Evaluation of the Integrated Care and Support Pioneer Programme in England, 2015-22: overview of findings and policy implications

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on behalf of the Pioneer Evaluation Team

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The Pioneer programme – locally constructed health and social services integration focused on the user

- *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'*
- 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)
- DH et al. 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'*
- 25 sites selected in two waves in late 2013 and spring 2014
- Formal end date March 2018

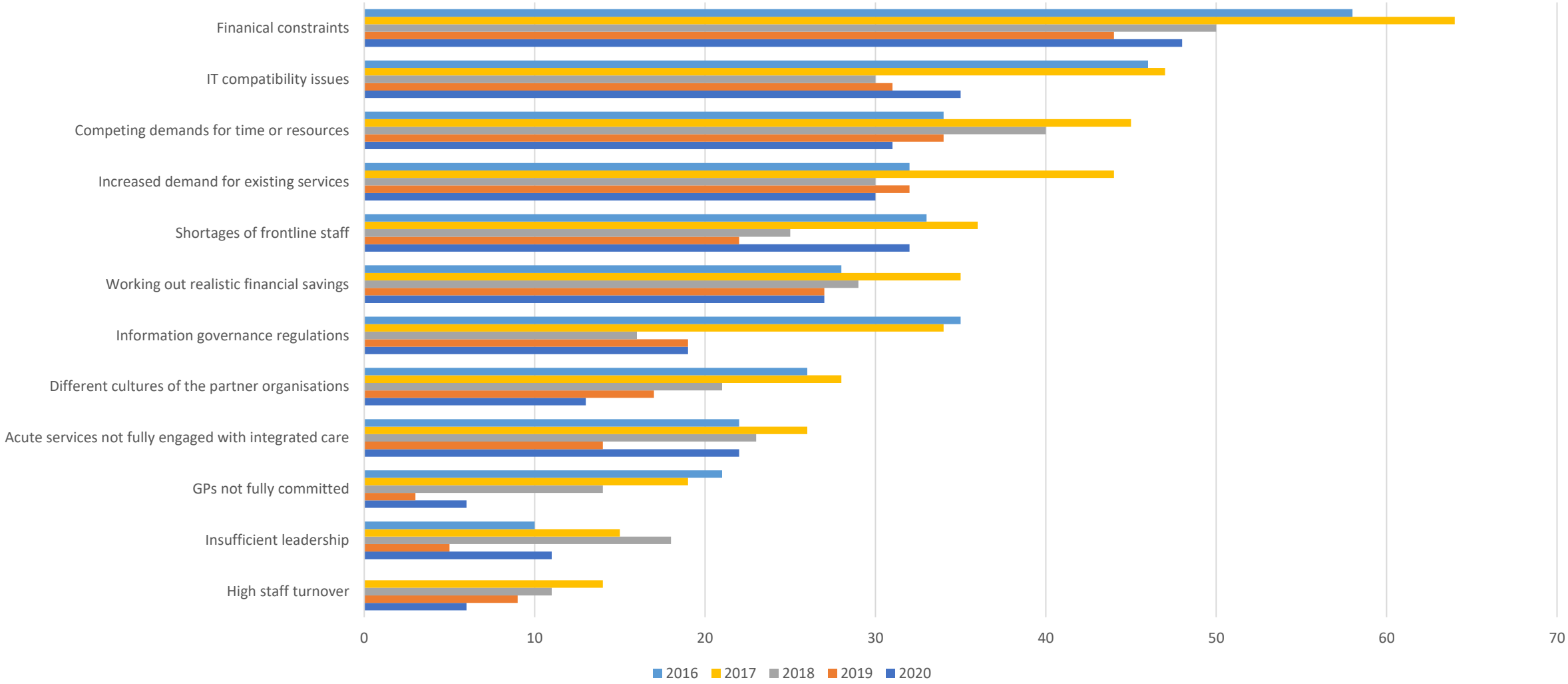
Pioneer longer term evaluation (2015-2022)

Three work packages:

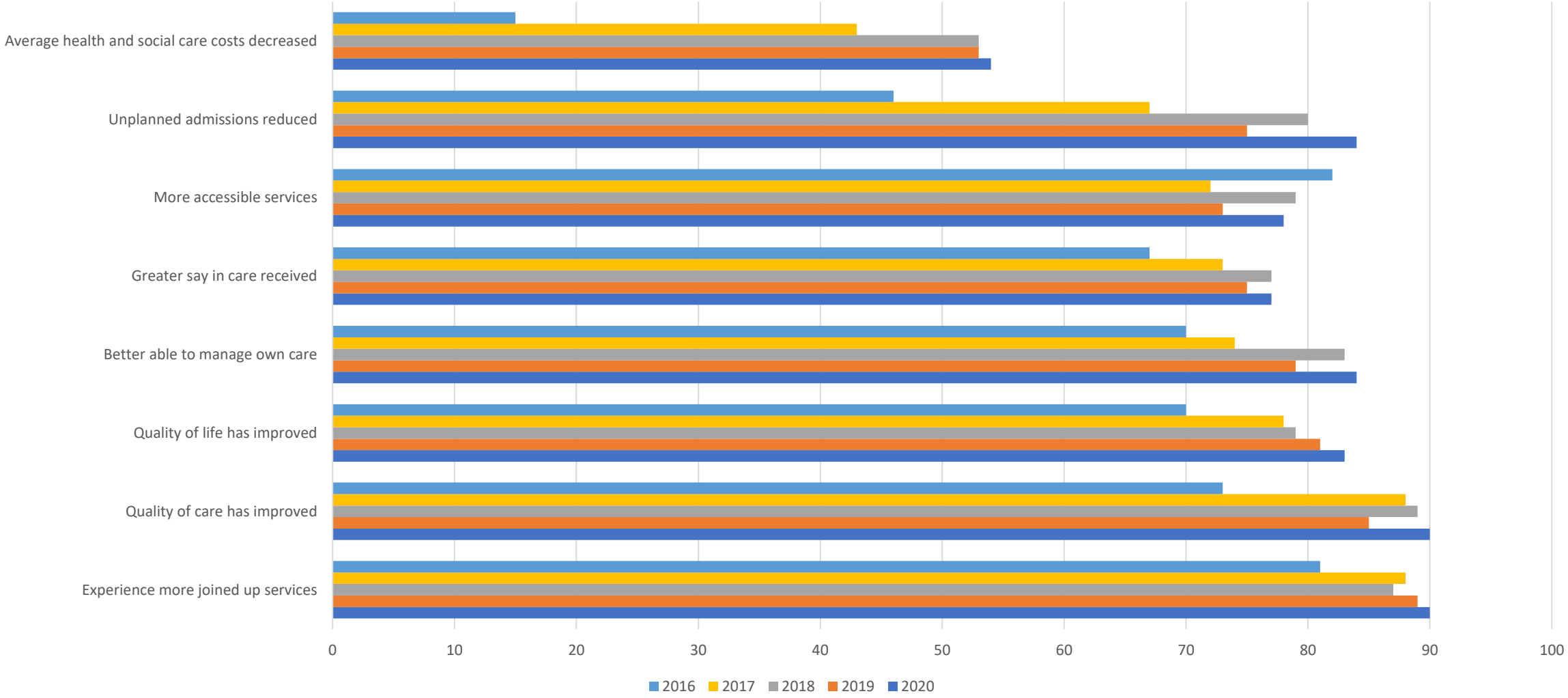
- WP1: Pioneer level process evaluation and (limited) impact evaluation
  - Analysis of indicators of care integration
  - Annual online panel survey of key informants supported by semi-structured interviews
- WP2: Initiative level impact and economic evaluation
  - Mixed method, quasi-experimental design
  - Evaluation of community based integrated MDTs as most frequently reported initiative
  - Impossible to implement planned economic evaluation, able to collect multiple sources of qualitative data
  - Comprised observation of meetings, staff survey, and interviews with strategic & frontline staff, patients & informal carers
- WP3: Working with Pioneers, national policy makers and other partners, patient/user organisations and experts to derive and spread learning
  - 6-monthly workshops, blogs, website, indicator dashboard

WP 1 Findings – annual key informant surveys and analysis of indicators from routine data

Significant barriers to integration by key informant survey year (% reporting) (Erens, et al., 2019 & 2021)



‘Substantial/some’ progress in meeting objectives as a result of integration activities by key informant survey year (%) (Erens, et al., 2019 & 2021)

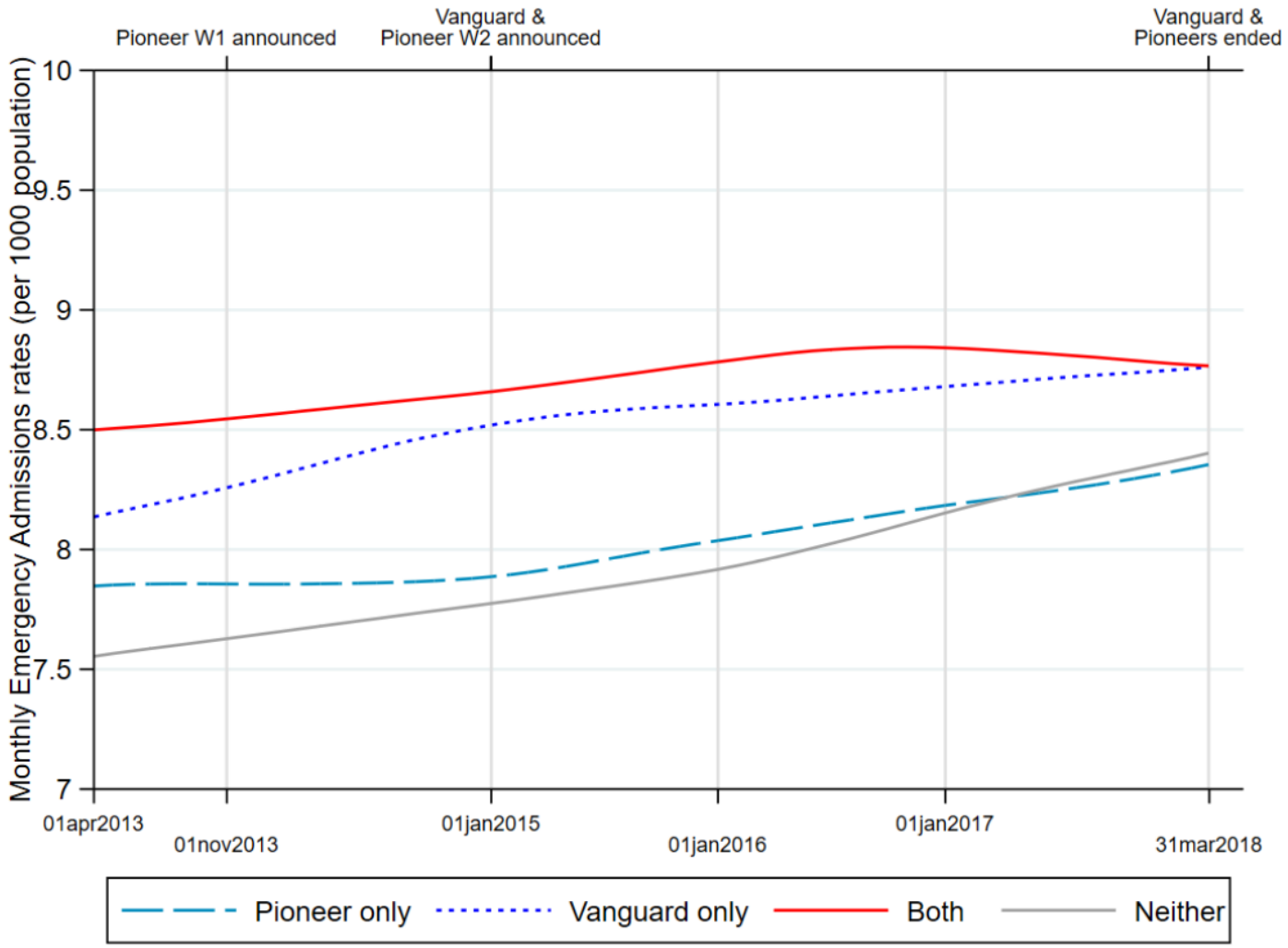


Comparison of change in emergency admission rates (adjusted for age, sex & deprivation) from baseline (April 2010 - March 2013) for Pioneer and non-Pioneer areas, difference-in-differences (Keeble et al., 2023)

Year	Wave 1 difference in emergency admissions per 100,000 population from baseline (%)	Wave 2 difference in emergency admissions per 100,000 population from baseline (%)	Non-Pioneer difference in emergency admissions per 100,000 population from baseline (%)	Wave 1 p-value difference-in-differences	Wave 2 p-value difference-in-differences
2014/15	16 (1.82)	36 (3.83)	42 (4.74)	0.04*	0.40
2015/16	34 (3.92)	33 (3.57)	55 (6.24)	0.19	0.09
2016/17†	39 (4.46)	20 (2.14)[a]	71 (8.03)	0.06	0.02*[a]
2017/18	53 (6.08)	65 (7.03)	90 (10.37)	0.05*	0.06
2018/19	108 (12.61)	102 (11.11)	135 (15.64)	0.24	0.03*
2019/20	124 (14.44)	108 (11.83)	152 (17.61)	0.22	0.01*

[a] In 2016/17, a third of records at Nottingham hospital were erroneously recorded as anonymous and subsequently did not link to a Pioneer area, resulting in artificially low counts of emergency admissions for these years.

Monthly emergency admission rates, April 2013-Mar 2018, by national integration programme in England (Morciano et al., 2021)



Average per 1000 emergency admissions rates (and confidence intervals) in Pioneer areas, Vanguard areas, and areas in both and neither programme in the pre- and post-implementation periods (Morciano et al., 2021)

Programme	Periods				
	(1) Pre-Pioneer & pre-Vanguard period (7 months, Apr 2013 to Nov 2013)	(2) Period with Pioneer wave one only (14 months, Nov 2013 to Jan 2015)	(3) First year following the announcement of Vanguard & Pioneer wave two (Jan 2015 to Jan 2016)	(4) Second year following the announcement of Vanguard & Pioneer wave two (Jan 2016 to Jan 2017)	(5) Last 15 months of the programmes (Jan 2017 to March 2018)
Pioneer only	7.79 (7.64-7.93)	7.90 (7.79-8.02)	7.90 (7.78-8.02)	8.14 (8.01-8.26)	8.29 (8.17-8.41)
Vanguard only	8.03 (7.86-8.20)	8.46 (8.33-8.59)	8.53 (8.38-8.68)	8.67 (8.51-8.82)	8.72 (8.58-8.87)
Both	8.48 (8.20-8.75)	8.64 (8.41-8.87)	8.63 (8.37-8.89)	8.92 (8.66-9.18)	8.77 (8.55-8.99)
Neither	7.46 (7.37-7.55)	7.76 (7.69-7.84)	7.78 (7.7-7.86)	8.03 (7.94-8.11)	8.33 (8.26-8.40)

WP2 – MDT evaluation findings

- Context:
  - 11 MDTs in 2 contrasting Pioneers with 4 different operating models
  - P1 – urban setting (8 MDTs operating to the same model around groups of GP practices)
  - P2 – mixed urban/rural setting (3 MDTs operating individual models)
  - Community-based MDTs with caseloads which included patients aged 55+ with multiple chronic conditions, living at home, and staff from both health and social care services
  - Patients did not routinely attend MDT meetings

Observations of MDT meetings (Douglas, et al., 2022)

- **Aim:** to understand how MDT members work together to produce coordinated, integrated, person-centred care and to identify the 'added value' of meetings/teams
  - 28 meetings in total (2 rounds) across the 11 MDTs (June 2019 - Feb 2020)
  - Structured observation checklist and field notes; group thematic analysis

- Key findings:
  - Adopted similar processes of case management in meetings
  - Resources to enable MDTs are crucial (e.g., suitable space; good Wi-fi, admin support)
  - Barriers - information governance; IT interoperability, etc.
  - Mismatch between number/range of health services' staff and their LA counterparts
  - Mutual respect and collegiality; non-hierarchical decision-making; however, lack of challenge
  - 'Added value' - rapid patient information sharing; better understanding of contributing agencies' services; planning strategies for 'hard to engage' patients; managing risk and providing mutual support in stressful cases

Interviews with local system leaders and operational managers
(Pacho, et al., 2024)

- **Aim**: to understand the place, role and value of MDTs in local HSC systems
- 32 qualitative interviews with 25 local system leaders and operational managers in P1 and P2 (October 2018 to April 2021)
- Thematic analysis

- Key findings:
  - MDTs essential mechanisms for coordinating improvements in health and wellbeing
  - Organisational differences between/ within sites influenced decisions re MDTs' purpose & structure
  - However, similar challenges to MDT implementation in both Pioneers
  - Valued national policy frameworks as enablers of integrated care but recognised role of local contexts in shaping local implementation decisions
  - Perceived benefits - potential for more holistic care, fewer instances of work duplication, speedier access to care and enhanced home care provision
  - Concern that benefits not always captured by commonly used performance indicators and value of MDTs could be under-estimated

Interviews with MDT frontline staff
(Thana, et al., 2024)

- **Aim**: to understand how frontline staff experience working in and with MDTs
- Semi-structured interviews and FG with 54 frontline staff from a range of professional backgrounds in the 11 MDTs (Dec 2018 - March 2021)
- Thematic analysis

- Key findings:
  - MDT working valued – gave a shared sense of purpose to deliver holistic care that helped to level traditional professional hierarchies, enable collective and non-hierarchical problem-solving and share responsibility for patient care
  - Despite strong similarities between the MDTs in members' understandings of the role and purpose of a MDT, each MDT was adapted to the context and the needs of the population served
  - Many perceived benefits of MDT working to both staff and patients
  - Concerns about lack of routine MDT performance and outcome measures

Interviews with MDT patients and their informal carers
(Durand, et al., 2024)

- **Aim**: to explore patient and carer experiences of care
- Qualitative interviews with 44 patients 55+ with multiple long-term conditions on the caseload of one of the 11 MDTs, and 15 informal carers (Nov 2019 -March 2021)
- Thematic analysis

- Key findings:
  - Reliance on informal sources of care and support
  - Valued aspects of care – interventions which helped maintain independence; timely access to and continuity in care; effective information sharing and communication; professionals who engaged with them in a manner that suggested that their needs mattered; and having a named point of contact
  - Range of challenges also experienced, often related to absence of above – e.g., with access and communication
  - Many did not mention specific MDT involvement
  - Significant impacts of informal caring on those caring

Conclusions

- Findings very similar to evaluations of other schemes e.g. Vanguards
- Takes 3–4+ years before self-reported and indicator changes become visible
- Impact of integration initiatives seems to be cumulative but interventions need to be designed to change nature of patient care to be identifiable
- Many structural barriers to HSC integration still largely in place, e.g. lack of shared records, despite over a decade of promises
- HSC integrated MDTs generally valued but depended on scarce LA expertise and resources
- Lack of routine data on what integrated HSC is trying to achieve e.g. improved user experience, better quality of care
- Challenging to evaluate costs and benefits of integration both at programme and specific intervention (e.g. MDT) levels

Special supplement of *Journal of Health Services Research & Policy* on the MDT component of the Pioneer evaluation is due out later in 2024

Journal of Health Services Research & Policy: Sage Journals (sagepub.com)

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