Evidence review update
August 2013

A rapid search of the evidence and literature for integrated care (primarily in the UK) has been undertaken. The approach has included grey literature review, collation of information using a respondent-driven process, consultation with senior stakeholders, and on and offline search.

The nature of the evidence base for the interventions is primarily case studies or qualitative data. There is a paucity of robust systematic reviews or peer-reviewed articles providing quantitative evidence, particularly of cost outcomes. One explanation has been the historic difficulty of accessing linked health and social care system data at scale. Another is the relatively recent development of integrated care initiatives across the UK.

As result, the search used a "snowball" approach combined with respondent-driven sampling as opposed to a systematic review. The findings so far have been broken down into the following categories:

Current Document Contents (page number)

Overarching/systematic reviews of integrated care

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability
Bardsley, M. Car, J. Smith, J.	2013	**Evaluation of the first year of the Inner North West London Integrated Care Pilot: summary**	Nuffield Trust	This summary is based on an evaluation undertaken by a team of researchers from Imperial College London and the Nuffield Trust of the Inner North West London (INWL) Integrated Care Pilot (ICP), which aimed to develop new forms of care for older people and those with diabetes.	• Better care planning has real potential to improve patients' experience of care, in particular in reducing duplication and improving access. Patients who had a care plan reported improved access to NHS services (64%), that they now had to spend less time booking appointments to see their GP and other health professionals (55%), and that health care staff asked them fewer questions about their medical history (67%).	The INWL ICP is a large-scale innovative programme designed to improve the coordination of care for people over 75 years of age and adults living with diabetes. The pilot started in July 2011.
RAND Europe, Ernst & Young LLP	2012	**National Evaluation of the Department of Health's Integrated Care Pilots Final Report: Summary Version**	Department of Health	This review provides a summary of a longer final output of an evaluation of the 16 Department of Health (DH) integrated care pilots (ICPs), the activities conducted, the data collected and the analyses completed. Identified are the key findings and conclusions about the processes and outcomes seen within the pilots during the evaluation	• Patients reported receiving care plans more frequently (26%) and felt that care was better coordinated when discharged from hospital (71%) • However, patients also reported finding it more difficult to see the nurse of their choice and they reported being listened to less frequently (15% reduction) • Reduction in elective admissions and outpatient attendances by 4% and 20% respectively	The programme of ICPs was a two-year DH initiative that aimed to explore the different ways of providing integrated care to help drive improvements in care and well-being.

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					• For case management sites, there was a 9% reduction in overall secondary care costs in the 6 months following intervention • Staff felt there was improved team working and improved communication (60%) • 54% of staff thought that care of their patients had improved	
Institute of Public Care, Oxford Brookes University	2010	**From the Ground Up: A report on integrated care design and delivery**	Institute of Public Care, Oxford Brookes University	This report was jointly commissioned by Community Health Partnerships and the Integrated Care Network. It is based on a combination of literature review, stakeholder interviews and four in-depth case studies of integrated services - 1) Mill Rise Village, Knutton and Cross Heath, Staffordshire, 2) The Walkden Centre, Salford, 3) Community Homes Resettlement Project, NHS Norfolk and Norfolk County Council, 4) Oxfordshire Older Peoples' Services. It analyses the elements	• The report concludes that for integrated services to flourish managers must: 1. Clearly map the strategic fit of each of the partner organisations to identify opportunities as they arise. 2. Make the time and effort to understand each other's agendas. 3. Have the right people with the right level of decision making power together around the table. 4. Integrate services that offer a logical fit. 5. Agree with partners the core principles of the services to be developed and work out which areas can	This report aims to support service commissioners; including those involved in planning, service delivery, finance and infrastructure as well as local partnerships, who are looking to develop integrated care services. A guide is available which provides a practical interpretation of the full report:

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				of success in integrating care, and presents a model of design and delivery for managers to consider in relation to their own services and planning new facilities. .	be compromised on further down the line. 6. Look at integrating processes as well as services. 7. Seek management solutions which are both flexible and innovative. 8. Have trust and confidence in each of the partners and recognise that all are working to the same outcomes. 9. Keep the service user at the heart of the process of change with a strong focus on achieving better outcomes. 10. Recognise that efficiency does not lead to integration, but integration can lead to more efficient working practices. 11. Pay attention to issues in procurement early on, whether they are about how to integrate different legal and planning processes or address issues around building design and IT infrastructure. There	

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					are numerous examples where good planning at the start of projects saves considerable expenditure further down the line. 12. Finally, underpinning all of the above remain the reasons for integration. For a successfully integrated care service, the outcomes must shape the form that enables them to happen	
Heenan D	2012	**Health and Social Care Integration: Reflections from Northern Ireland (Presentation to The King's Fund Summit - Tuesday 1 May 2012)**	The Kings Fund	This presentation looks at the lessons that can be learned for integration elsewhere in the UK by looking at the Integrated Health and Social Services Boards that were introduced in Northern Ireland in the 1970s.	• Integrated Working: • Has the potential to provide a seamless system • Improves access, referral and assessment processes • Provides a single point of entry and only one assessment process • Reduces waiting times and duplication of services • Facilitates preventative work and intermediate care, reablement and discharge. • Can provide evidence of professional	The lessons from Northern Ireland demonstrate the positive impact of integrated working and highlight some of the issues that need to be addressed.

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					boundaries disappearing – user centred
					• There are still issues with the system notably:
					  • The need for constant vigilance to ensure health does not completely dominate the agenda
					  • There are some issues with levels of GP engagement	

Care Planning

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability
Dick inson H, Glasby J, Nicholds A, Jeffares S, Robinson S, Sullivan	2013	**Joint Commissioning in Health and Social Care: An Exploration of Definitions, Processes, Services and Outcomes**	National Institute for Health Research, Service Delivery and Organisation Programme	This study seeks to provide a theoretically and empirically robust understanding of the dynamic relationship between joint commissioning, services and outcomes. The authors sought to map out the range of ways in which joint commissioning is understood across five case study sites which all have different types of joint commissioning arrangements in place.	• There may not be anything that is specific about joint commissioning that is different to other ways of working and it is far from a coherent model with a set of clear organisational processes and practices. • The very value of joint commissioning may then be in its ambiguity and symbolism as a concept that is seen as inherently good and able to deliver against a range of the very sorts of pernicious issues that contemporary health and social care organisations struggle with (e.g. health inequalities, constrained budgets, involving the public and service users in the design and delivery of care services). • The study confirms the findings of numerous previous studies of patient and public involvement; that it is difficult, time consuming and fragile in the face of radical organisational or policy change.	This study seeks to address three key questions: 1. How can the relationships between joint commissioning arrangements, services and outcomes be conceptualised? 2. What does primary and secondary empirical data tell us about the veracity of the hypothesised relationships between joint commissioning, services and outcomes? 3. What are the implications of this analysis for policy and practice in terms of health and social care partnerships?

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Newman M, Bangpan M, Kalra N, Mays N, Kwan I, Roberts T	2012	**Commissioning in health, education and social care: models, research bibliography and in-depth review of joint commissioning between health and social care agencies**	EPPI-Centre, Social Science Research Unit, Institute of Education, University of London	This report was funded by the National Institute for Health Research Service Delivery and Organisation (NIHR SDO) programme in order to examine the available evidence on joint commissioning. The study sought to identify good practice and/or help with the production of better quality research on commissioning in the future.	• This project identified a far larger evidence base for service commissioning in health, education and social care than was previously known. A searchable database of research is available at: http://eppi.ioe.ac.uk/webdatabases/Intro.aspx?ID=22. • Synthesis of the results of these studies highlight the importance to successful joint commissioning of: trusting relationships between commissioners, and how these are built up over time by continuity of staff; clarity over responsibilities and legal frameworks, particularly in the context of any shared or pooled financial arrangements; the importance of co-terminosity between organisational geographical boundaries; the development of clear structures, information systems and communications between stakeholders.	The evidence in the report may be helpful in improving the practice of commissioning and/or undertaking better quality research on commissioning in the future.
Weatherly H, Mason A, Goddard M,	2010	**Financial Integration Across Health And Social Care: Evidence Review**	Scottish Government Social Research	This study reviewed the recent evidence and practice outside Scotland relating to better use of	• The goals driving integration need to be made explicit to all those involved in providing the service.	This is an extensive review of literature from across the world that describes and examines

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Wright K				joint resources with a specific focus on financial and resource integration within and across health and adult social care services. The review was undertaken by a team from the Centre for Health Economics and the Centre for Reviews and Dissemination, University of York.	• Full structural integration is rare. • Recognition of different perspectives on key issues such as client risk, financial constraints and accountability is vital if the partnership is to flourish. • Financial and non-financial incentives and organisational processes may be used to help align aims of the Integrated Resource Mechanism (IRM) with the appropriate behaviours and actions of those involved. • The use of common objectives would help to support integrated care on the front line. • All programme staff need to see how integration benefits them and their work. • Use of a central co-ordinator or team may be useful for driving change and supporting staff within the integrated system. • It is important that there is agreement from providers on a key set of data to be recorded routinely and uniformly. • A one-size-fits-all approach to integration should be	the different tools, techniques, systems and processes that have been used to enable financial integration between health and social care

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					avoided: • The type and degree of integration should reflect programme goals and local circumstances. • Approaches to integration require some flexibility, adapting to stakeholder views including those of front-line staff, users and managers. • The evaluation process can be useful for identifying successes and challenges and in supporting change. • Allowance for a local approach within the framework of central/national guidance may be appropriate. Some of the case studies mentioned in the report that are not included elsewhere in this literature review are: • Hertfordshire Integrated specialist mental health service found that the team approach was helpful and supportive. Service-users viewed the integration of care positively, as did carers. • The Audit Commission's 2009 report 'Working Better Together?' found no	

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					evidence that pooled budgets impact on emergency bed days, no significant effect on delayed transfers of care and little impact on per capita spend. • Somerset mental health services found an improvement in self-reported mental health status by service users following the introduction of Joint commissioning through a Joint Commissioning Board • Qualitative evidence with Care Coordination Trials in Australia suggested an increased sense of wellbeing in participants due to care coordination • SIPA in Canada which showed the positive impact of case management provided by a multidisciplinary team. There was a 20% reduction in emergency room use, a reduction in bed blockers and a reduction in the number of nursing home admissions. There was also increased carer and care recipient satisfaction. • PRISMA in Canada demonstrated that an integrated service delivery	

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					system could decrease the incidence of functional decline amongst service users, decrease the burden for caregivers and lead to a smaller proportion of older people wishing to be institutionalised • Rovereto in Italy resulted in a requirement for fewer hours of home support, fewer GP home visits, a lower number of days spent per year in acute hospitals and lower rates of admission to nursing homes, indicating a 23% saving in per capita health care costs • Vittorio Veneto in Italy found that integrated home care services were cost effective and resulted in a reduction in hospitalisations that meant a 29% cost reduction in the intervention group compared to control group. • Jönköping County Council, Sweden introduced 3 major initiatives which resulted in reductions in hospital admissions, length of stay and waiting times.	

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Challis, D.J., Darton, R.A., Johnson, L., Stone, M. and Traske, K	(publication 1995, Abstract 2011)	**Care Management and Health Care of Older People: The Darlington Community Care Project** (Abstract)	University of Kent, Kent Academic Repository	Evaluation of Darlington project designed to enable frail elderly people, who would otherwise need long-stay hospital care, to remain in their own homes.	• The study found that elderly people receiving the Darlington model of care had a higher quality of life and their care was provided at a lower cost than would have been the case if they had been in hospital.	The study describes the development of a service designed to enable frail elderly people, who would otherwise need long-stay hospital care, to remain in their own homes.

Care Navigation

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Goddard, M. K.	2008	**Quality in and Equality of Access to Healthcare Services in England (CHE Research Paper 40)**	Centre for Health Economics, University of York	This "country report" for England is part of a larger, collaborative effort between eight European countries to document and analyse access to health care services. The report uses available research to identify and analyze barriers to access to health care services which are faced by vulnerable groups in society, especially those most exposed to social exclusion.	• Increasing supply is probably less important than devising ways of supporting people in accessing existing services
					• The author suggests that the following are likely to be key features of promising policy initiatives in England:
					  • A national context: Initiatives are likely to have a greater impact across the board if they are part of a larger scale initiative that is clearly thought out and provides a framework within which local schemes can be developed and assessed.
					  • A pilot phase: piloting or experimentation of initiatives seems useful and policies that have worked in one sector can be adapted for other sectors or locations.
					  • Financial incentives: many initiatives have focused on providing extra funding for providers to develop
						The report identifies the barriers to access that are faced by vulnerable groups and discusses the characteristics of those initiatives which appear to be helpful.

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					new services or to re - organise services. Similarly, initiatives at the level of the individual health professional (eg expansion of physical health screening for those with mental health disorders) are more powerful when accompanied by financial incentives for additional effort. • Co - ordination: a major barrier to access for many vulnerable groups is the difficulty in negotiating entry points to services – whether this is due to language or cultural barriers or to the complexity of the organisation of services. Many policy initiatives therefore focus on providing extra help in co-ordinating services, streamlining care, providing advice and support on eligibility, or ensuring a single point of assessment rather than multiple	

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					assessments.	

Raime M	2012	**Patient Navigation Project Pilot Report Improving earlier diagnosis of breast cancer in black women**	Public Health England	This report describes the Patient Navigation Project undertaken by Betterdays Cancer Care which was developed in order to reduce breast cancer mortality in black British women who, although having a lower incidence of breast cancer than their white counterparts, nevertheless have a higher mortality rate.	• Through Patient Navigation women who would otherwise have been lost to follow-up were identified and subsequently attended screening as a result of Navigators making appointments on their behalf.
					• The report includes the following recommendations:
					  • Update GP lists to ensure the details of women are correct
					  • Better follow up of women who have DNA' d to introduce a more personalised approach to the screening process. This can be achieved through a Patient Navigation approach
					  • Introduce more flexibility in the appointment system such as evening or weekend appointments
					  • More community outreach work targeting the African Caribbean community
						Patient Navigation has been developed in order to eliminate the barriers to timely diagnosis and treatment amongst particular groups.

Transitions (e.g. acute reablement and intermediate care)

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability
Glendinning, C., Jones, K., Baxter, K., Rabiee, P., Curtis, L., Wilde, A., Arksey, H. and Forder, J.	2010	**Home Care Re-ablement Services: Investigating the longer-term impacts (prospective longitudinal study)**	Social Policy Research Unit, University of York	Research by the Social Policy Research Unit, University of York and the Personal Social Services Research Unit, University of Kent which examined the immediate and longer-term impacts of home care re-ablement, the cost-effectiveness of the service, and the content and organisation of re-ablement services. People who received home care re-ablement were compared with a group receiving conventional home care services, both groups were followed for up to one year.	• Taking total healthcare, social care and re-ablement costs together, there was no statistically significant difference in the costs of all the services used by the re-ablement and comparison group over the 12 month study period. • Re-ablement had positive impacts on users' health-related quality of life and social care-related quality of life up to ten months after re-ablement, in comparison with users of conventional home care services. • Effective re-ablement services require good initial staff training and on-going supervision; clear outcomes for users and flexibility to adapt these as needs change; and prompt supply of equipment. Prompt transfer to home care for those who need it at the end of re-ablement is essential to maintain capacity in re-ablement services.	Re-ablement is a new, short-term intervention in English home care. It helps users to regain confidence and relearn self-care skills and aims to reduce needs for longer term support. Home care re-ablement services are usually provided or commissioned by local authorities responsible for adult social care. Some services are selective, prioritising people discharged from hospital or recovering from illness and accidents; others are more inclusive, accepting almost all those referred for home care.
Information Centre	2013	**Intermediate care and reablement** (Kings Fund – Reading List)	The Kings Fund	Reading list covering a wide range of books, reports and journal articles that discuss	• There is a wide range of evidence available to demonstrate the effectiveness and cost-	

				intermediate care and re-ablement. Includes summaries and internet links of each resource.	effectiveness of intermediate care an re-ablement services.	

Prevention (e.g. public health and prevention services)

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Windle K, Wagland R, Forder J, D'Amico F, Janssen J, Wistow G	2009	**The National Evaluation of Partnerships for Older People Projects: Executive Summary**	Personal Social Services Research Unit	Summary of findings from the twenty-nine local authority sites involved in the Department of Health funded Partnership for Older People Projects (POPP). These projects involved the development of services for older people which promoted their health, well-being and independence and reduced the need for higher intensity or institutional care.	• The evaluation discovered that there were a wide range of projects which not only improved the quality of life of participants, but also resulted in significant financial savings and improved working relationships • Every extra £1 spent on the POPP services resulted in approximately £1.20 in savings on emergency bed days • There was a 47% reduction in overnight hospital stays and use of Accident & Emergency departments reduced by 29% • Improved relationships were generally reported between health agencies and the voluntary sector as a result of the pilots.	The pilot sites spent £50.7m (two-thirds on community-facing projects and one-third on hospital-facing projects) which benefitted 264,000 people. Services ranged from low level services, such as lunch-clubs, to more formal preventive initiatives, such as hospital discharge and rapid response services.

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Knapp M., Bauer A., Perkins M., Snell T.	2010	**Building community capacity; making an economic case (PSSRU Discussion Paper 2772)**	PSSRU	The aim of the study was to develop simple 'models' of interventions that can contribute to local community development programmes by examining some of the possible impacts. The authors used findings from previous studies, combined with the expertise of people delivering services and shaping initiatives, and then pulled the information together in simple simulations of what local economic consequences might follow. They concentrated on three examples of ways in which community capacity can be built: time banks, befriending, and debt and benefits advice from community navigators. They focused on the costs of such projects and on the monetary value of some of their consequences.	The authors found that all three community initiatives that they looked at (time banks, befriending and community navigators for people with debt or benefits problems) generated net economic benefits in quite a short time period. Each calculation was conservative in that it only attached a monetary value to a subset of the potential benefits.	The study helps to demonstrate that novel and effective approaches to prevention can be affordable.

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability
Tian Y., Thompson J., Buck D., Sonola L.	2013	**Exploring the system-wide costs of falls in older people in Torbay**	The Kings Fund	This paper uses Torbay's unique patient-level linked data set to explore the cost of the care pathway for older people admitted to hospital as a result of a fall by tracking their care costs (health and social care related) in the 12 months before and after their fall.	• On average, the cost of hospital, community and social care services for each patient who fell were almost four times as much in the 12 months after admission for a fall as the costs of the admission itself. • Over the 12 months that followed admission for falls, costs were 70 per cent higher than in the 12 months before the fall. • Comparing the 12 months before and after a fall, the most dramatic increase was in community care costs (160 per cent), compared to a 37 per cent increase in social care costs and a 35 per cent increase in acute hospital care costs. • While falls patients in this study accounted for slightly more than 1 per cent of Torbay's over-65 population, in the 12 months that followed a fall, spending on their care accounted for 4 per cent of the whole annual inpatient acute hospital spending, and 4 per cent of the whole local adult social care budget. The authors also found evidence of significant under-coding of co-morbidities such as dementia.	The findings strengthen the case for an integrated response for frail older people at risk of falls.

Support (e.g. home care, personal budgets, direct payments, telehealth and telecare)

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Glendinning, C., Challis, D., Fernandez, J., Jacobs, S., Jones, K., Knapp, M., Manthorpe, J., Moran, N., Netten, A., Stevens, M. and Wilberforce, M.	2008	**Evaluation of the Individual Budgets Pilot Programme: Final Report**	Social Policy Research Unit, University of York	National evaluation of Individual Budget (IB) pilot projects in 13 English local authorities that ran from November 2005 to December 2007 undertaken by Individual Budgets Evaluation Network (IBSEN). The evaluation was undertaken on behalf of the Department of Health and included a randomised controlled trial examining the costs, outcomes and cost-effectiveness of IBs compared to conventional social care. Almost 1,000 people were interviewed about their experiences and outcomes 6 months after being offered an IB (or using conventional services).	• IBs were generally welcomed by users because they gave them more control over their lives, but there were variations in outcomes between user groups • Satisfaction was highest among mental health service users and physically disabled people and lowest among older people • IBs appear cost-effective in relation to social care outcomes • Developing processes to determine levels of individual IBs and to establish legitimate boundaries for how IBs were used provided challenging for the staff involved • Integrating funding streams also proved to be challenging	The pilot sites began by offering IBs to only one user group, but by the end of the pilot period all sites were offering IBs to additional user groups. IB resources were typically used to pay for personal care, domestic help and social, leisure and educational activities.

Miscellaneous (e.g. IM&T)

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McRae I., Butler J., Sibthorpe B., Ruscoe W., Snow J., Dhigna Rubiano D., Gardner K.	2008	**A cost effectiveness study of integrated care in health services delivery: a diabetes program in Australia (Research article)**	BMC Health Services Research	This study addresses the cost effectiveness of an integrated approach to assisting general practitioners (GPs) with diabetes management. This approach uses a centralised database of clinical data of an Australian Division of General Practice (a network of GPs) to co-ordinate care according to national guidelines. The centralised database of diabetic patients is regularly updated with clinical information from the general practices. This database, which includes information on care provision as well as clinical indicators such as HbA1c measures, is used to send recall reminders to GPs, to provide regular audit reports to GPs on their adherence to guidelines, and to provide regular and ad hoc clinical alerts. In particular, the Division identifies patients who may be at risk of	The clinical data show that the program is effective in the short term, with improvement or no statistical difference in most clinical measures over 5 years. Average HbA1c levels increased by less than expected over the 5 year period. While the program is estimated to generate treatment cost savings, overall net costs are positive. However, the program led to projected improvements in expected life years and Quality Adjusted Life Expectancy (QALE), with incremental cost effectiveness ratios of $A8,106 per life-year saved and $A9,730 per year of QALE gained.	This study provides evidence of the cost effectiveness of a centralised database of clinical data.

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				developing complications, and reports on them to their GPs.		