Summary: Progress Report on the Evaluation of the National Integrated Care Pilots

This report has been produced by Ernst & Young and RAND Europe on behalf of the Department of Health

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Better integration of providers is increasingly being seen, both nationally and internationally, as an effective approach to delivering services in a way that best meets the needs of individuals and makes effective use of resources. The recent white paper *Equity and Excellence* proposed a vision for health services that included the creation of the Public Health Service, the empowerment of GPs to commission services and new responsibilities for local authorities. For each of these to be successful will require some form of integration and more effective partnership working across all sectors.

The NHS alone cannot tackle health inequalities and challenges such as the ageing population. The Programme of Integrated Care Pilots is an excellent showcase not only of integrated and personalised services, but also of clinical leadership and innovation. The pilots are all locally driven according to clinical need and demonstrate excellent and innovative relationships, which have been established for the benefit of the patient or service user. A number of the pilots are led by Practice Based Commissioning (PBC) consortia and are well-placed for the proposed GP Commissioning arrangements. Such clinicians are in the driving seat on decisions about services and the evaluation is starting to show that GPs (and other clinicians) involved with the pilots are taking on new responsibilities around whole-system care. It is imperative against this changing environment that the lessons learned from the pilots are shared across the health and social care community to help others.

It will come as no surprise to many that better integration is not easy and there can be a number of challenges - from the development of organisational form and infrastructure to cultural difference. However, the benefits can be more rewarding from both a patient and service perspective, and there is an appetite among frontline staff to explore integrated working.

This independent evaluation will provide a valuable addition to the evidence base for integration and will support commissioners in the future. The final evaluation report is expected at the end of 2011. It is key to continue to share the ongoing learning both prior to and following the final report in order to support consortia in considering different options for integration locally.

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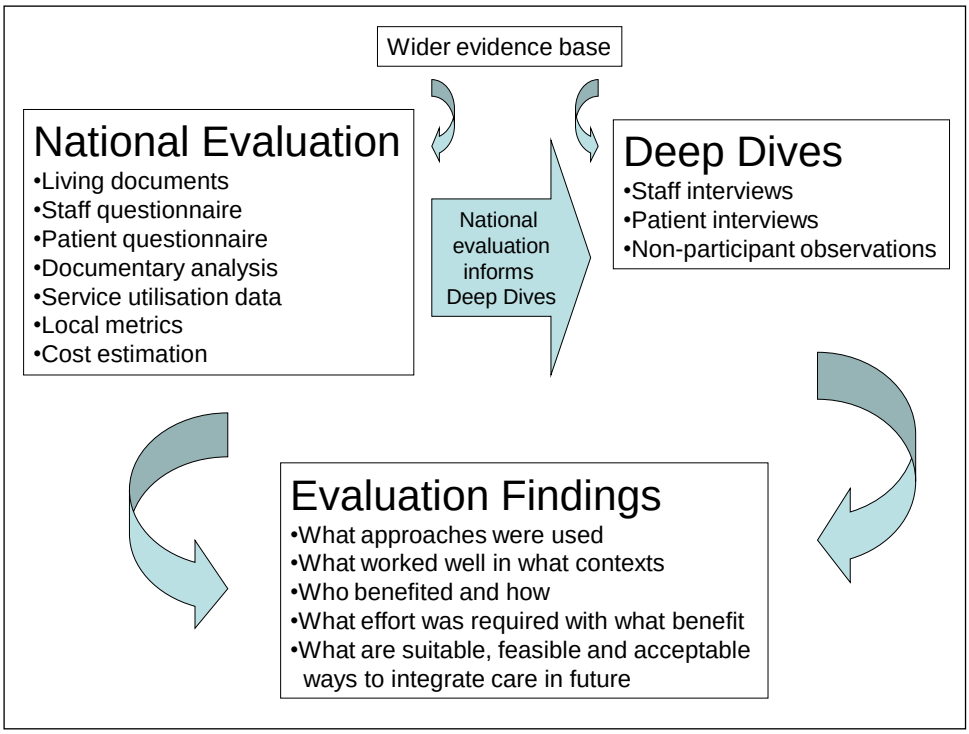
This Summary provides an overview of the progress made on the evaluation of the Department of Health Integrated Care Pilots (ICPs). Since the Progress Report was submitted to the Department of Health (DH) in June 2010, it has been necessary to make some minor amendments to the evaluation as a result of the reduction in DH funding. The updated evaluation is outlined in the figure below.

Figure 1: Summary of Evaluation methods used



The programme of ICPs is a two-year DH initiative that aims to explore different ways of providing integrated care to help drive improvements in care and well-being. Ernst and Young, in partnership with RAND Europe, were appointed to

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conduct the evaluation, involving both quantitative and qualitative measures. This independent report was produced by the evaluators on behalf of the DH[1].

This report is not intended to contain interim conclusions but to provide information about the evaluation activities conducted, the data collected, and the analyses completed thus far. It therefore summarises the evaluation and reflects on the development of the ICP programme to date. It concludes with a summary of impressions and an outline of the evaluation stages to follow. It is primarily intended for the stakeholders involved in the Pilot programme – the Department of Health, the ICP Measures and Evaluation Steering Group (MESG), and, of course, the ICPs themselves. Others interested in the processes involved in evaluating complex interventions and programmes in health and social care, and integrated care in particular, may also be interested.

Evaluation Methodology

The evaluation involves both qualitative and quantitative research designed to clarify what the ICPs are doing, how they are going about this, what effort is required, and what are the types and scale of outcomes are. We have balanced the need for both breadth and depth by collecting a common set of data across all 16 ICPs and investigating four in greater depth (the so-called 'Deep Dives').

Quantitative Evaluation

The quantitative evaluation seeks to quantify the scale of any changes, focusing mainly on hospital utilisation, and comparing the results with a control group of patients (matched by demographic characteristics as well as by their hospital readmission profiles). Usage data have been taken from Hospital Episode Statistics (HES), both for outpatient services, secondary care referrals, and inpatient care (including emergency admissions, ambulatory sensitive admissions, and length of stay for selected conditions). This is an important and innovative aspect of the evaluation, which The Nuffield Trust has been supporting.

Quantitative data are also being collected through two standardised questionnaires (both 'before and after[2]'). In 11 of the 16 pilots, data have been collected from patients/service users, and in all pilots data has been collected from staff. The patient/service user questionnaire includes questions on numbers of GP consultations, community nurse contacts, social care use, and use of out-of-hours services, alongside questions on experience of the services offered.

The use of a set of 'national measures' will enable a rich picture of the outcomes in the pilots and also enable comparisons between groups of patients with shared characteristics in pilot and non-pilot sites. In addition to the national measures, pilots have also chosen a number of very specific measures

[1] Throughout the executive summary and the Progress Report, there are references to 'we', 'our', 'us' etc. Such references refer to the evaluators rather than the DH.

[2] The 'before and after' refers to identifying the impact before the intervention(s) has taken place and then comparing this with the findings post-intervention.

relevant to the aims of their own pilot which have been incorporated into this evaluation; for example, the proportion of people dying in their preferred place of death. The role of the evaluation team is to report on these local metrics as an adjunct to the national data collection: we will not be conducting analyses of the data for sites.

Qualitative Evaluation

While the quantitative dimension of the evaluation allows us to assess the scale of changes across a range of dimensions and judge how these differ from experiences elsewhere, it will not, even with comparator data, allow us fully to attribute these changes to the activities made possible by the pilot. Nor will it allow us always to judge which ingredients in the 'mix' of integrative activities have the greatest impact.

We are therefore drawing upon structured insights from the pilots collected through 'Living Documents' (LDs). These Living Documents are a means by which each pilot team can record experiences in a broadly consistent way and on a regular basis. The documents develop over time to create an informed narrative about what each pilot seeks to do, why it did so, what its activities have been, what the costs are and what measurable consequences there have been. They include a question focusing on the costs incurred through being a pilot. The documents allow us to track changes in the evolution of the pilots creating an increasingly rich narrative as each Living Document builds on previous accounts.

Deep Dives

To support this qualitative dimension further we are also conducting a sub-set of more detailed studies – the so-called 'Deep Dives'. In these we have conducted a large number of more detailed interviews with both staff and users/carers near the start of the pilot and have interviewers staff again towards the end. We will identify not only accounts of what happened but also perceptions about why it happened. The Deep Dive sites are: Church View, Northamptonshire, Norfolk and Principia.

Progress of the evaluation to date

So far, the evaluation activities have progressed to plan. A multi-method evaluation involving the active reflections of each Pilot, the collaboration of the Implementation Team, and an awareness of the needs of decision-makers, was always going to require enthusiasm for evaluation and an appetite for collaboration and this has been apparent from the outset. The original evaluation plan proved to be robust and was strengthened by involving The Nuffield Trust in helping to quantify impacts. However, we also acknowledge the challenges to be faced in completing the evaluation and these are detailed below.

To date the following methods have been carried out giving the evaluation a baseline for analysis (the 'before'):

- Staff interviews
- Staff questionnaires
- Patient/service user interviews
- Patient /service user questionnaires
- Collection of Living Documents
- Non-participant observation
- Local metrics collection
- Cost collection
- Collection of hospital utilisation data

As anticipated, the narratives provided in each round of the LDs have become increasingly rich, allowing a 'thick' narrative to be developed that describes the context of each Pilot and the activities involved in delivering it. We are now beginning to work into these narratives a better understanding of the costs involved. All of this is added to and triangulated with detailed data from staff and user interviews and surveys, and the analysis of service utilisation data.

Each site has sent out staff and user questionnaires. Their distribution has been timed to balance the need for pilots to have begun establishing themselves and identifying target populations, and the need to capture data relating to the situation before the ICPs had made a significant impact. The same is true of the interviews; we were able to interview staff earlier than patients, carers and users. Over 135 interviews have been conducted and analysed.

We have collected aggregated cost data from every site and we will continue to refine our understanding of these costs. Sites will continue to provide further cost information through a more detailed cost template to add to the information collected through the LDs and the staff and service user questionnaires.

Impressions of progress of the ICPs to date

We know that there can be considerable lags separating the time when changes to services are implemented, and the points at which service users experience changes. Outcome data indicate how successful these changes might be. Therefore early impressions have been associated more with the speed and success of the first steps towards increasingly integrated care, rather than 'proof' that they offer long term and sustainable value for money.

Our impressions so far of the progress of the ICPs can be summarised as follows:

- **Context matters:** Each ICP is deeply influenced by the personal journeys of its leaders, the inter-institutional histories of the partners, local geographical, social and economic circumstances and the evolving

national policy context. Any generalisations and recommendations will need to be sensitive to this.

- **Clusters not models:** We are not thus far seeing solid and distinctive models of integrated care emerging. Instead we are seeing a more fluid process of adaptation to a changing environment in pursuit of some broad overarching aims and values. Bringing care closer to patients, providing support for more preventive interventions and strengthening and simplifying informed choice are all being pursued, but in different ways.
- **There exists an appetite for collaboration:** In every ICP there are examples of professionals collaborating well and (despite anxieties about standards, professional accountability and governance) the willingness to find integrated solutions is apparent. Whether this will be easy to sustain is yet to be seen.
- **Building the infrastructure can be demanding:** In the early months, the ICPs have focused on building a platform for integration and it will be interesting to see how the focus of attention can be moved from this activity to a focus on changing the experiences and care of service users.
- **Decision-makers work with limited cost data:** The LDs and our follow-up interviews reveal that decision-makers are by no means careless about costs, but they struggle to find reliable and readily available cost information.

In summary, through our analysis of the early stages of the ICPs, we are clearer that within each pilot there is a cluster of inter-related activities which describe a variety of journeys towards increasingly integrated care. Some of these, such as service reconfigurations, are delivered through 'traditional' project management (such as might be identified through a logic model). Others are more similar to negotiations and involve compromise and tactics among different agencies, including service users, (such as might be identified through process mapping). A third feature involves repeated cycles of learning and adaptation, for example as professionals come to understand each other better, modify their behaviour, and then stimulate further changes in others. We have preferred to refer to this as a cluster of activities. To evaluate these activity clusters will require a set of evaluation approaches that can match the complicated and varied nature of the activities.

In complicated and complex practices intended to improve health and social care, we are faced with some interesting evaluation challenges. First, how important is context in shaping outcomes, and if each context is different, can we generate lessons that can be more widely applied? Second, if the theory of change is one of negotiation and compromise, building trust and improving inter-disciplinary understanding; how can we isolate the 'active ingredient'? Third, where the improvement activities have no definitive boundaries, how can we calculate the costs associated with integration as opposed to the other costs of running a changing health and social care system? Finally, in all of this, how can we provide a counterfactual advising us how much better (or worse) the value for money achieved was in the Pilots compared with what might have been achieved in other ways.

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Fortunately the mixed methodology underpinning the evaluation is capable of generating a sufficient variety of data to support a series of judgements about what kinds of contextual factors appear to be supportive or to undercut integration, including, for example, how successful negotiation and change is achieved, and where the core costs lie (and broadly how great they are). There will be comparator data on service utilisation and outcome data along with comparisons from user and staff experiences between the Pilots, and between the Pilots and the wider health and social care system. During the next and final stage of this evaluation, these data will be derived from the following sources:

- Second round of patient questionnaires
- Second round of staff interviews (including non-participant observations)
- Second round of staff questionnaires
- Cost evaluation exercise
- National service user data collection and analysis
- Two more Living Document analyses

Next steps

Over the next 12 months the evaluation will continue to take shape as the second round (providing the 'after') of various methodologies will be carried out. The analysis will take place following this collection and feed into the final report due to be submitted to the DH at the end of December 2011.

Since completion of the Progress Report, the DH has sought to make cost savings across a number of programmes, including the Integrated Care Pilots. As a result, part of the Evaluation has been amended: namely, there are two fewer deep dives, a more focused cost methodology, and the second round of service user interviews has been removed. As these changes occurred after the progress Report had been compiled, the body of the Progress report refers to the original parameters of the evaluation which were applicable at the point of submission. However, we are confident that the integrity of the approach shaping our evaluation remains intact.

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