient/user organisations and experts to derive and spread learning
WP1: Pioneer level process (and impact) evaluation – Indicators

**Aim:** To analyse key indicators of integrated care and its consequences, comparing Pioneers with non-Pioneer areas/populations.

**Methods:** Analysis of routine national and local data (led by Nuffield Trust)
- To produce a range of indicators (either at population level or covering relevant providers) for each of the Pioneer sites:
  - For each indicator test for:
    - changes in trend over time (where possible) associated with Pioneer status
    - different rates of change in Pioneer sites compared to matched non-Pioneer sites
  - Initially using a generic set of indicators on ‘integration’ performance, drawn from routine sources before moving on to more site-specific local indicators

**Progress:**
- 12 indicators selected initially – interactive dashboard designed and data being collected
Screen shot of Pioneer indicators package in Excel
WP1: Annual interviews with Pioneer Leads and other key stakeholders

• **Aim:**
  • More in-depth perspective on integration initiatives, progress, successes, barriers/facilitators, planning for the future
  • Help explain survey findings

• First wave – Oct 15-May 2016
• Second wave – May 2017
  • telephone interviews (approx. 40 mins)
WP1: Key informants’ panel 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: 23
  - Other (e.g. patient reps): 25
Main findings of first panel survey I

• 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 panel survey II

• 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
Progress of programme reported by Pioneer leads

<table>
<thead>
<tr>
<th>Patients/service users are now able to experience services that are more joined up.</th>
<th>% reporting ‘substantial’ / ‘some’ progress</th>
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</thead>
<tbody>
<tr>
<td>The quality of care for patients/service users has improved.</td>
<td>91</td>
</tr>
<tr>
<td>Services are now more accessible to patients/service users.</td>
<td>91</td>
</tr>
<tr>
<td>The quality of life for patients/service users has improved.</td>
<td>86</td>
</tr>
<tr>
<td>Patients/service users are now able to continue living independently for longer.</td>
<td>82</td>
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<tr>
<td>The experience of carers has improved.</td>
<td>82</td>
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<tr>
<td>Patients/service users now have a greater say in the care they receive.</td>
<td>82</td>
</tr>
<tr>
<td>Patients/service users are now better able to manage their own care &amp; health.</td>
<td>77</td>
</tr>
<tr>
<td>Patients/services users now have a greater awareness of the services available.</td>
<td>77</td>
</tr>
<tr>
<td>GPs are now at the centre of organising and co-ordinating patients'/service users' care.</td>
<td>77</td>
</tr>
<tr>
<td>Service providers are now able to respond more quickly to patients'/service users’ (changing) needs.</td>
<td>73</td>
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<tr>
<td>The number of readmissions to hospital have reduced.</td>
<td>68</td>
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<tr>
<td>Unplanned admissions have reduced.</td>
<td>64</td>
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<tr>
<td>Job satisfaction among frontline staff involved in the Pioneer programme has increased.</td>
<td>59</td>
</tr>
<tr>
<td>On average, per patient/service user health &amp; social care costs have decreased.</td>
<td>27</td>
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<tr>
<td>Most important Pioneer achievements to date by organisation</td>
<td>CCG (%)</td>
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<tr>
<td>-----------------------------------------------------------</td>
<td>---------</td>
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<tr>
<td>Planned/agreed vision/strategy</td>
<td>31</td>
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<tr>
<td>Improved working relationships; provider alliance</td>
<td>23</td>
</tr>
<tr>
<td>Integrated teams; MDTs; joined-up services</td>
<td>19</td>
</tr>
<tr>
<td>Joint commissioning; joined-up budgets</td>
<td>19</td>
</tr>
<tr>
<td>Specific named programme</td>
<td>15</td>
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<tr>
<td>New roles introduced/piloted</td>
<td>15</td>
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<tr>
<td>Involved patients/service users/voluntary groups in co-design</td>
<td>15</td>
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<tr>
<td>New models of care/pathways implemented (unnamed)</td>
<td>12</td>
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<tr>
<td>Self-care; greater independence for patients/service users</td>
<td>12</td>
</tr>
<tr>
<td>Improved patient/user experience/quality of care</td>
<td>12</td>
</tr>
<tr>
<td>Promoting/championing new initiatives; engaging staff</td>
<td>12</td>
</tr>
<tr>
<td>Integrated IT; shared care records</td>
<td>8</td>
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<tr>
<td>GP involvement</td>
<td>8</td>
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<tr>
<td>Reduced hospital admissions/transfers of care</td>
<td>0</td>
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<tr>
<td>Obtaining feedback; evaluation plans developed</td>
<td>0</td>
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<tr>
<td>Biggest challenge in next 12 months by organisation</td>
<td>CCG (%)</td>
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<td>---------------------------------------------------</td>
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<tr>
<td>Getting/keeping all partners on board/working together</td>
<td>19</td>
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<tr>
<td>Workforce planning/recruitment; staff shortages</td>
<td>15</td>
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<td>Budget pressures/reduced funding</td>
<td>8</td>
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<tr>
<td>Competing priorities/initiatives; focus on short-term targets</td>
<td>8</td>
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<tr>
<td>Integrated commissioning; budget pooling</td>
<td>8</td>
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<tr>
<td>Integrated IT; shared records</td>
<td>4</td>
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<tr>
<td>Changing staff culture; changing practice/mind-sets</td>
<td>4</td>
</tr>
<tr>
<td>Demonstrating value of initiatives</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>15</td>
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Conclusions: 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 Sustainability and Transformation Plans help?
Conclusions (2)

• Difficult to make rapid progress
  • reported achievements still tend to relate to ‘vision’, plans, less tangible changes
  • difficult to involve clinicians, especially GPs
  • circumstances are decreasingly favourable

• Activities increasingly focused on narrower range of similar initiatives, especially community MDTs
WP2: Scheme level impact and economic evaluation

• Aim:
  • Undertake economic evaluations of systemically important *integration initiatives* undertaken by Pioneers by relating the resources used to the benefits for patients/users in terms of user experience, and health and/or social care-related quality of life (using a range of designs depending on circumstances) and;

  • Understand how and why these initiatives’ impacts differ depending on different contexts and different modes of implementation employing an integral qualitative component designed to identify the facilitators and barriers encountered compared with the experience of similar initiatives provided by other Pioneers in different contexts.

  • First economic evaluation is of community based health and social care MDTs.
WP3: Interactive component

• WP3: Working with Pioneers, national policy makers and other partners, patient/user organisations and experts to derive and spread learning through:

  • 6-monthly workshops, each with a theme relevant to the evaluation (3 to date)
  • Blogs/ reports on our website

• Opportunity for stakeholders to help shape the research and ensure that it remains relevant to them
Next steps

• 2017 panel survey about to commence

• 2017 annual interviews with Leads started recently

• MDT evaluation

• Some preliminary analysis of some of the indicators data

• Next Pioneers workshop being planned for autumn 2017
The longer term evaluation team

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