Integrated Care evidence review
November 2013

The purpose of this evidence review is two-fold: the first being to provide a short document with evidence pertaining to specific aspects of integrated care. The second is to provide details of the evidence base used in the LGA model which aims to demonstrate the financial benefits of integrated care.

This was a rapid search taking place between August and November 2013. As integrated care encompasses many different studies across the health, social care and other services, an iterative research strategy was used. 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. Where possible, this evidence review has used systematic reviews or peer reviewed publications. There is a paucity of robust systematic reviews or peer-reviewed articles providing quantitative evidence, particularly of cost-effectiveness in integrated care. This may be a question of scaling: integrated care needs to be rolled out on a significant scale in order to support the reconfiguration of services and demonstrate significant cost savings. Another contributory factor around the paucity of evidence might be the fact that improved outcomes are only likely to be seen over the longer-term (the Nuffield Trust suggests 3-5 years). There is a wealth of evidence about the challenges of providing sustainable care across the health and social care spectrum. There is less strong evidence on the effectiveness and costs of potential solutions which integrated care related interventions address, however across both the UK and internationally there are some examples that document improved health, wellbeing and financial outcomes as a result of integration schemes and their specific components. Whilst evidence for integrated care is still emerging, the evidence base does not offer a complete vacuum and this review serves to capture evidence for a variety of different interventions and models which can be used to inform strategic planning and implementation of integrated care in local areas.

Summary of Findings

The review of available evidence shows that integrating care is yielding results such as reduction in waiting times and duplication of services. There is some evidence of reduction in elective admissions and outpatient attendances. Case management demonstrated some reduction in overall secondary care costs and there was evidence of reduced use of hospital beds, low rates of emergency hospital admissions for those aged over 65 and minimal delayed transfers of care. Case management has also resulted in a reduction in use of residential and nursing homes and an associated increase in use of home care services.
There is general consensus that person-centred, population-based care with both vertical and horizontal integration health and social services, with a single point of entry and one assessment process, offers the greatest benefit.

However, the majority of research available is concerned with the overall learning points for integrated care. There is overwhelming agreement that building a shared vision and goals across different providers or teams and establishing shared, trusted and respected clinical leadership is key to successful integration.

Implementing large-scale changes takes time and it takes many people to transform a system. Structural mergers of organisations is not necessary (and indeed will not in itself deliver outcomes) to deliver integrated care, but partners need to make the time and effort to

understand each other's agendas, find common cause and be prepared to share sovereignty.

It is important to realise that no 'one size fits all', but to integrate services that offer a logical fit and where the impact will be greatest based on the local population and geography. Better care planning has real potential to improve patients' experience, in particular reducing duplication and improving access. Hospital use and costs are not the only impact measures and it is vital to be explicit about desired outcomes, how they will be achieved and to use interim markers of success.

The findings have been broken down into the following categories:

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The following search terms have been used to categorise the items in the literature review. The relevant terms can be found in the Search Categories column of each table and are based on the Social Care Online Topics used by the Social Care Institute for Excellence (SCIE):

- access to services
- black and minority ethnic people
- cancer
- care planning
- carers
- cost effectiveness
- diabetes
- emergency health services
- falls
- general practitioners
- home care
- information management
- information technology
- integrated services
- intermediate care
- intervention
- joint commissioning
- mental health problems
- older people
- outcomes
- patient admission
- personal budgets
- physical disabilities
- prevention
- primary care
- reablement
- social exclusion

Overarching/systematic reviews of integrated care

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories (based on Social Care Online Topics (alphabetical) 25 March 2013)
CQC	2013	**The state of health care and adult social care in England in 2011/12**	Care Quality Commission	The Care Quality Commission (CQC) has today published its most comprehensive 'State of Care' report. The report examines all care sectors for the first time and explores why some care services are failing to meet CQC standards.	With an increase in the number of people with complex or multiple illnesses, and the rising numbers of older people with dementia, the report notes a growing demand for nursing care within social care settings. This is reflected in an increase in the number of nursing homes registered with CQC in 2011/12 (the total rose by 1.4% [64 nursing homes] with a 3.3% increase in the number of registered nursing home beds). At the same time, the number of residential (non-nursing) care homes is falling. Based on the evidence of over 13,000 inspections, the report suggests that pressures on care services are increasing the	Overview of the state of health and adult social care in England in 2011/12 with particular focus on whether people receiving care – in the NHS, independent health care or adult social care – are treated with respect and dignity	mental health problems; home care; older people;

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories (based on Social Care Online Topics (alphabetical) 25 March 2013)
					risks of poor or unsafe care for people who are less able to speak up for themselves and those, who as a result of their circumstances, are more vulnerable. The report notes many examples of organisations that meet these challenges and deliver an excellent quality of care. But CQC's inspectors on the ground also see others across both health and social care that are failing to manage the impact of these challenges effectively, and delivering care that is task-based, not person-centred.		
Bardsley, M., Steventon, A., Smith, J., Dixon, J.	2013	**Evaluating integrated and community-based care: how do we know what works? (Research Summary)**	Nuffield Trust	Over the last five years the Nuffield Trust has undertaken evaluations of over 30 different community-based interventions. This paper outlines the main interventions evaluated and their impact. It also identifies nine points	• The service models evaluated to date generally appear not to be associated with reductions in emergency hospital admissions. • From their experience of evaluating new service models, the authors offer	By analysing a wide range of community-based interventions the authors are able to provide useful lessons for the future of health and social care integration.	cost effectiveness; emergency health services; integrated services; intervention; outcomes; patient admission

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				that may help those designing, implementing and evaluating such interventions in future.	the following points to consider: 1) Recognise that planning and implementing large-scale service changes takes time 2) Define the intervention clearly and what it is meant to achieve and how, and implement it well 3) Be explicit about how desired outcomes will arise, and use interim markers of success 4) Generalisability and context are important 5) If you want to demonstrate statistically significant change, size and time matters 6) Hospital use and costs are not the only impact measures 7) Pay attention to the process of implementation as well as outcome 8) Carefully consider the best models for evaluation 9) Work with what you have: organisation and		

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					structural change may not deliver outcomes.		
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.	access to services; care planning; diabetes; general practitioners; integrated services; older people
Valentijn P., Schepman S., Opheij W., Bruijnzeels M.	2013	**Understanding integrated care: a comprehensive conceptual framework based on the integrative functions of primary care**	International Journal of Integrated Care	This review is based on a combination of electronic database searches, hand searches of reference lists and contact with researchers in the field. The authors identified the general principles of primary care and	• The authors conclude that to deliver integrated, person-focused, and population-based care, vertical-and horizontal integration through inter-sectorial partnerships across the health and social service system is needed. Their conceptualization	This paper proposes a conceptual framework that combines the concepts of primary care and integrated care, in order to understand the complexity of integrated care.	integrated services; primary care

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				integrated care along with the connections between them. They then held several meetings with researchers to develop and refine their conceptual framework.	includes multiple dimensions of integration that play complementary roles on the micro (clinical integration), meso (professional- and organisational integration) and macro (system integration) level to deliver comprehensive services that address the needs of people and populations. Functional and normative integration can ensure connectivity of all the levels of a system.		
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 • For case management sites, there was a 9%	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.	care planning; cost effectiveness; integrated services; intervention; outcomes; patient admission

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					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	• 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.	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.	care planning; integrated services; older people

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories (based on Social Care Online Topics (alphabetical) 25 March 2013)
				and Norfolk County Council, 4) Oxfordshire Older Peoples' Services. It analyses the elements 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.	5. Agree with partners the core principles of the services to be developed and work out which areas can 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		

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					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 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.		
Ham, C., Walsh, N.,	2013	**Making integrated care happen at scale and pace**	The King's Fund	This paper describes what the King's Fund believes is now	• Find common cause with partners and be prepared to share sovereignty	The paper includes key principles to follow when pursuing	cost effectiveness; information management;

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				required at a local level to develop integrated care at scale and pace. It is based on the lessons that they have learned from their experience in this area.	• Develop a shared narrative to explain why integrated care matters • Develop a persuasive vision to describe what integrated care will achieve • Establish shared leadership • Create time and space to • develop understanding and new ways of working • Identify services and user groups where the potential benefits from integrated care are greatest • Build integrated care from the bottom up as well as the top down • Pool resources to enable commissioners and integrated teams to use resources flexibly • Innovate in the use of commissioning, contracting and payment mechanisms and use of the independent sector • Recognise that there is no 'best way' of integrating care • Support and empower	integration.	Integrated services

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					users to take more control over their health and wellbeing • Share information about users with the support of appropriate information governance • Use the workforce effectively and be open to innovations in skill-mix and staff substitution • Set specific objectives and measure and evaluate progress towards these objectives • Be realistic about the costs of integrated care • Act on all these lessons together as part of a coherent strategy.		
Heenan, D.	2012	**Health and Social Care Integration: Reflections from Northern Ireland (Presentation to The King's Fund Summit - Tuesday 1 May 2012)**	The King's 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	The lessons from Northern Ireland demonstrate the positive impact of integrated working and highlight some of the issues that need to be addressed.	integrated services; intermediate care; general practitioners; prevention; reablement

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					• Reduces waiting times and duplication of services • Facilitates preventative work and intermediate care, reablement and discharge • Can provide evidence of professional 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.		
Haye, S., Mann, M., Morgan, F., Kelly, M., Weightman, A.	2012	**Collaboration between local health and local government agencies for health improvement (Review)**	The Cochrane Collaboration	In order to evaluate the effects of interagency collaboration between local health and local government agencies on health outcomes in any population or age	• The review did not identify any reliable evidence that interagency collaboration, compared to standard services, necessarily leads to health improvement. • The results demonstrate	The review highlights the importance making sure that robust evidence is gathered to demonstrate the effectiveness of models of inter-agency	integrated services; intervention; outcomes

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				group, the authors conducted a wide ranging literature review.	that collaborative community partnerships can be established to deliver interventions, but it is important to agree goals, methods of working, monitoring and evaluation before implementation to protect programme fidelity and increase the potential for effectiveness.	collaboration.	
Burgess	2012	**SPICe Briefing: Integration of Health and Social Care; international comparisons**	Scottish Parliament Information Centre	This briefing highlights some of the key enablers and barriers to integration and provides information on integrated approaches to health and social care in the UK, Europe and further afield.	Succinct briefing covering enablers and barriers of integrated care. International comparisons including policy and case study for England, Wales, NI, Italy, Sweden, Canada and New Zealand.	Useful document for quick international case studies including policy context.	integrated care
Parker et al	2010	**Integrated Services for People with Long-term Neurological Conditions: Evaluation of the Impact of the National Service Framework: Final Report**	SPRU: University of York	Many people with long-term neurological conditions (LTNCs) require support from a range of services, but these these services do not always work in a joined-up way. The National Service Framework (NSF) for	Existing literature Our review of existing literature on integrated models of care for people with LTNCs found that the evidence base was weak regarding: the impact and costs of integrated models of care for people with LTNCs; and what is needed to make	Our in-depth case studies found that nurse specialists, CINRTs and certain types of day opportunities are particularly successful in promoting continuity of care for people with LTNCs. However,	outcomes; care planning; integrated services; interventions

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		Includes summary and technical report		Long-term Neurological Conditions recognised the need for an integrated approach to service delivery. Our study explored what helps or hinders service integration and identified three types of service that promote continuity of care. We then conducted a survey of all English Primary Care Trusts (PCTs) to assess the initial impact of the National Service Framework on integrated service provision.	these models operate well. Moreover, the choice of outcome measures for many of the studies was limited. Measures that addressed issues of personal choice, empowerment, or the experience of continuity of care were largely absent. In light of the lack of existing evidence on the outcomes of integrated services for people with LTNCs, we chose to make the experience of people with LTNCs a major focus of our own case study research. Services that promote continuity of care for people with LTNCs. The optimum outcome we would expect to find from the provision of integrated services is continuity of care. Bringing together the views and experiences of the people we interviewed in our six case sites, we identified three models of good practice for integrated service delivery, each of which contributed to people with LTNCs experiencing	our benchmarking data confirm that in many PCT areas these services are not available and, even where they are, not everyone with an LTNC has access to them. If statutory service commissioners and providers want to meet the continuity of care requirements encapsulated in the NSF, and needed by people with LTNCs, it is important that all people with an LTNC are able to access one or more of these models close to home, irrespective of where they live or what LTNC they have.	

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					continuity of care. These were: ● Community interdisciplinary neurological rehabilitation teams (CINRTs) People in receipt of services from a CINRT (rather than lone therapists or out-patient hospital services) tended to have improved experiences of continuity of care. Ongoing access to community rehabilitation was important for the people we interviewed, to generate improvements and also to maintain physical functioning and psycho-social well-being. The interdisciplinary way that team members worked, undertaking joint assessments and interventions and sharing case information, meant people with LTNCs received a seamless service from a wide range of professionals. Responsive, flexible services were valued most, particularly where interventions could be provided at a time and		

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					location convenient for the person with the LTNC and their families or carers. When social workers and health care professionals worked in an integrated way in these teams, a more holistic approach could be taken and cross-sector boundaries became less problematic.● Nurse specialists This model is highly valued by people with LTNCs, their families and carers, and the professionals and volunteers working with them. Where the model worked most effectively, nurse specialists acted as key-workers, engaging in active care co-ordination and advocacy to ensure that people with LTNCs could access a broad system of joined-up support. Nurse specialists were often people's first port of call. Their specialist knowledge and accessibility meant that they were able to answer questions, allay fears and access further services		

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					as the need arose. ● However, access to these services is frequently compromised by restrictive eligibility criteria, ill-defined pathways and a lack of availability or capacity locally. ● Neurological charities and other voluntary sector organisations play a key role in improving access and promoting continuity of care.		
Curry, N., & Ham, C.	2010	**Clinical and service integration – the route to improved outcomes**	The King's Fund	This paper describes and summarises relevant evidence about high-profile integrated systems and outlines examples of integrated care for particular care groups or people with the same diseases or conditions. It also reviews ways of achieving closer integration for individual service users and carers through care co-ordination and other approaches. It offers a selective summary of experience and evidence, focusing on	This report summarises relevant evidence about high-profile integrated systems in the United States, such as Kaiser Permanente and Geisinger Health System and outlines examples of integrated care in North America and Europe for particular groups, such as older people or patients with long-term conditions – for example, the integrated health and social care teams in Torbay. It also explores the range of approaches to improving co-ordination for individual patients and carers – for example, the Care Programme Approach in	Useful document for an overview of integrated care and a summary of key, relevant evidence from high-profile integrated systems.	integrated services; older people; care planning

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				examples of integrated care that appear to have most relevance to the NHS in England in the context of the coalition government's programme.	mental health.		
Timmins, N., Ham, C.	2013	**The quest for integrated health and social care – a case study in Canterbury, New Zealand**	The King's Fund	This paper tells the story of the journey made by the District Health Board for Canterbury, New Zealand, towards its goal of providing integrated care for all. It looks at the drivers for change, the leadership values shown by key players and considers the lessons that can be learned from the Canterbury experience.	• The stimulus for change in Canterbury was a health system that was under pressure and beginning to look unsustainable. • Canterbury adds to the small stock of examples of organisations and systems that have made the transition from fragmented care towards integrated care with a degree of measurable success. • Creating a new system takes time – Canterbury has been working to create 'one system, one budget' for at least six years and the journey is far from complete. • It takes many people to transform a system. A small number of leaders	Useful case study of an international journey towards integrated care, including policy context.	integrated services; joint commissioning

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					were at the heart of Canterbury's transformation, but this leadership rapidly became collective, shared and distributed.		
Thistlethwaite, P.	2011	**Integrating health and social care in Torbay – Improving care for Mrs Smith**	The King's Fund	This paper tells the story of health and social care integration for older people in Torbay, and how the known barriers to this were overcome. It shows how integration evolved from small-scale beginnings to system-wide change. Central to the work done in Torbay was how care could be improved for 'Mrs Smith', a fictitious user of health and social care services.	The results of integration include reduced use of hospital beds, low rates of emergency hospital admissions for those aged over 65, and minimal delayed transfers of care. Use of residential and nursing homes has fallen and at the same time there has been an increase in the use of home care services. There has been increasing uptake of direct payments in social care and favourable ratings from the Care Quality Commission.	This paper outlines how Torbay went about integrating health and social care and serves as a useful example of practical implementation.	integrated services; older people; patient admission; home care;
Rosen, R. et al	2011	**Integration in action: four international case studies**	The Nuffield Trust	This research report is part of the Nuffield Trust's programme of work on integrated care, which is examining the potential of new forms of care	This was a small study of four organisations that sought to identify generalisable features of use to the NHS from diverse international initiatives. The sites revealed the influence	Helpful illustration of the key factors which influence the success of integrated care initiatives, with evidence for each case study.	integrated services; joint commissioning

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				that are intended to benefit patients and taxpayers. It also forms part of their work to examine international best practice and use this intelligence to inform policy-making and practice in the UK.	of six sets of factors – integrative processes – which, between them, acted synergistically and drove progress towards integrated care. The structural merger of organisations was not necessary to achieve integrated care. The case studies also underlined the fundamental importance of building shared vision and goals across different providers or teams, and of trusted and respected clinical leaders.		
KPMG	2012	**A bitter pill to swallow: a global view of what works in healthcare**	KPMG	Review of international and national health case studies to highlight what has worked well in healthcare service and system redesign.	This paper presents the findings of national and international case studies about service redesign and transformation. Measurement evidence is listed with each case study and lessons learnt. Alongside contact details of people who can provide more detailed information.	Examples of successful integrated care with particular reference to measurement.	integrated services; cost effectiveness
Goodwin, N.	2012	**Integrated Care: Making it Work and**	The King's Fund	Presentation on examples of successful	Summary of organisational, delivery and systematic	Examples of successful integrated	integrated services; joint commissioning

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		Avoiding the Pitfalls Lessons from National and International Experience Working Together (PowerPoint Presentation)		integrated care.	characteristics are given in this presentation. Key challenges: scale and pace, clinical commissioners' commitment, strength of health and wellbeing boards, financial pressure and separate outcome framework. Key policy barriers: payment policy which encourages providers to expand and is about episodic care, under developed commissioning that lacks clinical leadership and engagement, regulation that focuses on episodic care and lack of political support to change local care. Key organisational and management barriers: primary and community care that wraps around the patient, developing new primary care services, developing new care models,	care.	

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories (based on Social Care Online Topics (alphabetical) 25 March 2013)
					effective clinical leadership, overcoming professional barriers, addressing lack of good information systems, involving the public, establishing new governance and learning from elsewhere on what success looks like and how to achieve it.		
Goodwin, N., Smith, J., Davies, A., Perry, C., Rosen, R., Dixon, A., Dixon, J., Ham, C.	2011	**Integrated care for patients and populations: improving outcomes by working together**	The King's Fund Nuffield Trust	A report for Department of Health and NHS Future Forum	This report seeks to provide a framework for the Department of Health to help meet the challenge set out by the NHS Future Forum and support the development of integrated care 'at scale and pace'. It examines: • the case for integrated care • what current barriers to integrated care need to be overcome and how • what the Department of Health can do can do to provide a supporting framework to enable integrated care to flourish • options for practical and technical support to	This paper has been written as a contribution to the work of the NHS Future Forum and in support of the government's espoused aim of placing integrated care at the heart of the programme of NHS reform.	integrated services; outcomes

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					those implementing integrated care, including approaches to evaluating its impact.		
The Audit Commission	2011	**Joining up health and social care: improving value for money across the interface**	The Audit Commission	This report is the second in a series of briefings looking at adult social care.	At a time when the whole of the public sector must find significant savings, the report says that integrated working across health and social care offers opportunities for efficiencies and improvements to services. Without it, there is a risk of duplication and cost-shunting where savings made by one organisation or sector create costs for others. And a lack of integrated working means that people are less likely to receive the best care. But the briefing also finds that the NHS and councils have made patchy progress in improving this joint working across health and social care.	NHS and social care partnerships can benchmark their performance against others by using the tool that accompanies the briefing.	cost effectiveness; outcomes

Cost Savings

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Seymour, M.	2013	**Torbay Value Case** **LGA Torbay Value Case_v1 FINAL.pdf**	Integrating Care & Local Government Association	The goal of this work is to develop value cases which are aimed at Health & Wellbeing Boards and may incorporate: • Service user stories, capturing changes to the service user's journey • Features of the model, including enablers • Costs of the model • Evidence of benefit, including to activity, spend and outcomes	The creation of the Torbay Care Trust saved approximately £250,000 in management costs in its first year. Significant additional savings were made to the system as a whole (e.g. through reduced hospital admissions)	Outlines a model for integrated care and outlines the costs and benefits of it.	cost effectiveness; outcomes; integrated services
Forder et al	2012	**Evaluation of the personal health budget pilot programme**	PSSRU Discussion Paper 2840_2	The personal health budget initiative is a key aspect of personalisation across health services in England. Its aim is to improve patient outcomes, by placing patients at the centre of decisions about their care. Giving people greater choice and control, working alongside health service	The main findings of the cost analysis were: • The cost of inpatient care (an 'indirect' cost) was significantly lower for the personal health budget group compared to the control group after accounting for baseline differences. • The ('direct') cost of wellbeing and other health services were both significantly higher for the	Evidences (direct and indirect) cost efficiencies and savings and explains costing methods used.	care planning; outcomes; personal budgets

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				professional to develop and execute a care plan, given a known budget, is intended to encourage more responsiveness of the health and care system.	personal health budget group compared to the controls. • Other categories of direct and indirect cost showed no differences between the groups. • The difference in direct and indirect total costs between personal health budget and control groups after accounting for baseline differences were not statistically significant.		
Ham, C. , Edwards, N., Brooke, B.	2013	**Leading Healthcare in London – time for a radical response**	The King's Fund	An update on the service changes taking place in NHS London and address the issue of who will lead these changes in the NHS after the NHS restructuring which will take place after April 2013. The findings from this paper builds on the analysis already produced by the Kings Fund in 2011.	Estimated net saving of £70 million annually once the projects are fully implemented.	Demonstrates how savings have been made in London and how further savings will be made as further integration is implemented.	integrated services; cost effectiveness

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
Turning Point	2010	**Assessing the evidence for the cost benefit and cost effectiveness of integrated health and social care.**	Turning Point	This report provides an overview of the current evidence in the UK and abroad to support the case for integrated health and social care. It is concerned with reviewing the economic evidence base and establishing a clear understanding of the financial benefits that can be realised through developing an integrated approach to health and social care. The purpose of the report is to contribute to the development of a strong evidence base to support the development of integrated care.	This report finds that meeting people's needs with a preventative and integrated approach to health and social care can create efficiencies and savings. However, future studies do need to consider the long term financial benefits. Many of the studies that concluded that integrated care was not cost effective were conducted over short time periods, and many of the benefits will accrue as individuals remain independent well into the future. In particular, those integrated services that have a focus on early intervention are designed to prevent needs escalating in years to come, and therefore, the real benefits will be realised over time.	Focus on long term benefits of prevention and integration.	integrated services; prevention

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
PSSRU	2010	National evaluation of Partnerships for Older People Projects. Executive summary	PSSRU	The Partnership for Older People Projects (POPP) were funded by the Department of Health to develop services for older people, aimed at promoting their health, well-being and independence and preventing or delaying their need for higher intensity or institutional care. The evaluation found that a wide range of projects resulted in improved quality of life for participants and considerable savings, as well as better local working relationships.	POPP project, which received £60 million funding and involved over 250,000 people found that for every extra £1 spent on the POPP services, there was approximately £1.20 saving on emergency bed days; overnight hospital stays were reduced by 47%; use of A&E departments by 29%; Therapy and clinic/OPD appointments reduced saving £2,166 per person.	Illustrates real savings associated with POPP.	cost effectiveness; older people; prevention
NHS Confederation	2013	A primary care approach to mental health and wellbeing	NHS Confederation	Focus on how Sandwell CCG commissioners responded to specific health inequalities to develop a primary care-led approach to improving mental health and wellbeing.	Promising early outcomes, with over 4,000 people completing the wellbeing and health improvement programme; £800K saved in prevention, 3000 people accessed talking therapy saving £600K.	Illustrates savings made in mental health.	cost effectiveness; mental health problems; prevention

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
NHS Wales	2011	**Final (Year 3) Report from the Chronic Conditions Management (CCM) Demonstrators Learning to Support Integrated Primary and Community Care across Wales**	NHS Wales	This report summarises the learning from the final year of the Chronic Conditions Management (CCM) Demonstrator sites in Cardiff, Carmarthenshire and North Wales. Further details can be found in over 80 publications published and available on the CCM Demonstrators website. The final testing of the CCM Model and Framework (CCM&F) (1)(2), and the associated evidence based learning will inform Local Health Boards (LHBs) as they speed up changes on the ground and improve services for people with chronic conditions.	Across all three CCM Demonstrator sites: • There has been an 18% decrease in total bed days from 2008 to 2010, with a drop from 36,099 to 29,771, a calculated cost reduction of £1,723,131 • Further, there has been a reduction in the numbers of emergency medical admissions for key chronic condition by 11.3% over 2008-2010, from 5797 to 5142	This report, along with the accompanying locality reports is useful in terms of what they did and the resulting impact.	care planning; general practitioners; outcomes; diabetes; primary care; cost effectiveness
Tian	2012	**Data briefing: Emergency hospital admissions for ambulatory care-sensitive conditions** **Identifying the**	The King's Fund	Ambulatory care-sensitive conditions (ACSCs) are conditions for which effective management and treatment should limit emergency admission	18% (potentially saving £238 million) if all local authorities performed at the level of the best-performing local authorities. 8% (potentially saving £96	Useful for the impact of preventative or anticipatory care.	care planning; outcomes; information technology

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
		potential for reductions		to hospital. Nevertheless, ACSCs currently account for more than one in six emergency hospital admissions in England. These emergency admissions cost the NHS £1.42 billion each year. High levels of admissions for ACSCs often indicate poor co-ordination between the different elements of the health care system, in particular between primary and secondary care. An emergency admission for an ACSC is a sign of the poor overall quality of care, even if the ACSC episode itself is managed well.	million) if each local authority improved their service to the level of the next best local authorities. 11% (potentially saving £136 million) if the poorer (than the average) performing local authorities performed at the level of the better (than the average) ones.		
Mersey Care NHS Trust	2012	**Service redevelopment: integrated whole system services for people with dementia**	Mersey care NHS Trust Quality and Productivity – proposed case study	This case study is about keeping people with dementia independent for longer so they do not have to access more costly care, and where this is not possible, to ensure people are provided with appropriate support to	This case study has estimated net savings of £2.1 million or £246,000 per 100,000 population, providing all services changes are implemented across North Mersey. As this initiative is in the very early stages of	Potential evidence of cost savings associated with whole system integrated services.	integrated services; mental health problems

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
				get them back into the community quicker so they can regain their quality of life.	implementation information showing how implementation of this case study has actually demonstrated its aims is not yet available.		
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.	cost effectiveness; emergency health services; older people; prevention
Tummers, J., Schrijvers, A., Visser-	2012	**Economic evidence on integrated care for stroke patients: a systematic review**	International Journal of Integrated Care	Provides a systematic literature review of cost analysis and economic evaluations around	Six out of six studies provided evidence that the costs of early-supported discharge are less than for	Ten out of fifteen studies were set in Europe (of which five were in the UK), two in	cost effectiveness; reablement; older people; intermediate care

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
Meily, J.				trying to reduce the cost and resources needed to provide care to patients who have had a stroke.	conventional care, at similar health outcomes. Home-based rehabilitation is unlikely to lead to cost-savings, but achieves better health outcomes. Care in stroke units is more expensive than conventional care, but leads to improved health outcomes. The cost-effectiveness studies on integrated stroke services suggest that they can reduce costs. For future research we recommend to focus on the moderate and severely affected patients, include stroke severity as variable, adopt a societal costing perspective and include long-term costs and effects.	Australia and Canada, and one in Hong Kong. The time horizon of the studies was generally short; most of the studies followed the subjects for a year, and the rest for a shorter period. Most of the included studies were randomized controlled trials, and three were non-randomized. The study size ranged from 83 to 598 subjects. Even though 11 out of the 15 included studies were published after 2000, for all but one study the data were collected from trials performed before 2000.	

Care Planning

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
Dickinson, H., Glasby, J., Nicholds, A., Jeffares, S., Robinson, S., Sullivan, H.	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	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?	joint commissioning; outcomes

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					consuming and fragile in the face of radical organisational or policy change.		
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 coterminosity 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.	information management; joint commissioning

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
Weatherly, H., Mason, A., Goddard, M., Wright, K.	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 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.	• The goals driving integration need to be made explicit to all those involved in providing the service. • 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	This is an extensive review of literature from across the world that describes and examines the different tools, techniques, systems and processes that have been used to enable financial integration between health and social care.	carers; cost effectiveness; emergency health services; general practitioners; home care; intervention; joint commissioning; mental health problems; older people; patient admission

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					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 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		

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					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 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		

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					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 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		

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					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.		
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.	cost effectiveness; older people
All-party parliamentary group on Dementia	2011	**The £20 Billion Question - an inquiry into improving lives through cost effective dementia services**	All-party parliamentary group on Dementia	The purpose of this report is to build up a body of evidence that will be of use to commissioners and providers of dementia care everywhere, highlighting what can be done locally to ensure care is both cost-effective and meets the needs of the people with dementia and their families.	Wide ranging report covering areas organised by: whole systems, hospital care, community care, and care homes.	Summarises the evidence base for dementia across the whole care pathway.	care planning; carers; cost-effectiveness; home care; integrated services; older people; intervention; outcomes; mental health problems; prevention
Parker et al	2009	**Synthesis and conceptual analysis**	National Institute for Health Research	Despite continued attempts to alter policy	Patients generally talked about their preferences and	Several projects in the SDO programme	outcomes; diabetes; mental health

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
		of the SDO Programme's research on continuity of care	Evaluations, Trials and Studies Coordinating Centre, Southampton	and change practice, the ability of health and social care systems to deliver the type and level of continuity of care that service users desire remains in question. Lack of clarity about what continuity of care actually means, as well as imperfections in systems to deliver it, have been identified as part of the cause of this problem. The NIHR Service Delivery and Organisation (SDO) Research and Development Programme funded a series of research projects, both primary and secondary, on continuity of care, specifically to tackle this conceptual confusion. By formally reviewing all the outputs, we attempted to establish how far the programme had advanced conceptual clarity about continuity of care and increased knowledge about what influences it and to what purpose.	experiences of care and treatment using language other than 'continuity'. Their behaviour, influenced by personal, family and cultural beliefs and choices, interacted with service provision and sometimes influenced outcomes. ● We found evidence about carers' own preferences and needs mainly in studies on cancer and severe mental illness. Carers valued good relationships with professionals; recognition of their contribution to patient care, and acknowledgment of their own needs for support. ● In most of the studies health and social care professionals saw continuity of care as a relationship between an individual professional and a service user. Sharing information was important, as was working together effectively. ● We found mixed progress in measuring continuity of care. One measure seemed to offer potential for development for other long-term conditions.	developed measures of continuity of care, for service users, carers and professionals and then used these as part of their research. We reviewed both the measures and the findings they generated. The results suggested that different service user groups have different priorities in relation to aspects of continuity. For people with severe mental illness, service responsiveness to the needs of an individual over time (flexibility) and not having to deal with frequent staff changes (longitudinal continuity) are important aspects. Among people who have suffered a stroke, flexibility is most prominent. For people with cancer, flexibility and continuity across geographical or organisational boundaries and health-care teams are key	problems; carers

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
				Robust information of this sort, translated into service delivery and organisation, is crucial to the delivery of many aspects of current health and social care policy.		issues. By contrast, for people with type 2 diabetes, establishing and maintaining a satisfactory relationship between staff and service user (relational continuity) seem most important. However, service users recognised all types of continuity to some degree, underlining the overall general applicability of the Freeman model. Different approaches within the studies to developing valid and reliable measures meant it was difficult to assess whether continuity of care (or different types of continuity) led to different outcomes. The measure developed for people with diabetes (the simplest of all those developed) seemed to offer most potential for future development and extension to groups of people with	

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
						other long-term conditions.	
Da Silva	2012	**Helping people share decision making**	The Health Foundation	This report brings together evidence and provides an up-to-date single reference point for the current state of knowledge about shared decision making. This evidence shows that shared decision making improves patient's satisfaction, involvement in their care and knowledge of their condition.	A major gap in knowledge is whether and how shared decision making works. Specific tools and techniques may encourage patients and their carers to take more responsibility for their care, help people with long-term conditions feel more in control and improve the overall quality of care by encouraging health professionals to follow recommended care protocols. But shared decision making is complex, both conceptually and in terms of implementation. There is a need to explore in more depth the impacts of shared decision making, rather than merely assuming positive outcomes. This review suggests that impacts on clinical outcomes and resource use are mixed and impacts on safety, timeliness and equity are virtually unknown. There is also a need to better understand the conflicting and sometimes contradictory research findings. The	The report is useful in terms of defining "shared decision making" with international examples of how shared decision making is implemented.	care planning; general practitioners; outcomes

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					evidence for shared decision making may be mixed in some cases because a wide range of things are described as 'shared decision making'. Past reviews have tended to combine initiatives that focus solely on information provision with interventions that more actively target behaviour change and elf-efficacy. However, these varying interventions may have different outcomes so combining them could dilute the findings.		
Forder	2011	**Length of stay in care homes**	PSSRU Discussion Paper	Care home placements constitute the majority (57%) of net council spending in England on social care for older people. Information about the expected length of stay for people admitted to a care home is important for predicting lifetime costs and for understanding the implications of reforming funding arrangements for social care.	Residents of the 305 Bupa homes are largely representative of the England average in relation to age, sex and funding source. Bupa have more people in nursing beds with a higher level of frailty than the average in England, but we are able to re-weight the results to estimate average lengths of stay that more closely reflect the England situation. In the Bupa sample, the average length of stay was 801 days, but with a	This study is useful in determining the impact of admissions to care homes	older people; care planning; outcomes

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					considerable tail of long-stayers. Half of residents had died by 462 days. Around 27% of people lived for more than three years, with the longest stayer living for over 20 years. People had a 55% chance of living for the first year after admission, which increased to nearly 70% for the second year before falling back over subsequent years.		
Chitnis, X., Georghiou, T., Steventon, A and Bardsley, M.	2012	**The impact of the Marie Curie Nursing Service on place of death and hospital use at the end of life**	The Nuffield Trust	This study examines whether the home-based nursing service provided by Marie Curie Cancer Care helps more people to die at home, and reduces hospital use and costs at the end of life	The study found that people who received MCNS care were significantly more likely to die at home than those who received 'standard' care, and were less likely to use all forms of hospital care. There were also significant differences between the two groups in the costs of both planned and unplanned hospital care.	The results of this study offer evidence that home-based care can reduce hospital use at the end of life, and help more people to die at home. The findings provide evidence of the potential benefits of home-based end of life schemes, such as that operated by Marie Curie, and support increasing investment in such services so as to improve care for people at the end of life.	commissioning; evaluation; integrated care; quality of research; research methods & information tools; social care

Care Navigation

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
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 new services or to re - organise services. Similarly,	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.	access to services; mental health problems; social exclusion

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					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 assessments.		
Raime, M.	2012	**Patient Navigation Project Pilot Report Improving earlier diagnosis of breast cancer in black**	Public Health England	This report describes the Patient Navigation Project undertaken by Betterdays Cancer Care which was developed in	• Through Patient Navigation women who would otherwise have been lost to follow-up were identified and	Patient Navigation has been developed in order to eliminate the barriers to timely diagnosis and	access to services; black and minority ethnic people; cancer; general practitioners; social

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories

		women		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.	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.
						treatment amongst particular groups.	exclusion

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
Hughes-Hallett, T., Davies, C. and Professor Sir Alan Craft	2011	**Funding the right care and support for everyone – Creating a Fair and Transparent Funding System; the Final Report of the Palliative Care Funding Review**	The Palliative Care Funding Review	In the coalition agreement the Government made a commitment to introduce per-patient funding for palliative care. The Government set up this independent review to examine dedicated palliative care funding for adults and children in England, and to make recommendations on the way forward.	Key recommendations: • An assessment, on a regular basis, of the needs of a patient • All the clinically assessed palliative care needs of a patient irrespective of setting, as in any other branch of clinical care • A coordinator for the patient who will guide them through their journey, signposting patients and families to the full range of services including those provided by society and not funded by the state • At the end of life, as an addition to the tariff, the social care needs of a patient after they are added to an end of life locality register .	This review identifies the importance of better integration of services across health and social care and coordinated care packages as well as an increased focus on outcomes and patient choice.	commissioning; integrated services; care planning; outcomes

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

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
Francis J., Fisher M., Rutter D.	2011	**Reablement: a cost-effective route to better outcomes** (SCIE	Social Care Institute for Excellence	This briefing provides a summary of recent research into reablement and	• People using reablement welcome the emphasis on helping them gain independence and better	Reablement is a key service because it represents an investment which may	cost effectiveness; reablement; outcomes

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
		Research briefing 36)		signposts routes to further information.	functioning, although evidence on user and carer views needs to be strengthened. • Reablement improves outcomes, particularly in terms of restoring people's ability to perform usual activities and improving their perceived quality of life. From a social care perspective, there is a high probability that reablement is cost effective. • Reablement achieves cost savings through reducing or removing the need for ongoing support via traditional home care. However, there is currently little evidence to suggest that it reduces health care costs. • Managers and care workers are generally positive about reablement, valuing its flexibility and the more responsive way of working with people. • Occupational therapy skills are central to reablement. These can be accessed by training reablement staff rather than having an occupational therapist as a team member.	produce savings, and because it appears to meet the wishes of people who use services.	

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					• Complaints about reablement mainly relate to handover (to a traditional home care provider) and a lack of help with domestic tasks. • The delivery of reablement depends on suitably trained care workers. Care workers require specific training in reablement. Ongoing refresher training or shadowing of experienced workers is vital to sustain this approach. • Requirements for training, closer supervision of care workers and longer, more responsive and flexible visits all contribute to the greater costs of reablement compared with conventional home care. However, the higher price of reablement is likely to be offset by longer-term savings from reduced social care-related needs.		
Glendinning, C., Jones, K., Baxter, K., Rabiee, P., Curtis, L., Wilde,	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	• Taking total healthcare, social care and re-ablement costs together, there was no statistically significant difference in the costs of all the 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	cost effectiveness; home care; intervention; outcomes; reablement

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
A., Arksey, H., Forder, J.				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.	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.	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** (King's Fund – Reading List)	The King's Fund	Reading list covering a wide range of books, reports and journal articles that discuss intermediate care and re-ablement. Includes summaries and internet links of each resource.	• There is a wide range of evidence available to demonstrate the effectiveness and cost-effectiveness of intermediate care and re-ablement services.	Provides evidence to support the development of intermediate care and reablement services.	cost effectiveness; intermediate care; reablement

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
Winters	2009	**Reducing Emergency Admissions to Hospital - redesign of services**	Liverpool Public Health Observatory	The review examines the available research evidence into interventions to reduce emergency hospital admissions and reduce pressure on A&E.	Commentators have advised taking a whole system approach when redesigning services. For instance, while case management may reduce hospital admissions, flexibility is required to allow for local factors, such as type of existing services, as there is no model of case management which will fit all contexts. Ultimately delivery of services depends on local circumstances and on what is convenient for the majority of patients. Findings are split into primary, intermediate and secondary care.	Useful review structured by sector. Some limited cost-benefit evidence.	emergency health services; access to services; intermediate care; intervention; primary care
Øvertviet	2011	**Does Clinical Coordination improve quality and save money?**	The Health Foundation	The main question addressed in the review was 'Does clinical coordination improve quality and save money?' Both the author of this review and the Health Foundation, which commissioned this study, believe that decision makers are interested in: – which changes produce positive results	Wide ranging evidence review covering different aspects of coordination including grading the evidence for robustness. Includes recommendations for application of interventions as well as identifying the best solutions to address problems. Continuity of care specifically appears to have little quantitative data. However case management has some strong evidence In the United States, some well-evaluated	Useful document including a table identifying different problems, the relevant evidence and the recommendations for implementation.	cost-effectiveness; integrated services; outcomes; intervention; care planning; emergency health services; patient admission; primary care

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
				(higher quality and lower costs) that are worth the costs of the change, and are more beneficial than any negative consequences? – in which situations could such results be anticipated, beyond those where the research was undertaken, and what would be needed to implement the changes?	programmes for older people have been found to reduce admissions and improve outcomes, and many have reduced costs to the health system. (See, for example, Kane et al's 2003 evaluation of the US Evercare model). – The evidence from UK and later reviews is less clear in part because of the UK case management approaches being different and because of increasing heterogeneity in newer approaches, especially when comparing programmes in different countries with different payment systems. US 'Evercare' models used intensive home nursing for patients when they became ill. One review of home-based care for older people found no effect on hospital admission (Elkan et al 2001). – The Johari et al 2003 broad international review of a range of integrated care for older people, found that some models can reduce admission rates and costs of care. Two other reviews		

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					found little evidence that case management can reduce use of health services (Hutt et al 2004, Singh 2005).		
Arksey et al	2003	**Access to healthcare for carers**	PSSRU	The overall aim of the study was to document the evidence base, and the role of theory, in relation to the problems and barriers to access to health care for carers and interventions to remedy interventions. The research team examined the evidence from UK and international research (published and unpublished) in order to identify: 1. The problems and barriers which carers experience in accessing health care services (including health promoting and preventive services), and any associated issues relating to equity of access and level of unmet need 2. Evidence of specific	The consultation explored perceptions of the barriers carers faced in gaining access to health care services, canvassed ideas on how access can be improved and identified specific examples of interventions or good practice in facilitating carers' access to health care.	Although the study is relatively old, it has some important findings for commissioners to consider – as the authors comment, it is especially complicated in relation to carers, because carers are involved in looking after not only their own health, but also the health of the person they support.	carers; interventions

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
				interventions that can improve carers' access to health care services, and how these may vary according to carers' circumstances.			
Boutwell, A. Griffin, F. Hwu, S. Shannon, D.	2009	**Effective interventions to reduce hospitalization; a compendium of 15 promising interventions**	Institute for Healthcare Improvement	This document is intended to provide a sampling of the range of effective programs underway to reduce avoidable rehospitalizations across the US. The 15 programs highlighted in this document are all very promising approaches to improve patient care. For purposes of clarity, the programs that have documented, peer-reviewed evidence of success in reducing rehospitalizations are distinguished from other programs with less rigorous levels of evidence available to date.	In total, 15 programs are highlighted in this document: four with very strong trial or evaluation evidence of effectiveness, seven with very good evidence of reduction in rehospitalization rates, and four that are promising interventions but require further data. Our hope is that this overview will serve as a primer for understanding the range of interventions currently being applied or under study for reducing avoidable rehospitalizations.	US focussed but distinguishes between robust and weaker evidence.	emergency health services; intervention; cost-effective; outcomes
Ellins et al	2012	**Understanding and improving transitions of older**	NHS National Institute for Health Research	This project focuses on older people and their transition between	Care transitions involve far more than a move across services or settings. Different	This study contributes to the current context of dignity, compassion	older people; outcomes

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
		people: a user and carer centred approach		different services and agencies in health and social care. Research studies and reports from inspectors have shown that older people experience many problems before, during and after transitions. The project is conducted in four local areas and has two key aims: 1. Explore what information, support and care is needed by older people (and their carers) as they go through a transition. 2. The project team will work with people and organisations in the four local areas to put the findings into practice nationally.	transitions often simultaneously and if circumstances made coping difficult in one type of transition then it was likely to have an effect on others. Whilst the physical aspect of the transition are often a priority for service providers, the importance of the psychological and social aspects was frequently overlooked. The way older people are treated by professionals and staff has a considerable impact on their overall experience. Most of the suggestions participants made for improving services called for 'micro-changes'in the care environment and in interpersonal relationships. There was little suggestion that what was needed was new or different services; easier and earlier access to existing services emerged as a far greater priority. While these micro-changes may not cost large amounts of money, they do require committed and sustained effort to challenge existing ways of working that may be deeply ingrained in organisational	and person centred care.	

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					and professional cultures.		

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

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
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	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.	cost effectiveness; intervention; prevention

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
				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.			
Wallace, L., Turner, A., Kosmala-Anderson, J., Sharma, S., Jesuthasan, J., Bourne, C., Realpe, A.	2012	**Co-creating Health: Evaluation of first phase An independent evaluation of the Health Foundation's Co-creating Health improvement programme**	The Health Foundation	Report of the findings from an independent evaluation of phase 1 of the Health Foundation's Co-creating Health self-management support improvement programme. The report was written by evaluators from the Applied Research Centre in Health and Lifestyle Interventions at Coventry University. The first phase of the Co-creating Health improvement programme was a three year initiative in eight sites across the UK that aimed to demonstrate the impact, on clinicians and patients alike, of integrating self	• The self-management support programme for patients improved the activation and quality of life of people with long-term conditions. • Adopting self-management approaches requires long-term behaviour change, and the interventions to achieve these also need to be long-term. • Self-management support must be normalised into existing ways of working within health economies. • Techniques to support self-management, including agenda-setting and goal-setting, were well received and implemented following training. • Co-delivery is an important way of changing patients' and clinicians' perceptions.	The evaluation of the Co-creating Health self-management support improvement programme provides valuable insights into what worked and the further challenges health systems need to address in order to support people to develop confidence in managing their long-term condition(s) themselves.	intervention; outcomes

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
				management support into routine care for people with long term conditions.			
Nesta and Innovation Unit	2013	**People Powered Health Project Summaries**	Nesta	The report provides project summaries for the six People Powered Health localities that Nesta and Innovation Unit are working with. It includes expected outcomes for each project.	The six 'big ideas' described in the report are: • Calderdale and Huddersfield Foundation Trust and NHS Kirklees - aims to redesign future muskulo-skeletal pain service delivery pathways through shifting from a traditional model of medical care to a facilitative and preventative approach that supports patients to manage their conditions before they reach crisis point. • Lambeth Living Well Collaborative – aims to use "co-production" as the operating framework for the delivery and commissioning of services and provide support for people with long term mental illness. • Leeds Community Healthcare NHS Trust - has already initiated two key innovations: the use of risk stratification in primary	Provides details of six innovative projects built around co-production.	access to services; intervention; mental health problems; outcomes; patient admission; prevention

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					healthcare services, and the integration of health and social care teams. These innovations are aimed at identifying and implementing an early intervention strategy for people who are at risk of future admission, particularly targeting those patients who have low or medium-level long term conditions. • Newcastle Bridges Commissioning Consortium – aims to introduce a series of system changes that will embed a single, integrated process of social prescribing‟ into healthcare pathways for people with long term conditions. This will involve developing a more community-based, preventative healthcare model that will be made up of a range of locally accessible, social healthcare solutions that can be tailored to the needs of the individual. • Stockport Metropolitan Borough Council, Altogether Positive,		

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					Stockport MIND and Pennine Care NHS Foundation Trust – aims to improve the "social recovery pathway" for people with mental health issues. • Turning Point, Terrence Higgins, Greenpoint & NHS Dentists – aims to hardwire coproduction into the running of a new Health and Wellbeing Centre through the design and delivery of its services. The People Powered Health approach could reduce the cost of managing patients with long-term conditions by up to 20 per cent. The financial business case for People Powered Health rests on two key areas of benefit. The first is the ability to mobilise the asset base that is patients, service users and their communities. Joining up these individual efforts allows them to add to far more than the sum of the parts. The second area of benefit is reductions in unplanned admissions and the		

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					requirements for expensive, acute care. The NHS in England could realise savings of at least £4.4 billion a year if it adopted People Powered Health innovations that involve patients, their families and communities more directly in the management of long term health conditions. These savings are based on the most reliable evidence and represent a 7% reduction in terms of reduced A&E attendance, planned and unplanned admissions, and outpatient admissions. There is therefore both a social and financial imperative to scale the People Powered Health approach.		
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	• 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	The findings strengthen the case for an integrated response for frail older people at risk of falls.	cost effectiveness; falls; older people; patient admission

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
				and after their fall.	falls, costs were 70% 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%), compared to a 37% increase in social care costs and a 35% 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.		
Campbell, J., Pyer, M., Ward, A., Jones, J.	2013	**Crisis Response: Evaluation Report**	The Centre for Health and Wellbeing Research	The Centre for Health and Wellbeing Research were commissioned to undertake an evaluation	• A drop in the number of patients who were conveyed to hospital following a fall was observed when	This paper demonstrates that the introduction of a Crisis Response Service can have a positive impact	emergency health services; falls; intervention; prevention; older people; patient

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
		 Crisis Response Final Report FINAL.pdf		of the impact of the Northamptonshire Crisis Response Service. The Crisis Response Team works alongside the ambulance service with an aim to prevent elderly admissions to hospital following a fall. The evaluation was based on: 1) Total number of falls (before and after introduction of service) 2) Total calls to EMAS (caseload analysis of falls service) 3) Reduction of transfers to hospital / admissions to A&E (total numbers of transfers/admissions before and after introduction of service 4) Patient experience	conveyance rates were compared for the CRT service delivery timeframe with that of the previous year. Although the change was small it was statistically significant. • The conveyance rates for patients to hospital were lower during the hours that the falls ambulances were in service, than when only general ambulances were running. • During the evaluation period the CRT service received a total of 1,546 referrals. Most were related to single incidents. 85% of these referrals were accepted by the service. The number of referrals has steadily increased since the start of the service. • Over 40% of CRT referrals originated from the falls ambulances. Almost 50% of these were made for the purpose of avoiding hospital admissions and 43% sought to aid falls discharge from A&E departments. • A number of patients responding to the	on the number of patients admitted to hospital following a fall.	admission

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					telephone interviews and open text questions on the patient feedback survey showed confusion regarding which interventions had been offered by the CRT, and which had been forthcoming from other service providers. • The feedback offered from patients about the service was overwhelmingly positive; interventions were considered to be timely and staff were considered friendly, approachable and well-informed. Almost everyone responding to the questionnaire felt that they were respected as an individual, treated with dignity and appropriately consulted about their care. The authors make the following recommendations for the service: • Data recording: liaise with all agencies to ensure that routinely collected data is complete and collected in a form that can be used across the services.		

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					• Informing patients: provide better communication methods with patients and their carers about the service. • Confirming with patients that they are aware how to use any new equipment supplied to assist their living at home.		

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

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
Glendinning, C., Challis, D., Fernandez, J., Jacobs, S., Jones, K., Knapp, M., Manthorpe, J., Moran, N., Netten, A., Stevens, M., 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	• 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.	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	cost effectiveness; mental health problems; older people; outcomes; personal budgets; physical disabilities

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
				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 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.	and social, leisure and educational activities.	
Carr, S.	2010	**Personalisation, productivity and efficiency (Adults' Services SCIE Report 37)**	Social Care Institute for Excellence	This brief report examines the potential for personalisation, particularly the mechanism of self-directed support and personal budgets, to result in cost-efficiencies and improved productivity as well as improved care and support, resulting in better outcomes for people's lives. It provides an overview	• There is some evidence to suggest that self-directed support and personal budgets could lead to improved outcomes in individual cases for the same cost if implemented efficiently and effectively. • The strategic use of personalised approaches to integrated health and adult social care	The report provides emerging evidence of the impact that personalisation can have on the efficient delivery of patient care.	cost effectiveness; outcomes; personal budgets; prevention

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
				of some emerging evidence on efficiency from the implementation of personalisation so far.	and support can promote both primary and secondary prevention. The evidence that investment in prevention can generate savings is probably clearer than that presently associated with personal budgets and self-directed support. • Most notably, it appears that the personalisation agenda is stimulating review and change in business processes, administrative and management systems. The evidence so far shows that this appears to have reliable potential to generate efficiency savings and improve productivity in certain areas.		
Henderson,	2013	**Cost effectiveness of telehealth**	BMJ	The authors	• The QALY gain by	The research	cost

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
C., et al		**for patients with long term conditions (Whole Systems Demonstrator telehealth questionnaire study): nested economic evaluation in a pragmatic, cluster randomised controlled trial** (Research article - *BMJ 2013;346:f1035)*		undertook a net benefit analyses of costs and outcomes for 965 patients (534 receiving telehealth; 431 usual care) and measured the adjusted mean difference in QALY gain between groups at 12 months.	patients using telehealth in addition to usual care was similar to that by patients receiving usual care only, and total costs associated with the telehealth intervention were higher. Telehealth does not seem to be a cost effective addition to standard support and treatment.	provides evidence to suggest that a community based, telehealth intervention is unlikely to be cost effective, based on health and social care costs and outcomes after 12 months and the willingness to pay threshold of £30 000 per QALY recommended by NICE. A reduced cost of telehealth per QALY may be possible by combining the effects of equipment price reductions and increased working capacity of	effectiveness; information technology; intervention; outcomes

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
						services.	
Hurstfield et al	2007	**The costs and benefits of independent living** A report of research carried out by SQW on behalf of the Office for Disability Issues, Department for Work and Pensions	ODI	The study comprises two essential components: 1. An extensive review of the literature on the potential costs and benefits associated with investment in independent living (IL) support, as compared to more conventional forms of service provision. 2. Five illustrative case studies of individual circumstances were undertaken to in order to investigate different types of IL support in detail and uncover examples of costs and benefits to complement the literature review evidence.	At an individual level, there is substantial qualitative evidence, from both the literature review and the case study research, suggesting that IL provides significantly more benefits than conventional forms of service provision. Some of the case studies undertaken as part of this research also indicated that IL can also be cost effective for the individual recipients. At service delivery level, several published evaluations that were identified in the literature highlighted the reduced costs involved in the delivery of independent living support mechanisms. Consultations and the case studies undertaken reinforced this view, by highlighting the	The target population is disabled people; the definition used is the Family resources survey which defines a disabled person as someone with a long-standing illness, disability or infirmity, and who has a significant difficulty with day-to-day activities. This is a relatively old study but the individual and macro outcomes are still valid.	cost effectiveness; home care; outcomes

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					inherent inefficiencies involved in traditional care provision. It was also pointed out, however, that there would be considerable transformational costs involved in rolling out IL more widely. It is largely expected that these upfront costs will be offset in savings, at both service delivery and macro level, in the long term, suggesting, therefore, the need to accept an 'invest to save' approach. The published material at macro-economic level on the costs and benefits of independent living is relatively sparse. However, the literature does highlight that there are significant costs for the Exchequer in not addressing barriers faced by disabled people. Evidence from the case studies and consultations corroborates and		

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					strengthens this view, showing that investment in independent living would result in sizeable long-term cost savings for the Exchequer due to the increase in tax revenues, a reduced state benefits bill and less pressure on health and acute social care services.		
Rostgaard, T. with Glendinning, C., Gori, C., Kroger, T., Osterle, A., Szebehely, M., Thoebald, H., Timonen, V., Vabo, M	2011	http://www.sfi.dk/Files/Filer/SFI/LIVINDHOME/LIVINDHOME.pdf	SFI - Danish National Centre for Social Research, Copenhagen	The overall objective of the study is to identify how nine European countries have reformed their home help systems, in order to fund and deliver 1) high quality care which meets increasingly diversified and individualized needs, 2) an efficient and effective provision mechanism and cost containment 3) a stronger user-orientation in the provision of care	Overall, each country's approach to reforming home care services reflects its traditions, values and welfare state structures. However, two broad patterns can be identified among the countries in this study. In countries that have more family-oriented welfare traditions (Austria, Germany, Italy, Ireland), comprehensive approaches to long-term care have started to develop only relatively recently. Within these family-	Useful for international comparison of home care models.	home care; integrated services; carers

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
				4) an optimal balance between formal and informal care and other resources, and 5) the best way to attract and retain home care workers.	oriented countries, Germany and Austria have introduced new universal social rights relating to long-term care – including home care - that include changes to the traditional responsibilities of national and regional governments. Even so, their new arrangements for supporting people at home reflect each country's structures and traditions. In contrast, despite increases in funding for long-term care, home care provision in Italy and Ireland remains highly fragmented, with major local variations in access to services. The second group of countries (Denmark, England, Finland, Norway, Sweden) have had more or less comprehensive home care services in place for many years. These		

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					have been delivered by local authorities under a legislative framework set by central government. Reforms have here involved the introduction of market- and consumer-related mechanisms into the supply and delivery of home care. These include competition between home care providers and encouragement for new, for-profit providers to compete with traditional public sector providers. Associated with these market mechanisms, new ways of safeguarding service quality, increasing flexibility and improving efficiency have been introduced. Nevertheless, in England, Finland and Sweden, local authorities have increasingly targeted their home care services on people		

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					with the highest needs for support. This has meant a major shift in the balance between formal and informal care.		
Truscott & Mason	2010	**Evidencing the financial benefits of the Supporting People Programme**	Torbay Council	Supporting People (SP) provides support to help people live independent lives. Services Include: supported housing, sheltered housing, supported lodgings, a woman's refuge and floating support where workers visit people in their own homes. Support includes developing independent living skills, helping with finance and budgeting, helping people access education and employment, enabling people to maintain their tenancies and mortgage conditions and move on to more independent living	It is estimated the SP programme in Torbay realises £8.19m worth of savings in other public sector spend. Findings for older people were: • Residential care costs- these are eliminated as SP prevents people from entering residential and nursing care. • Health service costs- SP services reduce the need for hospital care, community healthcare, outpatient care and GP services through helping to improve general health. • Tenancy failure costs- SP services provide support and guidance to help	The results are not necessarily replicable since Torbay will have worked within a community context. However, the report is useful for the different target groups and the multi-intervention approach.	older people;, cost effectiveness; outcomes

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
				arrangements if necessary.	• people maintain tenancies and avoid homelessness. • SP services can prevent rapid decline in independence which would require a use of home social care services. Additionally there would be a significant deterioration in in health levels requiring the use of additional services, leading to many more people entering residential care or using domiciliary care services. This is prevented by SP improving health and quality of life, reducing dependence on informal carers, increasing participation in the community which in turn decreases social isolation and lessens fear of crime.		
Snell et al	2012	**Building a business case for**	PSSRU	For thousands of	The results suggest	Useful	cost-

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
		investing in adaptive technologies		dependent adults in England, equipment and adaptations play a vital role by allowing people to live independently in their own homes. Interventions vary from simple devices, such as grab rails, to major adaptations, such as stairlifts and bespoke bath and shower rooms. The range of benefits that can be attributed to these interventions are well documented, both in terms of their impact on quality of life and – in some cases – the significant reduction in the demand for care that can be achieved through the avoidance, or delay in the onset, of the need for health and social care services. Few studies, however, have attempted to provide an overall picture of the benefits to the	that equipment and adaptations lead to reductions in the demand for other health and social care services worth on average £579 per recipient per annum (including both state and private costs). In addition, the services lead to improvements in the quality of life of the dependent person worth £1,522 per annum. According to the conservative scenario (which incorporates more pessimistic assumptions about the outcomes achieved) reductions in the demand for health and social care equate to £261 per recipient per annum, with quality of life improvements valued at £1,379 per annum. According to the optimistic scenario, reductions in the demand for health and	evidence around cost-effectiveness of equipment and improvement in patient quality of life outcomes.	effectiveness; prevention; older people; falls; reablement; technology

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
				state and to the recipients of aids and adaptations in England. The study described in this paper reviews and uses the evidence available in the literature to generate estimates of the overall costs and benefits associated with adaptive technologies. A quantitative model was constructed to provide a range of estimates, given a central, conservative and optimistic scenario.	social care are estimated at £1,079 per recipient per year and quality of life gains at £1,723 per person per year. By comparison, in all scenarios the cost of providing the adaptations is estimated to be approximately £1,000 per individual per annum, taking into account the likely life expectancy of the equipment. Based on the central scenario, a client base of 45,000 individuals receiving interventions (at a totalcost of approximately £270 million, broadly equivalent to the total annual expenditure on Disabled Facilities Grants used to fund major adaptations), is likely to generate reductions in the demand for health and social care services worth £156 million over the estimated lifetime		

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					of the equipment, and to achieve quality of life gains of £411 million over the same period.		
Pickard	2004	**The effectiveness and cost-effectiveness of support and services to informal carers of older people**	Audit Commission	This literature review of the effectiveness and cost-effectiveness of support and services to carers of older people is one of three literature reviews that were commissioned by the Audit Commission as part of its study of support for carers of older people in England.	One of the issues that the literature review aimed to explore was whether it is more effective to support carers by supporting the older people that they care for or whether it is more effective to support carers by providing specific carer services. The evidence presented in the literature reviewed here suggests that both services aimed at the older person, such as the home help/care service, and services aimed at the carer, such as day care/institutional respite care, can be effective in improving the welfare of carers and reducing the negative psychological	Older people are the focus. Although relatively old, the findings are still relevant in the nature of support and services to informal carers.	carers; older people; cost-effectiveness; home care

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					effects of caring. The literature also suggests that both types of service can also be effective in delaying the admission of the older person to institutional care and both are consequently in the interests of older people who wish to remain in the community. It is, therefore, clear that both forms of service should be available to older people with carers. The literature also suggests that both services aimed at the older person and carer specific services are cost-effective ways of supporting older people with carers to remain the community for longer periods of time. Indeed, daycare, home care and institutional respite care were the three services that were most cost-effective in maximising older		

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					people's length of stay in the community (Davies and Fernandez 2000). The literature also suggests that daycare and institutional respite care are cost-effective in reducing carer stress and that, although the evidence in this respect for The effectiveness and cost-effectiveness of support and services to informal carers of older people home care is more equivocal, other services provided to the older person, like meals-on- wheels, are cost-effective. Taken together, the literature suggests, again, that both services aimed at the older person and carer specific services can be cost-effective. And again, this supports the conclusion that both forms of service should be availableto older people with carers.		

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
Reinhard	2008	Chapter 14. Supporting Family Caregivers in Providing Care in the Patient Safety and Quality: An Evidence-Based Handbook for Nurses	Agency for Healthcare Research and Quality	This chapter summarizes patient safety and quality evidence from both of these perspectives. The focus is on the adult caregiver who provides care and support primarily for adults with chronic illnesses and chronic health problems. The focus is not on those with developmental disabilities. In the first section, we discuss the evidence for protecting the caregiver from harm. The second section addresses research aimed at protecting the care recipient from an ill-prepared family caregiver.	Family caregivers are critical partners in the plan of care for patients with chronic illnesses. Nurses should be concerned with several issues that affect patient safety and quality of care as the reliance on family caregiving grows. Improvement can be obtained through communication and caregiver support to strengthen caregiver competency and teach caregivers new skills that will enhance patient safety. Previous interventions and studies have shown improved caregiver outcomes when nurses are involved, but more research is needed. There is more to be learned about the effect of family caregivers on patient outcomes and areas of concern for patient safety. Nurses continue to play an	Global evidence review although primarily US focussed. Useful in that some evidence is specifically addressing BME or religious patient groups.	care planning, carers; cost-effectiveness; outcomes; prevention; home care

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					important role in helping family caregivers become more confident and competent providers as they engage in the health care process.		
Forder et al	2012	**Evaluation of the personal health budget pilot programme**	PSSRU Discussion Paper 2840_2	The personal health budget initiative is a key aspect of personalisation across health services in England. Its aim is to improve patient outcomes, by placing patients at the centre of decisions about their care. Giving people greater choice and control, working alongside health service professional to develop and execute a care plan, given a known budget, is intended to encourage more responsiveness of the health and care system.	The main findings of the cost analysis were: 1. The cost of inpatient care (an 'indirect' cost) was significantly lower for the personal health budget group compared to the control group after accounting for baseline differences. 2. The ('direct') cost of wellbeing and other health services were both significantly higher for the personal health budget group compared to the controls. 3. Other categories of direct and indirect	Evidences the need for personalisation and outcomes focus together with the Individual Budgets Evaluation.	care planning; outcomes; personal budgets

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					cost showed no differences between the groups. 4. The difference in direct and indirect total costs between personal health budget and control groups after accounting for baseline differences were not statistically significant.		

Miscellaneous (e.g. information management)

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
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	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,	This study provides evidence of the cost effectiveness of a centralised database of clinical data.	cost effectiveness; diabetes; general practitioners; information management; integrated services

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
				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 developing complications, and reports on them to their GPs.	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.		
Pleace	2011	**The Costs and Benefit of Housing Support Services for Older People in Scotland**	Scottish Government	This paper reviews the evidence on the cost effectiveness of preventative support services that assist	• Handyman services: the most notable effect is in the number of falls experienced by older people. O'Leary et al	Useful findings section covering different interventions by level of need (p23)	prevention; intervention; older people; cost-effectiveness; falls; telecare; technology;

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
				older people with care and support needs to remain in their own homes. The costs of these preventative support services are contrasted with the costs of specialist housing options, such as sheltered and extra care housing and also with the costs of health services, as part of reviewing the value for money of preventative support services (henceforth PSS).	estimate that 32% of older people whose housing has been not been improved or adapted are at risk of a fall during the course of one year, which could result in hospital admission, community health service use and/or a need for social work department funded support. By contrast, the estimated annual rate of falls among those older people whose housing has been improved or adapted by care and repair/HIA services was 10% (O'Leary et al, 2010). O'Leary et al also estimate that 9% of older people whose housing had not been improved or adapted would need to make a move to sheltered housing during the course of one year. This compared to a rate of 5% of those whose housing had been improved or adapted by care and repair services. Reductions in the temporary and permanent use of residential and nursing care were estimated as being small. O'Leary et al also		cost savings

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					estimated a 10% reduction in the number of older people requiring personal care funded by social services (i.e. social work service funded care). Telecare, alarm and mobile warden services: A University of York review, commissioned by the Scottish Government in 2009, reported evidence that the National Telecare Development Programme had reduced unplanned hospital admissions and reduced the need for residential care. However, the review also reported that data collection was in need of development and that there was an "absence of a strong data collection, reporting and evaluation culture within most Partnerships" which had meant that collection of robust data had been problematic (Beale et al, 2009). This research estimated that the programme had reduced care home admissions by 518 and unplanned hospital admissions by 1,220, reducing		

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					expenditure by some £6.8 million. A survey of telecare users also found that 70% felt more independent and that 21% reported that their health had improved since they received telecare services. Another more recent piece of work reviewed the national Telecare Development Programme (TDP) for Scotland. This estimated that during the period 2006-2010 a very significant gross financial benefit of some £48 million had resulted from an investment in telecare of some £12.6 million nationally (including match funding). The collective impacts of telecare were estimated as having included, among other estimated benefits (Newhaven Research, 2010a) : 1. Avoidance of some 6,600 unplanned hospital admissions 2. Avoidance of some 2,650 residential care and nursing home admissions 3. Avoidance of some		

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					411,000 home check visits to monitor the well-being of older people and other groups. • Equipment and Adaptations: The savings, i.e. cost offsets to other services, produced by adaptations can be extensive and enduring. In 2009, the Home Adaptations Consortium estimated that 20 level access showers installed in the London Borough of Newham at a cost of some £110,000 had produced a five year saving of £1.86m (Home Adaptations Consortium, 2009).		
Henderson, Knapp et al	2011	**Unplanned admissions of older people; exploring the issues**	NHS National Institute for Health Research	This study looks at the ways in which social services, hospitals and community health services work together to finance, organise and deliver services, and particularly how this affects the use of hospital services by people aged 75 or older. Finding the best ways for these organisations to work together would	Describes the key characteristics of participating councils and PCTs, their performance on relevant indicators (such as delayed discharge, intensive home care, contract types, direct payments, supply of hospital beds and per capita expenditure). Most network arrangements were directed social partnerships – a type of enacted social	The design of the study means that we are not able to offer precise prescriptions about ways of closing this gap between strategic goals and operational practice. However, the study's findings do reinforce a number of messages surrounding the delivery of high quality care that have	older people; care planning; integrated services; commissioning; outcomes

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
				help to make sure that older people get the right services provided by the right people in the right place at the right time. Nine councils spread across England have been brought together as part of the government s Innovation Forum. They are aiming to reduce the number of days that older people spend in hospital by providing alternative services that are at least as good and which improve the lives of older people. Most people want to avoid going in to hospital or staying longer than is necessary, and many efforts are being made to develop alternative services. The councils in this study want to lower the total number of days that older people spend in hospital by 20% over a three year period. In each council the local Primary Care Trust(s) and the hospital trust(s) have agreed on this target and on ways to	partnerships differentiated by the level of involvement of government, which establishes or sponsors such networks to achieve specific policy goals. Sites were either moving or aspiring to move towards an increasingly 'joined-up' approach to commissioning.	been emphasised in previous research and policy papers. The main findings are summarised, particularly those in Section 10, to pull out some key messages, first looking at the phases of the 'journey' and then at the overarching systems issues relevant to operational managers, commissioners and planners.	

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
				achieve it. The study asks these questions: 1) What achievements have been made in lowering hospital bed use by older people? 2) How do health and social services staff together with housing providers, charities and others work together to run services that are alternatives to hospital care? 3) What changes have been made in these 9 areas so that they can have fewer emergency admissions to hospital? The research took 2 years to complete and includes activities to ensure that people working in the health and social services are aware of the findings.			
Coalition of care and support providers (CCPS)	2010	An outcomes approach in social care and support: an overview of current frameworks and tools	CCPS	The purpose of this paper is to provide an introduction to various models and tools associated with adopting an outcomes approach within social care and support	Outcome tools include: Better Futures • Talking Points • ASCOT • Outcomes Evaluation for Children and Young People Experiencing	Useful guide to outcome measures with a quick look up table.	outcomes

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
				settings. This will provide information to organisations thinking about adopting such an approach as well as provide a basis from which to invite organisations to share their experiences of using or developing outcomes frameworks and the tools associated with them.	Domestic • Abuse • REACH Standards in Supported Living • Realist Evaluation aka Real Time Evaluation • SROI • Outcomes Star • Carista/Intrelate • Leading for Outcomes, IRISS		

Workforce (e.g. multi-disciplinary teams)

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
Savage & Moore	2004	Interpreting Accountability : An ethnographic study of practice nurses, accountability and multidisciplinary team decision-making in the context of clinical governance	RCN	This ethnographic study used interviews, vignettes and participant observation to explore how accountability was understood within one team of clinicians working in a general practice, following the introduction of clinical governance. The three main areas of enquiry	1. How accountability was understood across the health care team The study found that the meaning of 'accountability' was elusive and ambiguous for participants and that this ambiguity mirrored the 'catch-all' use of the term in current government policy. It was described by some as a retrospective explanation of actions, particularly as a way of apportioning or	Ethnographic study based on one practice in southern England. The study authors state the findings are not generalisable but provide food for thought.	integrated services; joint commissioning

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
				concerned: 1. How accountability was understood across the health care team; 2. Who was involved in multidisciplinary decision making; and 3. The nature of the relationship between decision making and accountability.	accepting blame. At the same time, accountability could be seen as something that motivates action and good practice and implies a readiness to take the consequences of action. In addition, accountability was used as a way of describing certain relationships, such as those between practitioners and clients, or between employers and employees. 2. Who was involved in multidisciplinary decision-making The study found that multidisciplinary decision-making as a contemporaneous collective activity was unusual. Staff tended to make decisions about individual patients in isolation. Where such decisions involved different members of the team, they were often made in stages, involving different practitioners at different points. 3.The nature of the		

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					relationship between decision-making and accountability In certain contexts, some practitioners were seen as more accountable than others. For some participants, accountability for clinical decisions rested with those members of the staff considered to have the most expertise, whether or not they were present during decision-making. In some circumstances, and contrary to the legal position, lack of previous contact with a patient, or a poorer grasp of certain kinds of knowledge (for example, where a nurse took on a 'medical' task),were associated with a lesser degree of accountability. Data from across the study suggested that accountability could be passed principally by providing a colleague with a narrative or an account of decision-making.		
Mathieson	2011	**Integration of Health and Social Care; a snapshot of current practice**	RCN Scotland	This report was commissioned to provide evidence of nurses' practical	Despite the inevitable challenges and problems integration poses, those who work in integrated services	Although based in Scotland, the findings and general messages appear to be	integrated care; joint commissioning

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
				experiences of working in integrated teams. It focused on central issues identified as being important by the earlier literature review. These included: • team working and professional roles and boundaries • cultures • strategic (funding, management and communication systems) and operational (co-location, joint training) issues.	prefer them to what existed before. There seems to be a strong appetite for integration across all the teams, noticeably in services with a solid tradition of collaborative working and linkages across agencies – mental health, addictions, elderly care and learning disability. Perceived benefits of integration and its definition as a desirable goal were also evident in the two teams in which integration has followed an inconsistent pattern.	applicable to integrated teams.	
Dixon et al	2010	**The relationship between staff skill mix, costs and outcomes in intermediate care services**	BMC Health Services Research	The purpose of this study was to assess the relationship between skill mix, patient outcomes, length of stay and service costs in older peoples' intermediate care services in England.	Increased skill mix (raising the number of different types of staff by one) is associated with a 17% reduction in service costs. There is weak evidence that a higher ratio of support staff to qualified staff leads to greater improvements in EQ-5D scores of patients. This study provides limited evidence on the relationship between multidisciplinary skill mix and outcomes in intermediate care services.	Part of the National Evaluation of Intermediate Care based on five primary care trusts in England. The paper also looks at patient quality of life measured with the EQ 5D scores.	cost-effectiveness; intermediate care; outcomes; older people; integrated workforce

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
Shekelle et al	2009	**Costs and benefits of health information technology: an updated systematic review**	The Health Foundation	The use of health information technology (HIT) has been promoted as having tremendous promise to improve the efficiency, cost-effectiveness, quality and safety of medical care delivery. The hope is that healthcare can follow the example of many non-healthcare industries – in which implementation of computer information technology has been a critical part of increasing the accessibility of information – and automate labour-intensive and inefficient processes, and minimise human error.	An increasing number of published studies report on the adoption of HIT and barriers. These studies mostly show that adoption is lower than desired and that the key barriers are cost, perceived difficulties using the system and perceptions of adverse effects on work. Larger healthcare organisations and ones other than for-profit are more likely to adopt HIT. The most sophisticated analysis to date about factors important for implementation concludes that two important factors are to 'choose a system which allows a range of needs to be met and is tried and tested in a similar setting' and 'the overriding choice criteria should be for a system that works for clinical personnel and saves time'. The proportion of HIT articles that report information on variables vital to assess whether a published report involves 'a similar setting' is very small, and the evidence on 'saving time' and 'works for clinical personnel' (the human factors) is also tiny,	Evidence review covering five major themes with a predominantly US focus.	information management; information technology

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					leaving policy-makers and others considering implementation of an HIT in the dark about what kind of system to get and how to best go about successfully implementing it.		

Systems/Technology

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
Alcorn, R., Bardot, L., Bittlestone, S., Gostick, J., Kiddle, A., McNIsh, A., Oliver, A., Kell, M.	2011	**Transforming NHS Ambulance Services**	National Audit Office	The report describes how the use of NHS Pathways software within the North East Ambulance Service means the number of calls resolved through the 'hear and treat' method has doubled from 8,000 to 16,000 a year. This software uses a telephone clinical assessment to identify whether a caller's symptoms mean an ambulance should be dispatched.	Where an ambulance is not required, the software provides an electronic directory of services informing the call handler of appropriate treatments available locally for the patient. This reduces the cost to the service, improves the care received by the patient, and ensures that more vehicles are available for life-threatening cases. Across the ambulance service as a whole the number of calls also doubled between 2007-08 and 2009-10, but the NAO reports that use of 'hear and treat' is not consistent across the 11 ambulance services despite the software	Illustration of how technology used effectively can impact outcomes and save money.	cost effectiveness; emergency health services; information management; information technology

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					being declared clinically safe in 2008. The report estimates that increased take up of new response models could save the NHS between £100million and £280m a year.		
Brown, J., Platt, S., Taylor, P., Barber, G.	2013	**Putting Patients First**  PuttingPatientsFirst[8].pdf	Eclipse Solutions	This paper demonstrates how nhspatient.org can add value in a variety of uses including integrated care	The NHS has been slow to embrace improving telecommunications and data sharing. There are several significant consequences to this: 1. Patients are being treated by clinicians with insufficient patient data resulting in incorrect decisions, inappropriate treatments, increased morbidity, mortality and potential litigation. 2. Members of the Healthcare Team working against rather than in synergy with one another. 3. Duplication of assessments, procedures and tests with unnecessary expense and the waste of both the Patient's and the Healthcare Professional's time. 4. Delays in responding to potential medical emergencies. 5. Patients being admitted	This outlines how nhspatient.org has addressed issues in healthcare leading to more integrated care.	integrated services; cost effectiveness; information management; information technology

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					inappropriately into hospital by ambulances and out of hours GPs due to lack of information causing increased burden on secondary care and potentially dangerous for the patient. 6. The system makes it difficult for specialists to give advice remotely. Referrals are then generated with further delays and inconvenience for the patients / Carers. www.nhspatient.org has addressed the above by creating a skeleton Patient Summary Record for each patient, containing the essential information needed for healthcare professionals to make informed decisions whilst maintaining the confidentiality of the individual. This record is both available to the patient and can be accessed by the Healthcare Professional through a secure portal. The system allows complete integration of care whilst protecting the security and confidentiality of the Patient.		

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
					GP practice, Community services, Pharmacy, Hospital and Patient / Carer can interface with ease through our system with the creation of a completely functionally integrated generic team.		
Thiel, V.	2013	**IT systems – an overlooked cog in the integration machine?**	The King's Fund (blog)	A blog on the current thinking on the role of technology in integrated care.	Commissioners need to decide which system will best suit their local care-co-ordination needs. Whichever they choose, they need to make a conscious decision early on in the process – everything from patient identification and care co-ordination to future up-scaling of the model is simplified if suitable IT systems are in place.	Presents an opinion on the role of information technology in integration as well as a summary of the King's Fund report on care co-ordination for people with complex chronic conditions.	information technology; information management; integrated services
Goodwin, N., Sonola, L., Thiel, V., Kodner, D.	2013	**Coordinated care for people with complex chronic conditions**	The King's Fund	This report presents the findings from a two-year research project funded by Aetna and the Aetna Foundation, which aimed to understand the key components of effective strategies employed by studying five UK-based programmes to deliver co-ordinated care for	Certain design features appear more likely to deliver successful care co-ordination. • A holistic focus that supports patients and carers to become more functional, independent and resilient is preferable to a purely clinical focus on managing or treating symptoms. • Building community	Outlines key lessons learned from five UK examples of co-ordinated care.	integrated services; information technology; information management; joint commissioning

Author/s	Date	Title	Publisher	Study	Key Findings	Applicability	Search Categories
				people with long-term and complex needs. It elicits some key lessons and markers for success to help identify how care co-ordination might be transferred from the UK to the US context.	awareness of and trust in care co-ordination programmes promotes legitimacy and engagement. • Effective communication based on good working relationships between members of the multidisciplinary team is essential. Shared electronic health records can support the process, but a 'high-touch, low-tech' approach can also be very effective. • Care co-ordination programmes should be localised so that they address the priorities of specific communities. Leadership and commitment (from commissioners and providers alike) is vital to establish a shared vision and challenge silo-based working. • Integrated health and social care commissioning can support longer-term strategies and provide greater stability.		