Integrated care for older people or people living with frailty and waiting times/lists – a mixed methods rapid review

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EXECUTIVE SUMMARY

What is a Rapid Review?

Our rapid reviews (RR) use a variation of the systematic review approach, abbreviating or omitting some components to generate the evidence to inform stakeholders promptly whilst maintaining attention to bias.

Who is this Rapid Review for?

This Rapid Review was conducted on request from the Bevan Commission and Cardiff and Vale University Health Board. It is intended for policy makers but could also be of use for health and social care providers and third sector organisations.

Background / Aim of Rapid Review

Integrated care can be defined as the joining up of different health and/or social services to deliver care that meets individuals' needs in an efficient way. Increasing waiting times and an ageing population are well-recognised policy drivers for service integration, although there remains limited clarity about the effectiveness of integrated care interventions in improving the timeliness of health and social care delivery. To address this gap, a rapid review was conducted, incorporating both quantitative and qualitative perspectives that evaluate the impact of integrated care interventions on waiting times and waiting lists. Whilst the review includes a description of all relevant studies, the synthesis of the findings focuses on studies that included integrated care that operated across two or more services (primary, hospital, community or social care).

Results of the Rapid Review

Recency of the evidence base

- The review included evidence available up until January 2025. The included studies were published between 2015 and 2024.

Extent of the evidence base

- Sixty-one studies were identified out of which 30 reported integrated care interventions operating across two or more services (23 reported quantitative data and 7 qualitative data).
- Quantitative study designs included: uncontrolled before and after studies (n=12), cohort studies (n=6), controlled before and after studies (n=2), randomised controlled trials (n=2) and non-randomised controlled trials (n=1). Qualitative data was gathered from qualitative descriptive studies (n=4), mixed-methods studies (n=2), and a descriptive survey with open ended questions (n=1).
- Studies were conducted in European countries (n=12, including 2 from the UK), USA (n=8), Canada (n=4), Australia (n=3), Japan (n=1), and across multiple countries (n=2).
- Study population included older people (over the age of 65) with hip or other fractures (n=15), non-surgical traumatic injuries (n=2), various emergency (n=3) or urgent care needs (n=2), mental health conditions (n=2), dementia (n=2), complex chronic geriatric diseases (n=1), ageing associated diseases and aged care needs (n=2), or palliative care needs (n=1).
- The interventions involved integration across two (n=16), three (n=9) or four (n=5) different services, with most covering both health and social care (n=25), although the mechanism of integration varied. All interventions were multifaceted with the most consistently reported

elements being multidisciplinary team (MDT) working, development of pathways and protocols, and care coordination.

- Waiting times and waiting lists were categorised as inpatient, emergency, and routine care. Inpatient waiting times, such as time to surgery, were the most commonly reported (n=18).

Key findings and certainty of the evidence

- Weak quantitative evidence from multiple studies suggests that **integrated care interventions** including MDT, pathways/protocols and/ or care coordination as their main element **may help reduce** the following **waiting times**: time to admission and time to surgery for hip or other fractures; time to first goals-of-care assessment for non-surgical traumatic injuries; time until geriatric care review for older people presenting at the emergency department (ED); primary care wait time for older people with urgent needs; time to treatment initiation and time to appointment for older people with mental health conditions; and time to investigation of older people's palliative care needs and desires (GP self-report). The evidence was rated weak, due to weak study designs, low study quality, and inconsistencies in the findings.
- Strong quantitative evidence from two studies shows that a **multidisciplinary assessment** for older people presenting at ED for various reasons, is effective in **reducing time spent in the ED**.
- Qualitative studies mainly investigated waiting times from healthcare professionals' perspectives. The findings suggest that integrated care interventions could support early assessment and diagnosis of dementia and complex chronic geriatric conditions; enable more timely symptom management and care planning in nursing homes; reduce processing time of aged care referrals in primary and community care; help streamline inpatient care for ageing associated diseases; and reduce delays for hip fracture care.
- One qualitative study explored older people's and their relatives' experiences regarding an integrated ED avoidance service. The findings suggest that the ED avoidance service for older adults with urgent but non-emergency needs may help reduce emergency waiting times.

Research Implications and Evidence Gaps

- There is a need for high quality studies investigating the effect of integrated care on waiting times, particularly on routine care and elective waiting times.
- The majority of the identified studies focused on MDTs, integrated pathways/protocols and/or care coordination and their impact on waiting times. There seems to be less focus on organisational integration, such as coordination of governance across providers or joint commissioning. More research with rigorous study designs is necessary to evaluate the effectiveness of organisational integration on waiting times.
- There is a need for high quality qualitative research that explores people's experiences with waiting times in relation to integrated care, particularly from older and frail people's perspectives.

Policy and Practice Implications

- There is some evidence that MDTs, integrated care pathways, and care coordination may improve inpatient waiting times to surgery, and emergency waiting times in an ED. Thus, initiatives supporting the development and implementation of these integrated care interventions is crucial.

Economic considerations

- Hospital costs increase with length of inpatient waiting time, suggesting initiatives reducing time spent waiting may bring positive economic benefit to the NHS.
- An estimated £73 billion in total benefits may be generated between 2023 and 2027 if the NHS meets its waiting list reduction targets.

The certainty of evidence from quantitative studies has been assessed using the Critical Appraisal Tool (CAT) based on the guidance by Public Health Agency of Canada (2014).