



Early evaluation of the Integrated Care and Support Pioneers Programme

Interim Report

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Preface

This interim report is intended to provide a description of (roughly) the first twelve months of Pioneer development, drawing out some of the similarities and differences between the sites, the barriers they are encountering in their ambitious attempts to integrate health and social care services, and the approaches they are taking to overcome these barriers. This progress report of the development of the Pioneers during their first year presents interim findings which may be subject to change by the time the final report of the early evaluation is independently peer reviewed and prepared for publication in summer 2015.

It is very early to expect Pioneer status to be associated with delivering many substantial changes that were not already in train before the start of the programme. However, the details included in this report may be considered a description of their status in autumn 2014 and some of the key factors affecting the development of 'whole system integration'. The data should also prove useful for evaluators, sites and national partners in understanding the Pioneers' journey ahead of the final report of this early stage evaluation in summer 2015.

This report has eight sections and a Summary. Sections 1 and 2 provide: brief background information and context on integrated care and on evaluations of earlier initiatives; a framework and logic map for understanding and analysing integrated care; and short summaries of each of the 14 first wave Pioneers. Section 3 then sets out the objectives and methods used for this early evaluation. Sections 4 to 7 present the findings from this initial stage of the evaluation. Finally, section 8 provides some concluding remarks.

The information contained in this report is based on an analysis of interviews conducted between April and November 2014, as well as an examination of Pioneer documents, including their Better Care Fund (BCF) plans where available.

The research team would like to thank the members of staff in all the Pioneer sites who kindly agreed to give up their time to be interviewed in this initial stage of the evaluation.

The research team also thanks members of its PPI (patient and public involvement) Steering Group, who provided many helpful comments on this interim report, as well as on the earlier working paper written in summer 2014, and on the topic guide, leaflets and templates used during data collection for this early evaluation.

We also would like to thank the three independent peer reviewers for their many insightful comments which will be particularly helpful in shaping the final report of the early evaluation.

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Summary

1. The Pioneer programme

- 1.1 The Integrated Care and Support Pioneer programme is a nationally led initiative to improve the quality, effectiveness and cost-effectiveness of care for people whose needs are met best when the different parts of the (NHS) and local authority services (especially adult social care) work in an integrated way.
- 1.2 It is distinctive in adopting a definition of integrated care that is user-centred and endorsed by national agencies forming the Integrated Care and Support Collaborative: *"My care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes"* (National Voices 2013).
- 1.3 In spring 2013, the Collaborative called for expressions of interest from the 'most ambitious and visionary' local areas to become Pioneers to drive change 'at scale and pace, from which the rest of the country can benefit' (Department of Health May 2013).
- 1.4 Fourteen Pioneers were announced in November 2013 and are the focus of this early evaluation commissioned by the Department of Health. A second wave of 11 Pioneers was announced in January 2015.
- 1.5 Over a period of at least five years, the Pioneers are being given access to expertise and support from the national partners and international experts. Only minimal additional direct funding was provided initially (£20,000), with an additional £90,000 made available to each Pioneer in June 2014.

2. The Better Care Fund

- 2.1 The Pioneers are operating alongside other national initiatives designed to 're-balance' the health and care system and promote greater integration of care within highly constrained budgets.
- 2.2 Probably the most salient is the Better Care Fund (BCF), a universal mechanism for creating pooled budgets to protect adult social services and reduce demand for acute beds. It consists of a formula-based allocation of £3.8bn to fund locally agreed integration plans for 2014/15 and 2015/16. The funding is held under joint governance by NHS Clinical Commissioning Groups (CCGs) and local authorities through Health and Wellbeing Boards (HWBs).

3. Early evaluation

- 3.1 The early evaluation runs from January 2014 through June 2015. It aims to describe the vision, scope, objectives, plans, interventions, underlying logic and implementation of the first wave Pioneers.
- 3.2 The study is largely qualitative, with the principal data for this report being drawn from 140 interviews undertaken between April and November 2014.

4. Characterising the Pioneers

- 4.1 The Pioneers are heterogeneous, varying widely in, for example, their history of integrated care, population size, organisational complexity, ambition and user group focus. Many see the Pioneer initiative as a way of building on their past experience and maintaining progress towards more integrated care systems.

- 4.2 Pioneer governance arrangements primarily involve project boards reporting to HWBs or separately to CCGs and local authorities. Board members are typically senior managers from the CCG, local authority, local NHS providers and occasionally the third sector.
- 4.3 Project boards are usually supported by a small programme management team, which oversees progress, and by specific working parties. Costs of the programme management team are often shared between partners and may cover jointly funded appointments.
- 4.4 Interviewees generally communicated a strong sense of vision for their Pioneer, particularly emphasising the centrality of the patient/user perspective. However, the vision was still to be fully translated into concrete actions, particularly where these involved significant changes on the part of provider organisations. Providers were less likely to understand, be part of, or support the plans of the Pioneers than other participants.

5. Integration and service models

- 5.1 Most Pioneers were involved in both vertical and horizontal integration activities, covering primary and secondary health care, along with social care and other local services.
- 5.2 ‘Whole system integration/transformation’ of the entire health and social care economy was a common refrain, though few Pioneers were yet involving services such as housing, education or the police.
- 5.3 All Pioneers talked about shaping the system around the person or empowering people to direct their own care and support. Co-design of services and care pathways were frequently mentioned, and improved patient/user experience was universally anticipated as one of the primary outcomes.
- 5.4 Pioneers were strongly aware of the urgent system-wide need to design innovative and more cost-effective interventions, and planned to do so principally by
 - a) providing more care in the community, thereby directly reducing the demand for hospital services; and
 - b) promoting greater self-care and other preventive strategies to keep people healthier and more independent in the first place.
- 5.5 However, considerable uncertainties were expressed about the feasibility of these approaches, especially given continuing cuts in adult social care. Even so, some Pioneer staff were concerned about possible consequences for financial stability in acute hospitals if use of such services was reduced.

6. Pioneer initiatives

- 6.1 Pioneers were typically pursuing a range of inter-related initiatives, often starting with sub-populations and intending to scale up to the wider population.
- 6.2 Typically, the Pioneers described their main focus as people with multiple long-term conditions, frail older people, high service users, or people at high risk of hospital admission. A few were prioritising mental health problems or families and children. Staffordshire and Stoke is unique in focusing on cancer.
- 6.3 Many apparently similar initiatives appeared in Pioneer plans (see Table 2), though terms like ‘multi-disciplinary team’ or ‘rapid response’ can conceal different ways of working.

- 6.4 Programmes tended to combine different combinations of: risk stratification; care planning; case management; improved access (e.g. 7-day services, single point of access); increased support for self-care/self-management of conditions; telehealth and telecare; hospital discharge planning; GP networks providing a wider range of services; multi-disciplinary teams (MDTs); rapid response services to reduce avoidable admissions; personal health (and social) care budgets; joint commissioning; developing community assets and community resilience and an increased use of volunteers; and more support to carers.
- 6.5 A range of commissioning and payment innovations was being considered to implement these initiatives, such as needs-weighted capitated budgets for groups of providers, alliance contracting, whole care pathway funding, and payment for outcomes or quality standards. Pooled budgets were less frequently mentioned except in relation to the BCF or as a long term goal. Most reimbursement innovations were at an early stage.

7. Information sharing

- 7.1 All Pioneers recognised information sharing across agencies and services as an essential building block for integrated care. The current situation in this regard was framed as a barrier to progress. Information governance restrictions and technical problems (e.g. incompatible IT systems) were identified as making information sharing difficult or impossible.
- 7.2 All the Pioneers were working to improve information sharing and attempting to devise their own solutions to information governance restrictions, including shared agreements between organisations, acquiring the status of a data 'safe haven', or sub-contracting to accredited providers.

8. Workforce development

- 8.1 The workforce implications of integrated care were widely acknowledged, and many Pioneers were looking specifically at its training implications.
- 8.2 A few highlighted changes in team structures and working patterns, and the need for new job descriptions to pursue integrated care. There were examples where jointly funded (CCG/local authority) posts were in place and where integrated care 'navigators'/case managers were working. Other innovative roles that were already operational included:
 - a) interface geriatricians (working in acute and community settings);
 - b) rotation nurses (rotating between acute and community settings);
 - c) support workers in intermediate care (trained in nursing, physiotherapy, occupational therapy and social work);
 - d) discharge co-ordinators (based in acute hospitals);
 - e) baton phone (each day a nominated specialist carries a baton phone to provide specialist advice to community care when needed).
- 8.3 Pioneers noted their inability to modify training curricula to meet the demands of integrated working, as these were typically set at national level by professional accreditation bodies.

9. Progress towards implementation of plans

- 9.1 Pioneers shared two broad concepts of successful implementation: the improvement of outcomes, particularly in terms of patient/user experience; and the shift towards a model of care much less centred on the hospital.
- 9.2 Although Pioneers accepted that the purpose of the programme was to move at 'scale and pace', they also stressed that it might take five years or longer to produce demonstrable impacts, particularly in relation to complex interventions aimed at prevention. The Health and Social Care Act 2012 had brought about major upheaval at local level that was only just beginning to subside.
- 9.3 Pioneers were aware that many challenges still needed to be tackled. Relationships were being built and governance arrangements had been agreed but implementing new services and the timescales required posed more difficult challenges. Cultural change in the workforce was a similarly long-term task.
- 9.4 Some challenges were outside the control of local managers and assistance from central government agencies was likely to become increasingly necessary in future.
- 9.5 Operationally, Pioneers were often moving on several fronts at once through the:
 - a) continuation of pre-existing integrated care initiatives;
 - b) the 'roll out' or expansion of pre-existing initiatives into a new service area, population group, or over a larger geographical area;
 - c) the planning and implementation of new initiatives proposed in the Pioneer bid and begun since the Pioneer programme had started.

10. Impact of the Better Care Fund on Pioneers

- 10.1 Overall, local authorities thought the BCF process had strengthened their engagement in joint commissioning, while CCGs expressed diverse views about the extent to which the BCF was capable of supporting alternatives to in-patient services. NHS providers more often felt insufficiently included in BCF planning and generally expressed more concerns about the feasibility of delivering the planned activities.
- 10.2 Localities which faced the most challenging financial problems also expressed more concerns about the risks of not being able to deliver the BCF.
- 10.3 Analysis of the BCF plans shows considerable alignment with Pioneer activities, though a minority of Pioneers suggested that the BCF had been a distraction from wider service re-design and Pioneer objectives.
- 10.4 The underlying premise of the BCF – transferring funding from hospital to community and adult social care – was deemed appropriate, but still a significant gamble. Higher performing systems might have fewer avoidable admissions to trim back and reducing their hospital utilisation might not prove cost-effective.
- 10.5 The overall financial climate, and absence of transition funding to meet the running costs of hospital services while community alternatives were being developed, were substantial obstacles to BCF implementation.

11. Barriers to integration

The identification of barriers formed a large part of many interviewees' accounts.

11.1 National barriers

- a) National issues outside Pioneer control

- These included the perceived role of the Trust Development Authority (TDA) in promoting greater activity in NHS acute trusts, whereas the Pioneers were generally aiming to reduce such activity.
- Frequently mentioned were choice and competition policies that appeared to promote service fragmentation rather than integration. How far such perceptions are correct is perhaps less important than the extent to which they may lead to cautious approaches to integrated care for fear of falling foul of competition requirements.

b) National Leadership

- Some interviewees complained that Pioneers lacked sufficient freedom to experiment and innovate, although others thought there was a lack of clear national direction.
- Most Pioneers suggested there was insufficient support from the centre to tackle some of the systemic barriers to integrated care (e.g. information governance and competition rules), and that the most difficult challenges, such as persuading the public of the need to reconfigure hospitals, were not being tackled by the centre.

c) Financial Issues

- The local government situation was one of major spending reductions in cash terms and, while that for the NHS was significantly less severe, it still represented the longest period of roughly level spending (after inflation) known in NHS history.
- The financial environment was seen as potentially undermining longer-term strategies to re-balance service systems by diverting energy and resources to 'fire fight' more immediate pressures.
- Some interviewees interpreted the evolving nature of BCF criteria in that light, while also welcoming its contribution to meeting more immediate pressure points at the interface between hospital and non-hospital services.

11.2 *Organisational, professional and cultural barriers*

a) Organisational structures

- These could lead to tensions, e.g. whether acute trusts or GP practice federations would or should take the lead in integrating care services, whether different commissioners would be willing to give up control over part of their budgets to pool resources, etc.
- The structure (and workload) of primary care created challenges for integrating services and was perceived to be most problematic in areas with many single-handed GP practices.
- Structural issues also included the various types of competing demands facing different organisations, such as the need for NHS acute trusts to prioritise 4-hour A&E waiting times, which meant that integrated care was not always treated with the same degree of urgency by all stakeholders.

b) Professional boundaries and cultural differences

- The most common theme was the difference between health care and social care in terms of language, conceptions of health and ways of working.
- This was reflected at the management level, with very different systems of accountability between local authority social services and NHS organisations.
- There were difficulties in breaking down professional roles, and encouraging staff from different organisations and professions to trust one another. Even within organisations, there were difficulties motivating staff to become engaged with integration activities for any number of reasons, not least of which was the considerable time that it could take to see positive results from integrated care initiatives.

11.3 *Local barriers*

- a) In some cases, these were local manifestations of more general national and cultural issues such as financial austerity.
- b) The size and complexity of their local health and social care economies created their own challenges for the larger Pioneers, with different boundaries for local authorities and CCGs, acute trusts serving different populations, and multi-level governance systems.
- c) Dealing with such complexities places even higher demands on leadership and governance.

While the list of barriers is long, interviewees viewed them not as insuperable, but rather as challenges in need of resolution, which they were in the process of tackling in this early stage of Pioneer activity.

12. Facilitators of integration

12.1 *National context*

- a) Most important to participants was the advantage of being part of the Pioneer programme, which provided an impetus for local professionals to work together to improve care locally.
- b) Being part of a wider group of sites brought the added benefit of access to a range of people in other parts of the country facing similar challenges with whom staff could discuss and share what they were learning.
- c) The BCF was also seen by most Pioneers as positive for integration for bringing commissioners and providers more closely together.

12.2 *Professional and cultural enablers*

- a) Every Pioneer emphasised the importance of building and maintaining good working relationships across organisations and professions at all levels built on trust, so that people could speak frankly, come to understand each other's perspectives, and develop a shared vision and understanding of what the Pioneer was aiming to achieve.
- b) Creating multi-disciplinary teams was a specific key enabler in this respect, although there were different approaches, some involving a single management structure with all staff on a single site, others less formal.

c) Keeping a focus on the patient/service user's perspective at all times was seen as an important way of reducing the perceived importance of professional demarcations and sensitivities in the interests of more integrated working.

12.3 *Other local factors*

a) Most of the facilitating factors mentioned by interviewees were local factors which Pioneers could influence and control to varying degrees, such as having developed some form of integrated information system between organisations to enable sharing of patient/user records or having suitable facilities for cross-agency and/or multi-disciplinary teams.

b) Another important local contextual factor was the relative complexity of the organisational landscape. The most favourable situation was where CCG and local authority boundaries overlapped, and the area was served by a single NHS acute trust.

c) Another local factor mentioned as important in some Pioneers was a history of successful integrated care initiatives.

d) Good leadership was also identified as critical at all levels from local authority councillors through to senior managers, supported by appropriate governance structures.

e) Sufficient resources both in terms of uncommitted funding (e.g. to 'pump prime' innovation) and, probably more importantly given the current financial climate, experienced staff to manage integrated care initiatives.

f) Perhaps the most important factor was involving staff in developing integration initiatives and encouraging their 'ownership' of the new service models; i.e. a 'bottom up' approach was considered preferable to imposing changes from the top. Winning over the public and service users followed a similar approach, while ensuring they were fully informed at all stages, and that user representatives were involved in the design of the services.

13. Conclusions

13.1 After just under one year, in late autumn 2014, most of the 14 first wave Pioneers were still at a formative stage, or in very early stages of implementation. It is too soon to reach definitive conclusions about whether they might provide role models for other parts of the country to learn from. Their early focus on user experience and a shared definition of good integrated care has been helpful in developing a vision for each Pioneer. However, this appears to have been much less useful in supporting the implementation of plans for specific changes to services and professional behaviour. There is considerable diversity in progress between the 14 Pioneer sites. While many Pioneers have largely agreed locally how services should be re-designed, for the majority of sites, much remains to be done to put this in place.

13.2 One of the ostensible advantages of becoming a Pioneer was not only sharing learning with other sites, but also obtaining access to key decision-makers, and receiving advice and support from national and international experts. Access to external advice and support has continued to be perceived as patchy (at best) by many sites.

13.3 A number of barriers to greater integration are being gradually resolved at local level, but a number require changes led from the centre that Pioneers cannot initiate, in particular, in relation to workforce and information governance. Some participants in the Pioneers were critical of the extent to which national partners had thus far helped

them address the obstacles that related to national policies and systems, such as, for example, data sharing, payment systems, procurement, provider viability and the foundation trust 'pipeline'. The facilitators of integrated working tended to be related to factors such as leadership, vision, trust and shared values that are largely developed locally, while the barriers were more likely to be features of formal organisational structures and systems only amenable to resolution by national actors.

- 13.4 From the perspective of participants, the environment for whole systems transformation was not becoming easier. There was little evidence that the balance between facilitators and barriers had shifted in favour of the former. If anything, the balance appeared to be shifting in the contrary direction, particularly as the financial situation was deteriorating. This was resulting in an 'integration paradox'. The context of growing need and declining budgets provided an even stronger imperative for more effective integration. However, at the same time, this context made it more difficult to make progress. On the upside, the shared definition of integrated care as person-centred, coordinated care was helping to frame collective understandings of both the starting point and goal of Pioneer activity in difficult times. However, the priorities associated with the BCF and other policies driven by the financial difficulties of the system provided a competing set of pressures. There were signs of a narrowing of purpose and a greater focus on short-term, financially driven goals, most notably to contain costs through action at the hospital-community interface.

14. Next steps

The next phase of the evaluation and the final report in summer 2015 will: continue to identify and describe how the first wave Pioneers' plans are developing and being implemented; examine how the Pioneers are tackling barriers to integrated care and the extent to which they have been able to overcome them; continue developing a logic map for both the Pioneer programme as a whole and individual Pioneers with a view to developing a typology of Pioneer activities; and examine the implications of the findings for policy and for the longer-term evaluation.

1 Introduction

Background

“My care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes.” (National Voices 2013)

This statement of integrated care from the perspective of service users was published by National Voices in 2013 in response to a commission from NHS England on behalf of the Integrated Care and Support Collaborative. Together with its accompanying narrative on person-centred, coordinated care, it was subsequently endorsed by Ministers in the foreword to the Collaborative’s report *‘Integrated Care and Support: Our Shared Commitment’* (2013). As the document explained, the adoption of this definition meant that ‘for the first time...we have an agreed understanding of what good integrated care and support looks and feels like for individuals’. As such, it provided a description of what was involved in the Collaborative’s ‘shared vision.....for integrated care and support to become the norm in the next five years’ (National Collaboration for Integrated Care and Support 2013).

The need to develop such a definition and shared vision highlights perceived inadequacies of ‘integration’ between the various elements of the health and social care system throughout England. Not only are responsibilities for commissioning (and providing) health and social care services carried out by different systems – health care by the National Health Service (NHS) and social care by local authorities – even within the NHS, there is generally a lack of integration between primary, secondary and community health services, as well as between mental and physical health. The difficulties in integrating services provided by different organisations are compounded by a number of factors, including (Knight 2014; Kings Fund 2014):

- separate funding streams for health (a ring fenced budget financed through general taxation) and social care (local authorities’ budgets, largely funded through a non-ring fenced government grant);
- the NHS being free at the point of delivery and based solely on need, while social care services are tested for needs and means, with extensive charges for service users;
- different payment systems (with hospitals generally being paid for activity and social services through block contracts);
- the services commissioned separately which leads to problems of co-ordination;
- different professional and managerial cultures, and ways of working.

The lack of connectedness between services is a common grievance among many patients/service users who often:

- complain of having to repeat information over and over again to different providers;
- experience long gaps between services often without being given relevant information about next steps;
- suffer delayed transfers of care from hospital due to delays in finding places in care homes or putting together packages of home support;

- do not feel sufficiently involved in decisions about their care.

Poor integration between health and social care is judged to result in services that are inefficient and offer poor value for money as well as producing poorer patient outcomes and experiences (Goodwin et al 2012, Audit Commission 2011, Audit Commission 2009, Alltimes and Varnam 2012). There have been a series of initiatives over the last 50 years which have attempted to bring health and social care services more closely together, though with limited success (Wistow 2012, RAND Europe 2012, Bardsley et al 2013, Knight 2014). Within England, greater integrated care is now one of the priorities of the health and social care systems, largely driven by demographic pressures, the increasing number of people with one or more long term conditions and by financial austerity, which requires significant savings from both NHS and local authority budgets. This drive to integrate health and social care is not only found within England, but in many other developed countries (Busse 2014, Cash-Gibson 2014). The Institute for Healthcare Improvement has identified the ‘Triple Aim’ challenge of improving patient experiences and patient outcomes while also delivering more cost-effective services (2013). Better integrated care is central to this aim (Institute for Health Care Improvement 2014).

There are many perceived benefits of integrating or coordinating care between services, including:

- early access to preventive services and improved self-care;
- moving care from hospital to community settings in order to lower costs or reduce resources;
- earlier intervention with reduced demand for emergency care and hospital beds;
- shorter lengths of hospital stay and reduced readmissions;
- improved patient outcomes;
- improved patient experience;
- more efficient use of resources, reduced cost and greater value for money.

Over the past two decades, initiatives promoting integrated care in England and elsewhere have involved developments such as:

- the use of pooled budgets between health and social care organisations;
- case management and the use of multi-disciplinary teams;
- joint commissioning of services; and
- the creation of integrated care organisations.

However, there is little evidence that such initiatives have had significant impacts on, for example, levels of emergency hospital admissions, or cost savings (Nolte and McKee 2008, Goodwin 2013, Mason et al 2015).

Several of these integrated care initiatives have been independently evaluated including the Integrated Care Pilots (RAND Europe 2012, Roland et al 2012), the Partnership for Older People Projects (POPPs) (Windle et al 2009, Steventon et al 2011) and the Inner North West London Integrated Care Pilot (Nuffield Trust 2013). A number of key issues to consider and lessons have been learnt on how to deliver successful integrated health and social care from these initiatives, including (Nolte and McKee 2008, Wistow 2011, Kings Fund 2013; Knight 2014; Kings Fund 2014):

- don't start with an organisational model or approach, but with a clinical/service model relevant to patients/users;
- a person-centred approach is likely to have the largest effect on patient outcomes;
- risk stratification is essential to target resources on those most in need (e.g. in order to develop an appropriate care plan, case management and control costs);
- integrating care takes time, barriers need to be overcome, staff need to be engaged, etc ('there is no quick fix');
- sharing patient/service user information across systems and organisations is essential, so greater use of information technology is an enabler of greater integration;
- resources are not evenly matched between the health and social care sectors, which leads to inefficiency, so consideration needs to be given to reallocation or sharing of funds;
- additional funding/investment (e.g. in staff training) is usually needed to support new ways of working;
- incentives between health and care systems need to be better aligned (e.g. by pooling budgets in order to share risks, paying by genuine "results", or using capitated budgets instead of paying for activity);
- there need to be multidisciplinary teams, care planning, co-ordination, contact with a case manager, and a single point of access to provide continuity;
- staff (especially clinician) engagement and improved relationships across professions are important for implementing change and delivering high quality care (e.g. working in multi-disciplinary teams);
- there should be support for self-management of conditions and patient education/information (e.g. single point of access);
- simple interventions (e.g. case management) are unlikely to be sufficient on their own, and more comprehensive system-wide redesigns may be needed to achieve desired changes;
- a strong primary care orientation with specialist services in support generally leads to better results in managing chronic conditions;
- joint commissioning is needed to support long-term strategies and provide stability;
- links need to be made with secondary care throughout the system, to reduce admissions, improve discharge transitions, etc;
- health and social care have very different cultures, and overcoming their differences requires investment and training;
- visionary and stable leadership, and alignment from the centre, is needed as currently too much reliance is placed on local leaders to try to make change happen;
- integrated care should be seen primarily as a means of quality improvement rather than cost reduction, as cost savings tend to be limited (or at least have been so far in England);
- integrated care works best at local neighbourhood level so it is important to engage with the local community whose members should be seen as integral to care-coordination;
- integrated care should not impose 'top-down' models of care, but should be a 'bottom-up' process working within the local context, developing local relationships, etc;

- interventions that work in one context may not simply be transplanted to new settings, so there can be no prescribed methods for integrating services across all areas of the country;
- patient and public involvement is required to help develop the vision of integrated care as well as at all subsequent stages.

However, it has typically been the case that the integrated care ‘pilot’ and/or the evaluation did not cover a sufficient period of time to draw firm conclusions, particularly relating to impacts on resource use, costs and users’ quality of life. Researchers involved in some of the evaluations (Bardsley et al 2013) point out in relation to trying to evaluate service integration that:

- developing an intervention and an evaluation both take time, and impact is unlikely to be achieved after only one year or so of operation;
- integrated care initiatives and related interventions, their aims, the processes which will lead to the desired impacts (i.e. their model of change) and their measures of success are often not clearly defined making evaluation difficult to accomplish definitively;
- reduced cost is not the only important outcome;
- evaluations should be concerned about process as well as impacts (i.e. should contain both qualitative as well as quantitative elements);
- context is important, which affects the generalisability of the findings unless this is taken carefully into account when designing studies;
- the evaluation may need to change over time, starting with a ‘light-touch’ evaluation at the early stages, and then becoming more comprehensive as the range of integrated care interventions develops over time;
- the evaluation should be designed at the same time as the integrated care initiative or pilot so that the scheme is suitable for rigorous evaluation.

Integrated Care Pioneers

In spring 2013, a collaborative of national partners¹ called for expressions of interest from the ‘most ambitious and visionary’ local areas to become integrated care Pioneers to drive change ‘at scale and pace, from which the rest of the country can benefit’ (Department of Health May 2013). Over a period of five years, the Pioneers would be given access to expertise, support and constructive challenge from a range of national and international experts to help them in this task (Department of Health 2013). Each Pioneer would be expected to “articulate a clear vision of its own innovative approaches to integrated care and support, including how it will (i) utilise the Narrative developed by National Voices and Think Local Act Personal’s Making it Real, (ii) deliver better outcomes and experiences for individuals in its locality, and (iii) realise any anticipated financial efficiencies and present fully developed plans for whole system integration, encompassing health, social care and public health, other public services and the community and voluntary sector, as appropriate” (Department of Health 2013).

¹Association of Directors of Adult Social Care, Association of Directors of Children’s Services, Care Quality Commission, Department of Health, Health Education England, Local Government Association, Monitor, NHS England, NHS Improving Quality, National Institute for Health and Care Excellence, Public Health England, Social Care Institute for Excellence, Think Local Act Personal.

Details of the successful applicants were made known in November 2013, when the Minister of State for Care and Support announced that 14 Pioneers had been selected by an expert panel using the following criteria (Department of Health November 2013):

- clear vision of own innovative approaches to integrated care and support;
- whole system integration;
- commitment to integrating care and support across the breadth of relevant stakeholders and interested parties within the local area;
- demonstrated capability and expertise to successfully deliver a public sector transformation project at scale and pace;
- commitment to sharing lessons on integrated care and support across the system;
- vision and approach based on a robust understanding of the evidence.

A further initiative to promote integration was announced in the June 2013 spending review in the form of an 'Integration Transformation Fund' as a mechanism for creating pooled budgets in each upper tier local authority area in England. Subsequently to be re-named the Better Care Fund (BCF), the initial intention was to make a formula-based allocation of £3.8bn to localities as a pooled budget to fund agreed integration plans for 2014/15 and 2015/16. However, £1bn of the fund would be held back and be payable on the basis of local performance against a number of performance indicators covering, for example, delayed transfers of care, avoidable emergency admissions, effectiveness of 'reablement', admissions of older people to residential and nursing care, and patient and service user experience. The funding would be held in a local pooled budget under joint governance between CCGs and local authorities through local Health and Wellbeing Boards (HWBs). In 2014/15, £200m was transferred from the NHS to social care in addition to the £900m transfer previously planned in order to enable localities to prepare for the full application of the BCF in 2015/16 (LGA 2014).

The performance requirements were subsequently withdrawn because of concerns that their application would penalise local populations who were, by definition, already experiencing inadequately performing services. However, an element of performance reward was reintroduced in July 2014 when the arrangements for allocation and payment were further modified to enable risk sharing with hospitals and other NHS services. Around £1bn is to be reserved for non-acute services in the NHS, of which some £400m will be held back as performance-related payments which will depend on local areas' ability to reduce accident and emergency admissions to target levels. If BCF plans do not reduce such admissions, the money held back will be used to pay hospitals for the costs of continuing admissions.

In the summer of 2014, the government also introduced a Proactive Care Programme, requiring GPs to provide a package of proactive care and support to the 2% highest risk patients (of emergency admissions) within their practice (Department of Health 2014). NHS England also recently announced its desire to pilot integrated health and social care personal budgets in 2015/16 (Health Service Journal 2014, July). Both these schemes intersect with several of the initiatives being undertaken or planned by the Pioneers, and are therefore likely to make it more difficult to evaluate the distinct contribution of the

Pioneers. On 27 January 2015, the Minister of State for Care and Support announced a second wave of eleven Pioneers to start in April 2015 (Department of Health 2015).

In a potentially related development, the Secretary of State told Parliament on 2 December 2014 that £200m of the additional £2bn for the NHS in 2015/16 would be to support the new care models advocated in the *Five Year Forward View* of October 2014 (NHS England and others 2014). This work would encourage co-commissioning between CCGs, local authorities and NHS England, bringing together public health and social care as well as NHS agencies. Although its relationship to the Pioneer and BCF programmes is not currently clear, he indicated it would 'support the new [clinical commissioning groups] to take responsibility with partners for the entire health and care needs of their local populations' (Health Service Journal 2014, December). NHS England has now called for local proposals to become 'vanguard' areas to prototype some of those models.

Understanding and analysing integrated care

As noted in Section 1, one of the initiatives undertaken by the Department of Health and its partners in the Integrated Care and Support Collaborative was the development and endorsement of the first national definition of integration. The Collaborative emphasised that the definition adopted – person centred and coordinated care – was rooted in the perspectives and experiences of individuals receiving care and support rather than those of the organisations funding and providing it. Its approach, therefore, was to co-produce 'a narrative...that an individual person would recognise as integrated care and support' (National Collaboration for Integrated Care and Support 2013). A second purpose in producing the definition was to meet the perceived need for 'a common language and shared understanding' (National Collaboration for Integrated Care and Support 2013) of integrated care in a context where a previous review had identified as many as 175 different usages of this and related terms (Shaw et al 2011). The NHS Future Forum (Alltimes and Varnam 2012) had highlighted the tendency for 'integration' to be used by different people in different settings to mean different things. Such circumstances are incompatible with policy implementation based on a common purpose and a shared focus. So the commissioning of an overarching definition and its acceptance by the leading stakeholders in the national policy community could be seen as a substantial contribution to a more structured context for local implementation.

At the same time, however, the concept of integrated care contains a more complex mix of perspectives and dimensions, which relate to the ends and means of integrated care as well as the organisational and individual interests potentially served by it. A definition offering more 'personalisation' of care, individual autonomy and joined up service delivery might be useful in focussing policy and implementation more tightly on the individual beneficiaries of integrated care and support. However, the literature suggests that integrated care is more multi-levelled and multi-faceted (Nolte and McKee 2008, Wistow 2011, Valentijn *et al* 2013, Goodwin et al 2013). Such aspects of integrated care need to be captured if different approaches and models are to be analysed and compared. Goodwin et al (2013) draw on the work of Nolte and McKee (2008) and Valentijn et al (2013) to create a framework for comparing seven cross-national models of integrated care. From the outset, they highlight different features of integrated care: *types* (e.g. organisational, professional); *breadth* (e.g. vertical, horizontal); *degree* (i.e. from linkage to full integration); and *processes* of integrated

care (i.e. cultural and social as well as structural and systemic). From the second source, they focus on different levels at which integrated care may take place, including the macro (system), meso (organisational, professional) and micro (service and personal) levels (Goodwin et al 2013). In addition, they note that reviews of integrated care for older people 'commonly conclude that there is no 'single model' that can be applied universally' (Goodwin et al 2013). Indeed, given the wide range of local and national contexts in which integrated care must be designed and operated, any suggestion that there could be a universal model or approach should rapidly be seen as the chimera it is.

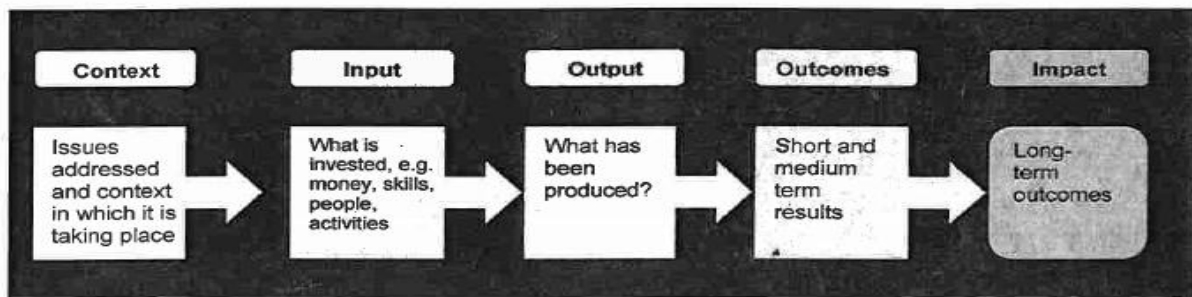
The analysis of different definitions and concepts of integration provides language and frameworks with which to describe and understand the field. Another perspective is provided by 'logic mapping', which helps us to describe and understand how integration is expected to work. This approach, which is derived from realistic and theory based evaluation (Pawson and Tilley 1997, Weiss 1995), has been described as the development of a 'plausible, sensible model of how a programme is supposed to work' (Bickman 1987). Thus, logic models provide a graphical depiction of the implicit or explicit theories underlying projects and programmes and the expected paths of change leading to the fulfilment of their objectives. They can be utilised, therefore, as tools for making explicit the rationale underlying public policy interventions in terms of the routes by which such interventions are expected to produce desired outcomes. Thus it provides, according to the Kellogg Foundation (1998), 'a picture of how your program works – the theory and assumptions underlying the program. ...This model provides a road map of your program, highlighting how it is expected to work, what activities need to come before others, and how desired outcomes are achieved'. Similarly, Hills' (2010) more recent report for the Department for Transport suggests logic mapping may be seen as 'a systematic and visual way of presenting the key steps required in order to turn a set of resources or inputs into activities that are designed to lead to a specific set of changes or outcomes'.

The logic chains underlying these pathways to change are depicted in different ways by sources. In essence, they seek to demonstrate linkages between the context in which a project or programme has been framed, the purpose underlying it, the resources to be deployed and the activities to be undertaken, and the results expected to be achieved. The Kellogg Foundation (2004) represents its basic logic model as comprising five linked components within two broader categories: 'your planned work' (resources/inputs and activities) and 'your intended results' (outputs, outcomes and impacts). Hills (2010) explicitly adds 'context' to her representation of the elements of a logic map: context, input, output, outcomes, impact (Figure 1). However, she emphasizes that 'dividing and labelling different steps is often quite an arbitrary exercise' not least because the maps try 'to illustrate something that is a continuous flow, and often an iterative process, in which outputs from one activity (become) the input to another' (Hills 2010). Communicating the underlying rationale of an intervention effectively to others is, she suggests, a more important concern than using the 'correct' terminology.

In addition, we should underline two related points. First, by its very nature, a map does not and cannot seek to capture all aspects of reality. It is a scaled-down version of what exists on the ground and, while it can be utilized to illustrate routes between different locations, it cannot capture the details of all the topographical features that may help or hinder journeys

between them. Second, a map is unlike reality in that it implies a linear progression between locations, albeit not necessarily only one route between them. In the 'real' world of project and programme implementation, feedback between different components of the logic map make pathways to outcomes more uncertain and far less linear. A logic map sets out, as we have suggested, the rationale for an intervention but does not predict that this rationale will necessarily be borne out in specific circumstances and times. However, it allows implementers and evaluators to ask more focussed questions about what they have observed in practice compared with what they expected, as well as to identify the points at which expected logic chains have broken, together with possible reasons why 'reality' diverges from the map (including inaccuracies in the latter).

Figure 1: Components of an intervention logic map



(reproduced from Hills 2010)

In England, logic maps have been widely used in transport but are less common in health and social care. They have been more frequently utilized in the USA, where the Kellogg Foundation has encouraged their adoption in theory-based evaluations and as a tool to support participatory evaluations (Kellogg 1998). Also in the USA, Elliott et al (2012) have developed a logic model (based on their own template) to provide a framework for developing an evaluation of Accountable Care Organisations, a field related to our own study of the integration Pioneers. Figure 2 locates the Pioneer programme within a logic map depicting its part in a wider set of activities designed to deliver desired outcomes through enhanced mechanisms for integrating commissioning and provision. We should emphasise the initial and interim nature of this map, which is based on analysis of national policy documents, will be revised following the next phase of data collection as we refine our understandings of the programme through further interviews with Pioneers and with national partners. Its purpose here is to provide a framework for understanding the national and local roles of the Pioneers and their place within an expected sequence of activities that have been embarked upon to produce improved outcomes. In effect, it represents an understanding of the rationale for the policy commitment to develop integration between health, social care and other functions, together with the rationale for establishing a programme of Pioneer sites and for the ways in which they are expected to work.

Figure 2: Logic map for integrated care Pioneer (version 1)

Context	Input	Output	Outcome	Impact
The issue to be addressed and the context in which it is located	What is invested e.g. money, skills, people, activities	What has been produced	Short and medium term results	Long term outcomes
>Services not experienced as 'joined up' or tailored to individual needs >Care models reactive, institution focussed, costly and disempowering >Little investment in prevention and wellbeing >Organisational responses are shaped by silo structures of services, systems and professions >Growth of demand and limits on resources rapidly making current care models and service infrastructures unsustainable >Initiatives to integrate care delivery and planning have had very limited success	>Definition of integration as personalised and coordinated care >Service models which promote independent living, prevention and proactive care >Local structures and processes for whole systems planning and commissioning of such models (HWBs, JSNAs, JHWS) >Financial incentive to support whole systems working (BCF) >Pioneer sites at which whole systems planning and delivery models can be tested, evaluated and lessons shared to enable spread of integration at scale and pace >Pioneers have freedoms and flexibilities to address barriers and national assistance available where needed	>'I statements' to structure more personalised and holistic assessments >Targeting 2% most at risk of hospital admission >Accountable professional, assessment, 7 day services and data sharing via NHS number >Protection of social care >BCF plans with rigorous approval process to ensure evidence based focus on avoidable hospital admissions, realistic savings projections and managed impact on acute care >2 waves of Pioneers (14 plus 11), National support programme, sponsors and ministerial commitment to remove barriers (e.g. to data sharing) >Radical new care models which promote (primarily vertical) integration	>Whole person and joined up support packages >At-risk users identified and needs proactively managed, avoidable admissions reduced >Integrated working based on personal accountability for whole person care >Targeted investment across whole system reduces demand for acute beds >Pioneers reduce avoidable admissions, lead the way through proven models of whole systems planning and delivery in absence of national or local barriers >Pioneer learning disseminated and applied	> More cost effective service models >Care is experienced as personal, joined up and enabling independent living >Demand pressures contained and managed >Sustainable fit between need and resources >Improved health and wellbeing in individuals and populations

(template derived from Hills 2010)

2 Overview of the Pioneers

The Pioneers were announced by the Minister of State for Care and Support on 1 November 2013. Before presenting our findings from this phase of the evaluation, this section provides a brief description of each of the 14 Pioneers. With some input from the research team, the descriptions in this section were largely drafted by the Pioneers themselves, and provide their own accounts of their vision and objectives. (The initial descriptions of the Pioneers that were included in the government press release announcing the 14 initiatives are included in Appendix A.)

Barnsley

The Barnsley Pioneer is located within a care and support system whose boundaries very largely correspond to those of a single local authority, CCG, NHS acute hospital trust and geographical division of a NHS community and mental health trust. It had been at the forefront of earlier developments in implementing statutory ‘flexibilities’ in partnership working such as lead commissioning and pooled budgeting. The framework for the Pioneer bid was provided by a ‘Stronger Barnsley Together’ initiative, whose vision was one of achieving ‘better outcomes and sustainable costs’ through an integrated transformation programme based on ‘three building blocks’: strength in partnership and governance; innovation in practice; and ‘inverting the triangle’.

The Pioneer programme is being developed through partnerships between the local authority, NHS, police and local communities, which in turn are being reinforced through a programme to strengthen local collaborative leadership systems and capacities. It is focussed on a number of key projects and activities that are designed to advance the delivery of integrated care for a growing range of local residents. Some of these activities build on aspects of integrated care in which the area had an established record of innovation (e.g. personal budgets and information sharing) while others are designed to provide significant developments of historic systems for coordinating care and shifting towards a more preventative approach to service delivery.

The principal projects include: a Universal Information & Advice service; ‘Be Well Barnsley’, which comprises a range of community focussed preventative services/peer models; ‘Right Care Barnsley’, which is organised around a care coordination centre; an Intermediate Care review and pre-procurement; exercise; a target operating model for assessment and care management systems; and the development of integrated personal budgets.

Further relevant interventions include: tele-health; personalised budgets; stronger and troubled families’ initiatives; an innovative model of involving communities in the design and delivery of neighbourhood services (the Dearne approach); and cultural change in dementia services through the “Home Truths” national development programme.

Cheshire

Connecting Care across Cheshire aims to join up local health and social care services on a wide pan-Cheshire footprint around the needs of 700,000 local people and take away the organisational boundaries that can get in the way of good care. It covers two local authorities and 4 CCGs. There will be a particular focus on older people with long-term

conditions and families with complex needs. This will involve a multi-pronged approach at Cheshire level focussed on integrated communities; integrated case management (people with complex needs including elderly and children); integrated commissioning; and integrated enablers. Integrated enablers involve delivering information sharing, the development of a single case management ICT system, and new funding contracting model to ensure that incentives are in place to shift activity from acute provision to community based care, joint performance framework, and joint workforce development. Integrated enablers will benefit from a cross-Cheshire strategy and produce corresponding economies of scale.

In each of the CCGs, existing programmes and activities that integrate health and social care will be further developed (Caring Together in Eastern Cheshire, the West Cheshire Way and the Local Partnership Board in mid-Cheshire).

Interventions that are being implemented across Cheshire include integrated case management for individuals with complex needs including single point of access, case management, single care plan, care coordinators and multi-disciplinary teams (seven multi-disciplinary integrated care teams are already active in West Cheshire and aligned to GP surgeries, virtual MDT active in central Cheshire); interventions to tackle unhealthy choices; roll-out of personal health budgets; community based intermediate care; joint specifications for care homes and scale up of hospital at home project in West Cheshire; support to carers; programme to tackle isolation; promotion of self-care models; and telehealth.

Cornwall and the Isles of Scilly

Living Well, Cornwall's Pioneer programme aims to create and implement holistic change that includes physical and emotional wellbeing, financial stability, social connectivity and purpose. This is being achieved through an equal partnership between the community and voluntary sector, local authority and health commissioners and providers, co-produced with local people. The heart of the programme involves expanding the role of the voluntary sector and the use of volunteers.

The Living Well approach starts with a guided conversation (rather than a formal health and social care assessment) about the person, their stories, their needs and their aspirations. Practitioners and partners in the community can then work together with the person to support them to achieve their goals and to provide appropriate health and social care in a way that supports this. The ultimate aim is to deliver a single shared holistic assessment carried out by the most appropriate practitioner for each individual.

Integrated care teams are based around a GP practice and include clinicians from the practice, along with volunteers, social care, mental health and community health practitioners. Instead of waiting for people to fall into ill-health, the team proactively contact people to support them to improve their health and well-being. A single management plan for the person is shared by the whole team. The aim is to build on the community assets, experience and services (formal and informal) available in a locality and to build on the strengths and assets that people themselves can offer.

The concept was first trialled in Newquay in 2012, where it helped to reduce hospital admissions, improved people's health and wellbeing and saved costs. It is now being tested in Penwith, west Cornwall, where the Living Well approach is currently supporting 800 people, and in East Cornwall supporting 250 people. There are plans to roll out Living Well across Cornwall and the Isles of Scilly during 2015.

A shared outcomes framework has been co-designed with commissioners and providers across health, social care and the voluntary sector that measures the objectives of the Triple Aim: improved health and wellbeing; improved experience of care and support; and reduced cost of care and support.

The Pioneer is exploring different contracting and payment methods to reshape the health and social care economy around shared risk and benefit, integrated care communities and integrated commissioning across health and social care.

Greenwich

Greenwich Pioneer focuses on integrating services across the whole system to enable people to manage their own health and wellbeing. This builds upon an already established successful integrated care system that has a major focus on prevention, reablement and intermediate care. Implemented in 2011, this includes emergency admission avoidance, hospital discharge and community rehabilitation/reablement. Key to its success are the well-established integrated health and social care teams, with shared management arrangements, in all parts of the pathway.

The current phase in the Pioneer builds on the above and seeks to identify those people with complex or complicated problems earlier in the pathway, prior to a crisis or breakdown of their situation. It is focussed around GP syndicates or groups of GPs. Rather than develop more services, the emphasis is on better utilisation and co-ordination of existing services both within health, mental health, social care, voluntary sector and community services.

A 'care navigator' role has been developed to act as the central co-ordinator and point of contact for the individual, their family/carers and staff. They ensure that the outcomes the individual wishes to achieve are documented in the form of their personal 'I' statements and are central to the discussions at the Greenwich Co-ordinated Care Meetings (GCCMs) that are held regularly with each GP practice. A multidisciplinary 'core team' from existing services attend the GCCMs as well as others already working with the person being discussed. A plan is developed and agreed with the individual and the care navigator ensures that this is implemented. The focus is to build a 'team around the person', working across organisational and professional boundaries to deliver the best outcomes for the person in the most creative and innovative way.

This model is being tested in Greenwich using an 'action learning approach' that allows changes to be made, following feedback and discussion to develop the most efficient and effective ways of working. Identifying the people who would most benefit from this type of service is ongoing as part of the action learning approach. A quantitative and qualitative evaluation framework has been developed and the impact of the model will be assessed in

April 2015 both in terms of experience of the person, staff, cost and financial risk before full roll out across the borough.

The next phase is to consider how the approach can be extended to a wider population and support health and social care professionals to steer less complex patients/service users to the wide range of services through the Greenwich community offer. This will be developed alongside the South East London Strategy to group primary and community services together in 'local care networks'.

Bringing about cultural change underpins all aspects of Greenwich's work so that person-centred co-ordinated care and inter-professional working can be achieved and sustained in front line practice.

Islington

In Islington the aim is to, firstly, support health and wellbeing at a population level, and secondly, provide better co-ordinated care for more intensive users of services.

To support health and wellbeing for the wider population, work is focussing on scaling-up existing pilots for self-care. To improve co-ordination of care for more intensive users of services work is focussed on three groups: older and vulnerable people; people with long term conditions; people with mental ill health.

A risk stratification tool is used in conjunction with four MDTs based around GPs. The intention is to develop a single point of contact across health and social care both to signpost the public and to process referrals.

As Islington is taking a life course approach to this work, the health and wellbeing of children is integral to all work streams. Initiatives for children include children's hospital at home, children's nurses in primary care and children's MDT teleconferences.

Islington has an Integrated Care Organisation in the form of Whittington Health which provides vertically integrated acute, community and primary care.

Kent

The Kent Health and Social Care Integration Pioneer is a partnership between Kent County Council, the seven local CCGs, community health trust, mental health, acute sector and district councils. The partnership also engages with the voluntary sector and the public. Its aim is the transformation of health and social care through complete system-wide integration of health and social care provision and commissioning. Kent's vision is to put the citizen experience at the heart of integration. Key groups targeted for intervention will be older people and people with long-term/multiple health conditions.

The key Kent Pioneer goals are to:

- transform local systems to develop a sustainable health and social care economy, getting the best possible outcomes within the resources available;
- coordinate and deliver to the individual and their carers the 'right care, in the right place at the right time by the right person';

- enable people to take more responsibility for their own health and wellbeing;
- support people to stay well - or to experience quality end of life care - in their own homes and communities wherever possible, reducing the pressure on acute hospitals by preventing avoidable admissions;
- develop integrated commissioning using the Year of Care approach, supported by both commissioner and provider organisations and informed by evidence-based intelligence systems;
- evaluate the benefits of integrated care across the system in real time at population level.

The key vehicle for care management and coordination will be the GP surgery, supported by a series of interconnected initiatives across the local health and social care economy to include: crisis response services; 24/7 access to Integrated Locality Referral Units and to multi-disciplinary neighbourhood teams; 7-day integrated hospital discharge teams and integrated home support; shared care plans on an integrated IT platform; bed provision outside of acute settings; incorporation of dementia services and end of life services; integrated therapy services in acute, community, social care and housing settings; self-care and self-management programmes for people with long-term/multiple conditions; and telehealth/telecare and assistive technologies.

The Kent Pioneer programme is scheduled to run until 2018 and is integrally linked with the localities' plans for the Better Care Fund.

Leeds

In Leeds, the Pioneer programme will underpin the effectiveness and impact of plans for transformation of both children's and adult services. The ambition is for truly seamless care to be the norm, wrapped around the needs of the individual. The programme has three strands:

- innovate: create an innovation hub that enables the development and application of new solutions and approaches to deliver the city's vision;
- commission: implement new care and funding models focussed on prevention and self-care as well as delivering better outcomes and experiences for people;
- deliver: create truly seamless care and support built around people's needs and expectations.

Innovative work to integrate services includes:

- thirteen health and social care teams to coordinate the care for older people and those with long-term conditions (with the aim to eventually include mental health);
- a new joint intermediate care centre, opened by the NHS and local authority, which offers rehabilitative care to prevent hospital re-admission, facilitate earlier discharge and promote independence;
- a programme to integrate health visiting and children's centres into a new Early Start Service across 25 local teams in the city, so that children and families will experience one service, supporting their health, social care and early educational needs, championing the importance of early intervention.

North West London

Health and social care partners across the eight boroughs of North West London are working together in pursuit of a shared person-centred vision: to improve the quality of care for individuals, carers and families; and to empower and support people to maintain independence and to lead full lives as active participants in their community. GPs will be at the centre of organising and coordinating people's care, drawing together all services and resources needed to support people to meet their personal goals. A fundamental focus of the Pioneer is to develop organisational systems that enable, not hinder, the provision of integrated care, e.g. payments for outcomes not activity; information sharing; providers accountable for outcomes and securing demonstrable efficiencies. Many of the specific interventions build on and extend previous pilot programmes and developments in integrated care.

The first stage in realising this vision was a process of co-design, bringing together patients and service users, clinicians and care professionals, commissioners and providers in a series of working groups, to develop practical ways of addressing what would otherwise have become barriers to implementing integrated care. This culminated in the launch of the North West London Integrated Care toolkit.

The next stage has been to develop a series of 'early adopter' projects (one in each borough) to trial new ways of integrated working. Beginning in 2015, these projects work within a common framework provided by the programme, but are based on models of care and ways of working appropriate to the needs and circumstances of each individual area. Each project is seeking to re-design its local system so that it provides the right incentives to deliver more integrated care. This means paying for services on a basis that rewards individual person-centred outcomes, and sharing information and budgets so that knowledge and resources can be used more effectively to deliver better clinical outcomes and personal experiences. It is hoped that delivering high quality joined up care at home and avoiding preventable emergency stays in hospital or long term dependency on institutional care can achieve better outcomes and experiences of care for people and their families as well as improved value for money across the system.

South Devon and Torbay

"It's what matters to me *not* what is the matter with me" underpins the shared commitment of South Devon and Torbay's senior leaders in the JoinedUp Board to a future in which multi-disciplinary teams take a personal, proactive approach to total wellbeing that goes beyond medical diagnosis and treatment and removes boundaries between acute, primary and community care. The Pioneer projects are part of a JoinedUp programme of work to design and implement integrated models of better care based on priorities for health care and support identified by local people. Two Pioneer hubs have been developed. The first is a frailty service that includes a single point of access, locality based multidisciplinary teams for care planning and case management, health and social care coordinators, crisis response/reablement initiatives, community and voluntary support at home and end of life support at home where appropriate. The second is a children and families hub led by a local neighbourhood partnership, which includes a range of community and voluntary organisations bringing together community abilities and resources. The aims of the young people's service are to reduce health inequalities across children and young

people's health, care and aspiration, and enable community resilience and enhanced social fabric. The young people's service includes design of a weight management programme by young people and will affirm and build on existing local projects and priorities.

The acute, community health and social care trusts are coming together into an Integrated Care Organisation that will provide both vertical and horizontal integration in respect of acute, community health and social care. The CCG is also working with mental health providers to incorporate mental health professionals into locality based multidisciplinary teams (community hubs).

South Tyneside

In South Tyneside, the focus is on prevention and improving self-management. A training programme has been developed with the aim of training staff how to have different conversations with their patients and clients, starting with how they can help the person to help themselves, and then providing a different range of options including increased family and carer support, voluntary sector support and technical support to help that person self-manage their care.

Other initiatives include a single point of contact for social care and 'time to think beds' to better support people at home, particularly after discharge from hospital. Going forward, South Tyneside is planning to embed the Pioneer principle of self-management within all integration workstreams (integrated community teams, integrated care services hub, urgent care hub).

Southend

The overall aim of the Southend Pioneer is to develop a model of integrated care which can be rolled out across Southend. This means better integrated services and better access (co-designed with patients, more choice and community care, integrated teams, single point of access); better integrated information (integrated dataset, uncomplicated pathways); better understanding of residents and their experiences; a focus on prevention and individual responsibility (telecare, telehealth, housing, individual budgets); better use of resources through joint planning and commissioning.

Interventions that are being developed include: single assessment and care planning; MDTs aligned with primary care hub footprint; seven day services in acute hospital and in the community; pooled budgets which follow the patient across health and social care; falls prevention pathway; frail elderly and dementia pathways; extending the single point of referral to reduce avoidable admissions and delayed transfers of care; integrated locality teams and pathways by joining existing health and social care teams; and piloting new pathways for stroke rehabilitation and intermediate care beds.

The development of GP level co-located multi-disciplinary teams and integrated locality teams are under-way. This is based on developing the existing multi-disciplinary teams and forms the model for rolling-out across Southend. Integrated locality teams involve a dementia nurse, CCG leads, ambulance, consultant geriatrician, therapist, and single point of referral. Multi-disciplinary teams operational at GP practice level involve GPs, nurses, social workers and community health in collaboration with the acute trust to case manage people with long-term conditions. Greater use of telehealth and telecare will be an integral

part of the intervention model. Greater involvement of the voluntary sector will contribute to the prevention agenda.

Staffordshire and Stoke

The Transforming Cancer and End of Life Care Programme was originally launched by five CCGs in Staffordshire together with Macmillan Cancer Support. The programme was eventually developed by four CCGs: North Staffordshire CCG, Cannock Chase CCG, Stoke-on-Trent CCG and Stafford and Surrounds CCG. Staffordshire County Council and Stoke-on-Trent City Council are represented on the Programme Board. The overall aim of the programme is to improve cancer care, where current outcomes are deemed unsatisfactory, and to secure sustainability and good quality for end of life care by means of a significant shift from the acute setting to different types of care.

The strategy adopted is to appoint a service integrator through a tendering process, one for each of the two branches of the programme (cancer and end of life care). The service integrator(s) will design and deliver integrated seamless care starting from the third year of the contract, while the first two years will be used to collect data and devise the best strategy for integration. From the third year on, the service integrator will manage a fixed budget for providing care (calculated on current expenditure) and will be expected to finance itself from efficiency savings. The tendering process is expected to be finalised by April 2015.

Waltham Forest, East London and City (WELC)

The Waltham Forest, East London and City (WELC) Integrated Care Programme is about putting the patient in control of their health and wellbeing. The vision is for people to live well for longer leading more socially active independent lives, reducing admissions to hospital, and enabling access to treatment more quickly. Older people across Newham, Tower Hamlets and Waltham Forest will be given a single point of contact that will be responsible for co-ordinating their entire healthcare needs. This will mean residents will no longer face the frustration and difficulty of having to explain their health issues repeatedly to different services.

The core of the Pioneer programme in WELC is to use risk stratification to identify the top 20% of the population most at risk of a hospital admission over the next 12 months. This is based on clinically relevant variables from linked GP and acute hospital records. The service model for the programme was created by adapting the national and international evidence base around integrated care services. WELC will provide nine key interventions: self-care, behaviour and expectation management; care planning; health and social care navigation; case management; specialist input in the community; discharge support for mental health patients; rapid response with short-term reablement; mental health liaison; discharge support from acute to community.

While working towards a capitation model in next few years, an interim contracting model promotes integrated services by contracting with a 'provider consortia' to deliver a specification for an 'integration function'. Work has begun on developing different models of financial flows, like capitated budgets, which aims to:

- align financial incentives of providers, and include incentivised payments based on providers' achievement of specified outcome metrics, building on available evidence about 'what works' for similar programmes with similar populations and programme objectives;
- develop new payment mechanisms intended to cover the entire integrated care population (to the extent that it is feasible);
- share learning about the development and implementation process within WELC, and with other Pioneers;
- inform national policy development through communication and collaboration with Monitor.

Worcestershire

The Worcestershire Well Connected Programme is a formal collaboration between Worcestershire County Council, all NHS organisations with responsibility for Worcestershire including both NHS commissioners and providers, Healthwatch and the voluntary sector. It is aimed at refocussing care from acute hospitals into the community by a process of improved integration, with a focus on older people and those with long-term conditions. This involves preventing and delaying crises in the frail population, improving the outcomes of their care and reducing the length of stay in acute settings, by means of integrated sub-acute, community and social care. The programme is built upon and is organic to the significant tradition in integrated care in Worcestershire, and its vision includes both enhancing existing initiatives to a larger scale and pace, and designing new strategies and activities to improve integration of care.

Six major transformation programme areas have been identified: children and young people; specialised services; future of acute services; urgent care; integrated out of hospital care; future lives.

Each programme encompasses several re-designed or new projects and activities that will be developed to a larger scale. They include the enhancement of the existing virtual ward integrated teams, together with a number of projects aimed at prevention and admission avoidance; a joined up approach to rehabilitation which contributes to promoting rapid discharge from the acute setting, together with a further enhancement of the primary care offer. Assistive technology and the provision of telecare/telehealth form part of the strategy aimed at increasing choice and control by patients, and reducing the need for long-term health and care services.

3 The early evaluation of the Pioneers

In autumn 2013, the Department of Health asked the Policy Innovation Research Unit (PIRU) to undertake an early evaluation of the Integrated Care Pioneers and the BCF as it is taken up and used by the Pioneers to pursue more integrated forms of care. While DH recently commissioned a longer-term evaluation, starting in summer 2015, which will examine progress in England toward better person-centred coordinated care and aim to understand what leads to successful integration, PIRU was first asked to carry out two short-term projects. The first project was to identify potential indicators that could be used by the Pioneers to measure their progress over time. This was carried out to a tight timetable and reported to DH in February 2014; the final report was published on PIRU's website in April 2014 (<http://www.piru.ac.uk/assets/files/IC%20and%20support%20Pioneers-Indicators.pdf>) and is designed to be used by the Pioneers to help them select locally suitable indicators of progress that they can use to self-monitor.

The second short-term project, to which the current interim report relates, was to undertake an early evaluation of the first 15 months (January 2014 through March 2015, with reporting in June 2015) of the Pioneers in order to identify and describe their vision, scope, objectives, plans, interventions, etc as well as their progress during this period.

The aims of the early evaluation are to:

- identify, describe and understand the vision, scope, objectives, priorities, plans and leadership/management of the 14 selected Pioneers;
- identify and describe the mechanisms and 'intervention logics' (in terms of structures, systems and causal pathways) adopted by the Pioneers to deliver those plans and priorities, and to compare them with other recent integrated care initiatives (e.g. the Integrated Care Pilots);
- identify the local and national financial incentives, reimbursement arrangements, contractual forms and budgetary innovations put in place to implement the Pioneers plans;
- analyse the plans in relation to the BCF put forward by the Pioneers, with particular focus on how these align with national performance requirements and expectations of the fund in 2015/16 (e.g. investment and disinvestment plans);
- describe how the Pioneers' BCF plans begin to be implemented in financial year 2014/15 (e.g. how budget pooling progresses);
- make a preliminary assessment of the extent to which Pioneers are able to address previously identified barriers to the integration of care and/or governance, together with the facilitators reducing the influence of such barriers;
- assess the degree to which the BCF focusses local authority and local NHS attention in the Pioneer sites on attempting to design and deliver investment and disinvestment plans intended to make specified improvements in the extent and quality of person-centred coordinated care;
- undertake an early largely qualitative analysis of the progress of the Pioneers in the first 12 months in relation to their first year integration objectives;
- distil and rapidly disseminate early learning from the Pioneers relevant to the Integrated Care Policy Programme of DH, NHS England and other partners.

The main research activities of the early evaluation include:

- reviewing documentation for each Pioneer including its initial proposal, its BCF plan, further plans and service specifications made available to the research team, and minutes of meetings of CCGs, HWBs and local authorities that relate to integrated care, Pioneer status and the BCF;
- in-depth interviews with key stakeholders in each of the 14 Pioneers, covering: history of integrated care in the area; reasons for becoming a Pioneer and expectations from the programme; models of integration; aims of the interventions; involvement of the independent and voluntary sector; workforce innovations; governance arrangements; linking information systems; contractual and payment arrangements; their BCF plan and its relation to integrated care more generally; progress in design and implementation; barriers and facilitators (i.e. conditions that appear to foster integrated care and those that do not);
- attending relevant national and local Pioneer meetings (which will vary from site to site), as resources allow;
- to the extent resources allow, attending local meetings, e.g. planning, progress or evaluation meetings within specific Pioneer sites;
- discussions (or interviews) with the NHSIQ's Delivery Service Managers (DSMs) who keep in regular contact with the Pioneers;
- production of published and unpublished reports, and presentation and discussion of these reports with national agencies and the Pioneers.

A template was developed for extracting and recording data from Pioneer documentation in a systematic and consistent way across sites; a sub-set of this information is included in Appendix C, Table C1.

The main focus of data collection is the semi-structured interviews carried out by five members of the research team working to a shared topic guide (included in Appendix B). The number of interviews per site vary depending on the complexity of the site, and are being carried out in several waves. The initial set of interviews was conducted between April and November 2014, and is captured in this report. Most interviews were carried out face-to-face, but a few were done over the telephone. Interviews varied in length but generally took about an hour. NHS R&D approval was obtained for interviewing NHS staff in all 14 Pioneers.

The number of interviews at each Pioneer completed by November and contributing to the current report is given in Table 1a) and the types of people interviewed are shown in Table 1b).

Table 1a): Individuals interviewed April to November 2014 per Pioneer site

Integrated Care Pioneer	Individuals interviewed:
Barnsley	11
Cheshire	18
Cornwall	7
Greenwich	5
Islington	4
Kent	10
Leeds	15
North West London	13
South Devon and Torbay	16
South Tyneside	5
Southend	9
Staffordshire and Stoke	6
Waltham Forest, East London and the City (WELC)	12
Worcestershire	9
Total	140

Table 1b): Types of individuals interviewed April to November 2014

Types of individuals interviewed	Number interviewed:
Primary care providers	2
Clinical Commissioning Groups	42
Acute care providers	15
Community/mental health providers	18
Local authorities	49
Voluntary sector	6
Pioneer staff	8
Total	140

To ensure comprehensiveness and rigour, a thorough and systematic approach to analysis of the interviews was employed. All interviews were recorded verbatim and transcribed, with each transcript reviewed by the original interviewer. To identify common themes, an iterative process of analysis involved all members of the research team through periodic team meetings where differences in interpretation were discussed and reviewed. NVivo software (version 10) was used to interrogate the data and facilitate analysis. The qualitative data was thematically analysed as follows:

- A coding frame was inductively developed based upon early rounds of interviews. This was refined by the research team until an agreed structured/hierarchical coding frame was developed.
- The interviews from each Pioneer were independently coded by the lead researcher for that site.
- Summaries of significant findings from each site were generated and reviewed collectively by the research team in order to identify recurrent themes and compare and contrast findings. The team were careful to look for divergent accounts and

issues as well as commonalities. This allowed the identification of key themes for the study as a whole to be identified.

- Research team members co-authored the thematic sections (4-7), selecting rich and descriptive illustrative examples from the transcripts, which were reviewed and commented upon by the entire team.

This pragmatic method for analysing the qualitative material was well suited to this highly applied context, being both rigorous and feasible for working with a large dataset.

A second round of interviewing with key Pioneer staff will be held in spring 2015. This phase of the early evaluation will continue to examine how Pioneer plans are developing and being implemented, develop logic maps at Pioneer level with a view to developing typologies of Pioneer sites, identify how Pioneers are progressing and the extent to which they have been able to overcome the barriers identified in this interim report, and to highlight the policy implications resulting from the early evaluation. The findings from the early evaluation will also inform the design of the longer-term evaluation of the Pioneer programme. The final report of this early evaluation is due to be provided in summer 2015.

4 Becoming a Pioneer

The following sections of the report (sections 4 through 7) present our findings from the initial stage of our early evaluation. Our findings are based partly on documentary analysis, but mostly on analysis of the interviews undertaken at Pioneer sites between April and November 2014. Section 4 covers issues to do with becoming a Pioneer; section 5 describes key features of the Pioneer sites, including their integrated care strategy and the interventions currently in place or being planned; section 6 describes their Better Care Fund plans in the context of Pioneer activities; and section 7 summarises barriers and facilitators to integrated care.

Pre-Pioneer history

Part of the selection criteria for Pioneer status was a 'proven track record' in successfully delivering 'public sector transformation at scale and pace'. Several Pioneers often described many years' experience of initiatives to integrate health and social care. There was consensus that it was essential to understand the specific context and historical experience of Pioneer sites in this respect as this provided the 'backdrop' that strongly informed current activities and approaches. An essential characteristic of this appeared to be a perception that integrated care activity had originated from the 'bottom-up' (as opposed to implementing national 'top-down' directives) and built upon local strengths, successes, interests and priorities in health and social care.

"It's never something that we've woken up all morning and said, 'Let's do integrated care.' It's just evolved and developed and matured and changed subtly over five or ten years I think."

"You have to use the local initiative because that is where you rely on relationships. Because that is what will make things happen, and resources. Because different people have different levels of investment in different areas of the programme, and a different appetite to deliver on different parts. We are all starting from a different edge, or a different corner of the plan."

The long-term history of many of the Pioneers in developing integrated care initiatives meant that much of the developmental activity that laid the groundwork for Pioneer status was already in place; there were examples of integrated care activity cited where NHS organisations and local authorities had been engaged in joint commissioning or joint appointments, which established a context for collaboration. Involvement in previous pilot programmes was mentioned by several interviewees as providing essential experience that the Pioneer programme built on.

"Okay, before the Pioneer, I mean, it really came about through the [previous] pilot, which we were one of three sites successful in getting that pilot status."

"[Previous pilot] gave us the basis on which to build our Pioneer bid. So they've moved, sort of, into one, from that, from my thinking of it. It's just that we're across a bigger patch now."

“Part of [our inheritance] is from the [previous pilot] work because everyone did it collaboratively...we do have a culture of collaboration.”

However, in reviewing the importance of the legacy of integrated care initiatives, it was reported that some areas felt, at times, that there had been too much experimentation and ‘over-piloting’. In some senses, the Pioneer programme was seen not as ‘another’ pilot but as an opportunity to implement and rollout the learning and experience gained through these earlier pilots.

“We've probably got more pilots in [our locality] than we have British Airways pilots, is what's said...So we, so our mission within the integration Pioneer is to change from that and trying to go towards rollout rather than pilots.”

Interviewees agreed that, central to the success of any Pioneer work, was the quality of the relationships between local stakeholders.

“The most important thing above anything else is trust in terms of how people working in multi-disciplinary teams trust each other to give the right information, trust each other's assessment and judgement of the situation and the person and how they are. It means trust between the practitioner and the person they're working with. It means strategic leaders trusting each other. It doesn't matter what discipline you work in, when you're working in an integration programme it has to be about relationships. That's the bit a lot of the time we pay lip service to when we're doing 'transformational change.' It's the bit we all know is really important but it's hard work and takes a lot of time.”

In some areas, the strength of such historical relationships provided a stable framework for integrating care, in a context where the system reform process had continuously modified the arrangements for NHS commissioning.

“There's been a history of [Pioneer area] working together, going back seven, eight, nine years, [...] we've got a long history of having a financial strategy across [Pioneer Area] and when the PCTs went and the CCGs came into being, even during the transition the PCT came into clusters within [Pioneer area] as three clusters. Subsequently when the CCGs came together, we came together in two groups and with an agreed principle that we would have two CCG federations that were collaborative but we would come across [Pioneer area] and we have a collaboration board across [Pioneer area] with a joint financial strategy which allows us to use the money more effectively.”

One impact of the Pioneer process was that it had often allowed these important historical relationships to be strengthened. This meant for example that in these areas, important philosophical and ‘territorial’ debates and discussions between key stakeholders about the need for integrated care and ways forward had already been had.

“[There were] massive barriers around the geographical distribution, lots and lots of push back. I think we managed to agree it [primary care networks] with them, and

now however many years later, you hear people ... go out and evangelise about the networks as the best thing ever. At the time there were some hard fought battles.”

Some interviewees, mostly providers, also pointed out that the local history of integrated care was not necessarily always relevant to the goals of the Pioneer. This was observed in particular in Staffordshire and Stoke, where the Pioneer was designing and implementing a comprehensive integrated care pathway from scratch, with the deliberate intention of providing a radical innovation in areas where outcomes of care were deemed to be inadequate. In such cases, having a history of local integrated care was not considered an asset to build on for the future of integrated care, and, instead, a new model was introduced.

“We work in partnership with hospices, general practice through our screening programmes through to our diagnostic capabilities, through to our treatment capabilities and then through to discharge and ongoing care and ultimately palliative care. So we’ve got those partnerships all over.”

“I guess my feeling is that the CCGs probably should have had a conversation with people about how those services could be coordinated and brought together [...] I think we should as providers have been given the opportunity to come together to redesign the services to deliver the outcomes that patients need.”

Reasons for becoming a Pioneer

The reasons for seeking Pioneer status and what localities hoped would result from doing so were often complex and varied. A precursor to applying for Pioneer status was the conviction that integration was a key mechanism for delivering care and support more efficiently and effectively.

“[Named LA] is not a rich [LA]... One of the key drivers was that we could see people were going into hospital when they could’ve been cared for in the community and the way that PBR works, that’s a cost for us. We knew people were having poor care in the community, it wasn’t joined up at all between health and social care.”

This was linked to a strong sense that integrating health and social care was an essential response to increases in demand, particularly driven by the needs of an ageing population and increased numbers of people living with long term conditions in a context of diminishing resources (Goodwin et al 2013, Oliver et al 2014). Maintaining the current arrangement of services was therefore described as untenable in such a rapidly changing context. Integrated care is expected to provide better value for money, and then to produce cost savings that are regarded as a necessity to ensure the sustainability of services for local populations.

“They are having to look at the way that they deliver services and there is a bit of “What are we statutorily obliged to deliver”? Because if we’ve only got a small pot we can really only afford to deliver what we have to deliver. And then you look at the demographics, which in five years’ time [our area’s] over-65 population will have doubled; I mean, you know, that doesn’t match. So you can’t say we will wait for people to hit eligibility and then we will support them and that’s how we’re going to

make financial savings, because it might work this year but even next year you're going to be stuffed.”

“As tax payers we want our money to be used as efficiently as possible so I think that is important. Better value out of the whole health and social care system. As potential users, we are all potential users of the service, we want it to be as high quality as possible. Best outcomes, best experience and I generally think that is what they want to do.”

It was frequently reported that localities perceived that their prior integration work was beneficial and therefore the opportunity to scale-up and develop the work presented by Pioneer status was attractive. Some interviewees suggested that Pioneer status would also provide an opportunity to proactively push the agenda on integration, to innovate, ‘barrier-bust’ and take risks in the search for ways to scale-up and accelerate the pace of change, and Pioneer status was seen as bringing those opportunities. There was also a strong belief that integration was the recognised way forward in improving the quality of care and the patient experience by providing services that were ‘joined-up’, consistent and patient-focused. However, questions remained in how best to take that agenda forward.

“No one really objects to trying to end all the barriers and stop the fragmentation until you start saying to people, ‘Well, the thing we’re trying to get is collective responsibility here, as opposed to it being in my individual organisation’s best interest to do X.’ And we’re yet to grapple with some of the big things like are [name removed] going to be able to make a foundation trust application – not using payment by results – for a large chunk of their income?’ There are loads of barriers – policy barriers – in the way. But, in theory, nobody says, ‘No’ because, politically, how can you actually say ‘No’ to an aspiration to get it right for patients?”

Integrated care was also hoped to address inequalities by bringing consistency of service across localities and communities.

“But there is no doubt about it that improving the quality of care and reducing the number of gaps that individuals could fall through as a consequence of organisations not working collectively together [is] in the interests of that patient, that is a good thing to do. It is a moral thing to do, it is a social justice issue to challenge professionals to work differently.”

“The biggest commissioning issue that got raised [in EOI process] was, ‘We do not want to commission something different for one part of our population to another part of our population because we don’t think that’s fair’. And, as it turns out, we’ve ended up with the whole geography being covered by an expression of interest that relates to the [LA]. So I suppose we’ve kind of made that happen.”

Pioneers often reflected that they were well placed to take on the challenge of scaling-up and accelerating integrated care because their previous experience with integrated care initiatives meant that key stakeholders were already on board. Pioneer status was seen as a

way to maintain commitments to integrated care and keep momentum going, particularly because of the perceived added interest and scrutiny that Pioneer status was likely to bring.

“It keeps lots of organisations within [the locality] at the table. So because we've all signed up to a shared vision and a shared programme it keeps people around the table. It keeps attention on us, so it means that, you know, when challenges get tough and providers tend to retreat back into their own organisations, actually the Pioneer focus is quite helpful.”

“And my personal feeling is around the Pioneer programme that, actually, part of it is very much around getting local partners signed up, having some clear commitments that everybody has to stick to and having a national spotlight that encourages you to stick to those.”

This value of having Pioneer status was also remarked by those areas whose plans were causing political controversy at a local level, providing a further motivation to keep the partners together.

“What it has done is actually bound the partners together even more, because having a national – being part of a national programme, it gives them a reason for being and a reason for staying, because this programme, as you know, is quite controversial.”

There was also a hope in some localities that Pioneer status might bring national kudos and recognition for work that was already in place and bring greater influence and access to key decision-makers. One interviewee discussed the interaction with senior politicians and civil servants that was attributed to being part of the Pioneer programme. This was felt to provide access, encouragement and recognition as Ministers were able to see the achievements of sites as well as provide opportunities for local system leaders to feedback the local perspective.

“What I think it has brought us is ... national recognition, a bit of a listening ear at sort of high-end level. I wanted to see some real support to solve some of the problems or at least if they couldn't be solved to flesh them out and do a bit of myth busting. To be given the freedom to be allowed to ask the difficult questions. And even if we don't always get the answer we want, actually being able to be sure that the answer we get is the right one.”

“We've had an awful lot of support from Norman Lamb, from civil servants, from major charities that have been down to hear about what we're doing and encourage us to keep on going.”

This was related to the hope that this may also help to attract additional resources, although it was clear that Pioneer status itself (initially) attracted no new government funding. In this regard, some interviewees mentioned extra staff who may support their work. However, the offer of additional help and support, as well as permission to challenge policies seen as barriers made, Pioneer status attractive.

“Well, actually, we wondered if we would get decent support in kind. So, would you have a ‘hit-squad’ of contract and finance advisors to come in and tell you how you could do some innovative contracting in your patch.”

“There is a bit about central support from the national side of things, which we’re hoping we can tap into through the Pioneer status, which is if we do go down the capitated budgets route, how do we get permission for that? If our providers do start to work together as organisations, how do we [handle competition issues] ... so there is the national support that we would need.”

Access to other Pioneers, information sharing and disseminating learning between localities was also an important driver for becoming a Pioneer. The opportunity of networking was identified as a strength of the programme at several levels. Interviewees highlighted the value of sharing experiences and learning, and also remarked on the importance of working within, and being aligned with, a larger group.

“I think the main thing is that we are able to establish a network with other Pioneer sites and that we are able to learn from others [...]. Just sharing that information about things that are working well and slightly distinctive things that may have been done in some Pioneer areas. Learning from that how we could apply it in our own area [...].”

“It was about the opportunity to work with other sites to learn from other people ... we don’t always have the opportunity to get out and about and attend lots of things that might be happening elsewhere. So it was a real opportunity to feel part of a bigger team and also recognising that we were at a relatively early stage in our integration in terms of the big picture.”

Concerns about becoming a Pioneer

However, becoming a Pioneer was not without concerns. Chief among them was the risk of reputational damage to the locality if the initiative failed. This was particularly salient because many Pioneer areas had a long history of integrated care initiatives with, in some cases, nationally recognised successes. This could be jeopardised if the Pioneer programme was unsuccessful. Such anxieties were at times exacerbated by negative reports or accounts from other localities of previous integrated care initiatives or similar high-profile policy measures.

“There is an expectation to succeed and that’s a good thing but it’s also a bit of a curse. You know, everything that you do you need to make sure that you can demonstrate how you’ve done it and what you’ve done and everything else. Again, that’s not a bad thing but it is a level of scrutiny that, you know, you could ask yourself ‘Do we need it?’ “

A key fear was also that of increased workload and, specifically more bureaucracy, that Pioneer status would bring and additional demands for information from the centre, as well as requests for advice and demonstrations from other localities. Such demands were

deemed capable of outweighing the benefits so that Pioneer status might actually slow down the integrated care process more than support it.

“I guess the only thing is whether the, as they say, the ‘feeding of the beast’ was more than the actual benefit of the beast, if you [like], or benefit of the change.”

“I think there was a concern that it would slow down what we were doing, in that there would be a lot of pressure to do data...filling in baseline assessments, and being told the way that you’ve got to assess what you’re doing, and extra layers of governance were certainly a concern.”

The idea of formalising the local integration process with Pioneer status raised some concerns, in particular in the larger Pioneers where variation in performance across services may be substantial. Several interviewees highlighted the risk that such a process could reduce the capabilities of the most promising local initiatives in order to align them with those from weaker areas within the Pioneer site.

“There’s a risk that you move at the pace of the slowest. There’s great work that’s happening in each of those areas, and there is a risk, and I don’t think it’s one that you’re seeing in the area, but it’s one that I think we do need to be mindful of, that a really great idea can take off in one part, and then another part will say ‘oh, we want to join in’, and all that happens is, it slows it down.”

There were also concerns about adding additional complexity to what were in many cases already complex health and social care economies and questions were raised about whether the additional demands that Pioneer status may make on a locality were worth the benefits, particularly as there were no new resources. In areas where there were deficits in health and social care budgets there were significant concerns that this would put further strain on resources or impede delivery of Pioneer activity.

Nonetheless, it must be noted that a large number of interviewees did not mention any specific worries about joining the Pioneer programme unless they were explicitly asked, and even then, the issues raised were often relatively minor.

5 Key features of the Pioneers

Table 2 (page 43) and Table C1 (Appendix C) compare key features and interventions of all 14 first wave Pioneers. As these tables show, while there are similarities across many of the Pioneers, each one has unique features and prioritises different activities and interventions, largely as a reflection of their different contexts, starting points and visions of integrated care. Even, in a broad sense, the fact of being a 'Pioneer' is interpreted in different ways by different sites. For example, some sites appear to define their Pioneer in terms of defined workstreams or interventions, whereas others identify all the integration activities taking place in the Pioneer area as constituting the Pioneer. In some cases, the Pioneer is closer to an ethos linked to a way of thinking about and providing care rather than a specific plan or set of initiatives.

Table 2 shows a list of 14 of the most prevalent Pioneer initiatives, and their status – i.e. whether they are active, being planned or for future development - within each site. Both Table 2 and Table C1 were completed by the Pioneers themselves with input from the evaluation team. However, in this context, it is important to note that the various categories in Table C1 and interventions in Table 2 are as interpreted by the Pioneers themselves and interpretations may differ between sites (e.g. Pioneers may mean different things by 'multi-disciplinary team' or 'rapid response interventions'). Furthermore, integrated care interventions that existed pre-Pioneer are treated differently by the sites: some Pioneers will include all integrated care initiatives within their area as part of their Pioneer programme, no matter when they started, whereas other sites will not necessarily do this. Key features from these tables are summarised below, along with comments from interviewees on each topic.

Governance

Unlike the formality of the partner organisations that choose to come together in each Pioneer, Pioneer intra-organisational governance arrangements primarily rely on an informal steering committee or project board that encompasses high level managers from the CCG, local authority, local providers and, in a minority of sites, local voluntary organisations. When the Pioneer involves more than one CCG and/or local authority, the governance will include representatives from all of these organisations. In some areas, this group will be accountable to the local authority's Health and Wellbeing Board (HWB), while in others accountability is dual and reflects the separate governance structures of the CCG and local authority. The Pioneer steering committee or project board is usually supported by a small programme management team which oversees overall progress and by specific working parties or workstreams. Costs of the programme management team are often shared between partners, especially the CCG and local authority, and, in some cases, the budget may include resources for jointly funded appointments. Only the NW London Pioneer has invested more significantly in support for programme management by top-slicing 2% of the budget of each of its eight CCGs.

In many Pioneers, there was a lead organisation (either officially or nominally) that was the 'driver' and the 'glue' that held the Pioneer work together. It was important that the right balance was struck between the 'driver' organisation and maintaining shared 'ownership' of governance among the other stakeholders.

“So if you have a strong CCG Chairman, for example, indicating this will be primary care led, GP led, and that means GPs will be in the driving seat, and the inference from that is the rest of the partners will be secondary ... Well it’s one thing to say that to me, as another NHS provider, you know, and I don’t particularly appreciate it but I can go along with it. It’s a whole other thing to say it to an autonomous local authority with an autonomous mandate, and I think the cultural issue that we’re wrestling here, with people not really understanding the implications of what it means to do extensive collaboration versus traditional ways of ‘Well you’ll just pass it over to me and I’ll run it’, you know.”

In many cases, the approach to governance and strategic management was a pragmatic one, with partners choosing to use existing governance arrangements rather than inventing new ones. Steering /working groups often operated as informal bodies reporting to existing formal governing bodies. This usually meant a role for the HWB, but the precise governance arrangements could vary between localities within Pioneers.

“What we’ve tried to do is get the balance between centrally driven, so that there is some progress, momentum, decision making, etc., but bottom-up really because actually we’ve always said that it won’t work unless it’s right locally and there is no real power in the governance structure that we have ... I mean, all decision making has to be taken locally.”

This issue was particularly pertinent for Pioneers with larger geographies and/or populations, where system and stakeholder complexity was especially pronounced. However, it could also be a feature of smaller sites with high levels of devolution to community or ward levels.

There were a number of other tensions identified regarding governance. For example, challenges were identified in involving the full range of stakeholders, with provider and third-sector organisations mentioned. Where a locality was large and had many diverse stakeholders (a large ‘footprint’), there were also differences of view about the pace and scope for innovation, with some stakeholders being better placed than others to accelerate and scale-up integration.

“There is a great deal of goodwill in working with local government and other partners. I think the challenge is sometimes the capacity of other partners to be able to engage in that. And, if we’re moving at scale and pace, it’s all too easy, sometimes, to move without them, I suppose.”

As noted above, a common model was for informal steering/working groups to drive forward Pioneer work, reporting to existing governance bodies (in CCGs, local authorities, etc.). However, at times there were tensions between informal and formally constituted governing bodies.

“I think there is sometimes tension between the [locality] integrated care board, the executive commissioning committee who make the decisions about the [locality]

programme ... The resources and the power come from local arrangements and they can't be mobilised or signed off until their partners have agreed it through their processes because it is money and resources."

Where governance bodies were not sufficiently integrated, it was difficult to obtain decisions and prevent issues being recycled without resolution. Cascading information amongst stakeholders also presented challenges. There were also said to be difficulties at times between middle managers (who tended to sit on steering/working groups) and more senior leaders.

"But the challenge there is that they are usually middle managers because it is about operational changes, all of those, and then again how do they feed up to their leaders on the boards to say what they are proposing for the changes, and how do they get them into their organisations? Equally, how do the people on these high boards know that these people are in those forums, advising on what the changes should be?"

In some cases, the involvement of all relevant stakeholders, particularly local providers, appears to have diminished in the months following the award of Pioneer status. This could be attributed to several causes, among which the BCF and the existing commissioner/provider relationship have played a prominent role. In fact, the convergence, at least in general aims, between the Pioneer programme and the BCF increasingly shifted responsibility for governance to the HWBs, which do not include representatives from providers.

"I think we could be more involved in some of the discussions around what it should look like to make some of these changes happen. But it's very commissioner focussed. That [Pioneer programme] feeds up to the Health and Wellbeing Board, but there are no providers on that Board, they're all commissioners or adult social care representatives."

While obtaining Pioneer status often generated enthusiasm and a willingness to cooperate among all the stakeholders, it did not necessarily outweigh the enduring separation between commissioners and providers. While in some areas a strong degree of cooperation was found among all stakeholders, in others this appeared to be undermined by the competition logic that informs commissioning. This happens especially, but not exclusively, in areas where commissioners are relying largely on procurement processes.

"[Voluntary sector organization] They've done all the work and the commissioners have now said that's got to be procured whereas the agreement was [Voluntary sector organization] were going to provide it. In our Pioneer, we have this constant tension. We're meant to be working together for integrated care but every time we say anything commissioners don't like, they threaten us with procurement. So this whole integration or procurement, what are the national rules that Pioneers are going to be allowed to have to stop that happening? It's really unhelpful. [Voluntary sector organization] spent six months intensively working on that piece of work. It's

all of their intellectual property in my opinion and its just been taken now and gone to market.”

Coverage

Many, but not all, of the Pioneers are aiming their initiatives at the whole population within their area, although certain sub-groups are also typically prioritised for greater attention. Most commonly the priority group is described as frail older people, or people with multiple long-term conditions (LTCs), or high service users, or high risk groups (i.e. people at high risk of hospital admission). While not identical, these different definitions largely cover a group of mainly older people with LTCs, who tend to be the most intensive users of health and social care resources. A smaller number of Pioneers are also prioritising people with mental health conditions or families and children. People identified as of moderate or low risk are often referred to in Pioneer plans as potential recipients of preventative or early intervention services. Staffordshire and Stoke is unique in focussing on cancer patients.

Pioneers tended to develop their own approaches to risk stratification and found it challenging to define a suitable methodology, including using an appropriate algorithm, cost effective risk threshold, and age and size of cohort.

“But it’s that – that’s what we’re trying to work out. That’s the bit we’re really working out at the moment is, where is our cohort of people? How big a chunk do we take in this coordinated approach?”

Vision for integrated care

The vision for nearly all the sites refers to ‘whole system’ integrated care, or integrating care services around the person, or adopting a ‘whole person approach’. Overall, interviewees were able to articulate a strong sense of the vision for their Pioneer programme. However, at this early stage, the vision was sometimes still yet to be fully translated into concrete strategies and action plans, and the greater challenge was often identified precisely in this translation process. The features of integrated care are usually specified from a patient’s perspective, but the issue that the Pioneers were trying to address was how to split those specifications into a feasible number of practical activities, to be delivered through an enhancement of the existing health and social care system.

“We want to deliver more joined up care to people who need health care and social care. We want to do it in a way that is more efficient, its experience is more joined up, it’s based on a whole systems approach that recognises that fewer people ought to be going into hospital, people ought to be supported more at home, whether they’ve health care needs or social care needs. We want to be promoting independence more. We want better and close working between health and social care professionals and at a strategic level, we want to use our combined resources in a much more integrated and flexible way to buy the best outcomes for people. [...] This is simultaneously incredibly complex and inherently simple and obvious, and it’s managing not the tensions, it’s managing both aspects of that, that is key to making it work.”

Moreover, there seemed to be some parts of the local health and care system where the vision was less clearly understood, particularly among providers. Nevertheless, the central elements of the Pioneers' visions were a health and social care system built around the patient/user, coordinated around their needs, affording them dignity, respect, choice and control.

“That the patient, that the citizen would feel, this is one my catchphrases, would feel safe to live and safe to die at home...That we met the needs in the terms of the priorities that I've described, so that their dignity had been preserved, that their relationships were understood and valued, that the communities were helping them to live there. To prevent them needing or wanting to move into either being admitted to hospital or moving in to long-term placements. So this support would be there 24/7 and it's not necessarily, it's moving from a medically dominated model of care that we have now to a much more personalised, empowered citizen model of care, particularly for people with increasingly complex conditions.”

There was also an understanding that solutions to the integrated care challenge would necessarily be different between Pioneers as well as within them, so that the task was not one of imposing uniformity 'from above', but encouraging organic growth while maintaining coherency and consistency of services for local populations. Pioneer status for most interviewees was about sustained progress toward change; challenging, developing, expanding and mainstreaming the best of local integration activities and provision.

“Yes, so we are adamant that it's not a service. It's not an integrated service; it is a set of processes to enable existing teams and professionals to work effectively together, and to make coordinated working for people living with complex problems part of business as usual. It's not to bolt on a service – it is to enable existing service providers to work more effectively together. It is about weaving together a whole fabric of local services, including the voluntary sector.”

Interviewees also articulated that the vision needed to be one that all key stakeholders could sign-up to, but that would and should challenge current models, existing systems and accepted ways of doing things to achieve integration.

“I say to my staff, ‘This is a really scary thing because we're going to defocus the organisation and refocus outcomes for people.’ ... I think we've lived in an NHS where the emphasis ... has been on the organisation, rather than on the individual and outcomes.”

The vision often included a strong requirement for full partnership with and inclusion of a range of professions and disciplines to achieve the objective of multi-disciplinary working, which was seen as vital. Its implications for changing power relationships was, however, less explicitly articulated and may not always have been appreciated by some interviewees.

All Pioneers share the greater vision of integrated care as a crucial means of providing good quality care and improving patient experience in a context where need and demand are increasing more than the resources available. Such a goal is thought to be achievable by

reducing acute hospital admissions by better managing patients with multiple conditions in non-acute settings. Nonetheless, different strategies are being adopted at local level in order to operationalise this vision, and some Pioneers have made choices for delivering integrated care that differ radically from those made by other sites, which can also be a matter of controversy.

“The one thing that’s really powerful in [Pioneer Area] is the vision is accepted by every single partner including me. And the vision is for my organisation to downsize, to close beds and wards, to work differently so that we only keep patients in an acute hospital setting when they absolutely need to be here. I think that’s really powerful. We now need to come together more to work out how we’re going to achieve that because at the moment, everything’s going in the opposite direction which it is nationally.”

“I’ve been talking to a number of different people and trying to get a sense of the programme. In terms of Pioneer, the first thing to say is it’s very different. And in that sense, it’s quite marked. It stands out, for a number of reasons. The first is that almost all the other Pioneers, as far as I can see, are about pure provision. They’re an experiment in integrating provision. We are much more about looking at how the commissioning is done. In that sense there is a ... it’s useful, but it’s not the same. The second point is that most of the Pioneers have been building on existing work, so they’ve been going sometimes for many years, whereas we started from nothing.”

Integrated care strategy/service models

Most Pioneers are looking at both vertical and horizontal integration, covering acute, primary and secondary care, along with social services. Being based on geographical boundaries and populations, rather than institutions or services, they also reflected a primarily place-based approach to integration. A number of Pioneers mention the importance of integrating mental health services, often in relation to dementia. Most also say they wish to increase involvement of the voluntary sector. ‘Whole system integration/transformation’ of all parts of the entire health and social care economy is a common refrain. In a smaller number of sites, references are also made to the inclusion of other public services such as housing, education or the police.

Given the focus on person-centred care and the National Voices ‘I Statements’, it is not surprising that all Pioneers talk about shaping the system around the person or empowering people to direct their own care and support. Co-design of services and care pathways are frequently mentioned, and improved patient/user experience is universally anticipated as one of the primary outcomes.

However, it is also recognised that, in the short-term, cost savings are required from the system, so the Pioneers urgently need to design innovative and cost-effective interventions, i.e. those that will lead to improved patient outcomes and experience, but at a lower cost than at present. There seems to be a widespread presumption among the Pioneers that this is best achieved in two relatively ambitious ways: firstly, providing more care in the community rather than in hospitals; and secondly, promoting greater self-care to keep people healthier in the first place.

While specific interventions vary between the Pioneers (see Table 2), particularly the details of their implementation, they share a variable combination of many of the following elements: identifying patients most at risk (of hospital admission) and providing them with care plans; use of case managers; improved access to services (e.g. 7-day services, single point of access); increased support for self-care/self-management of conditions; the use of telehealth or telecare; rapid assessment and discharge; GP practices forming local networks; getting professionals to work together in multi-disciplinary teams (MDTs) (e.g. of health and social care workers, often based around GP practices); rapid response services to reduce unplanned and unnecessary hospital admissions; personal health (and social) care budgets; joint commissioning; developing community assets and community resilience and increased use of volunteers; and, providing more support to carers. At the level of the individual Pioneer, the precise combination of these initiatives leads to a highly complex intervention, with all the difficulties for evaluation that such complexity entails.

While service development often built upon pre-Pioneer work, interviewees emphasised that the Pioneer programme itself was at an early phase so that much of the work on service models was still in development.

“What we're trying to tease out of [named locality] is what's the deal-breaker really? What absolutely has to be in place in every place, in every county, in every community, to be able to support this model, and what's variable? You know, what changes? And in a way we won't really know that, I don't think, until we've done it a bit longer.”

Sites that were still developing service models particularly valued the freedom to trial a new way of doing things.

“You need to start putting your foot in the water and you need to start doing it with people, because that's how you'll get the evidence to progress it and to change things if things are needed. You've got then evidence or examples of good practice where things have gone well, and you've got examples of where things haven't gone well and now you need to change things.”

Some procurement models (e.g. the prime contractor model) that were designed around a condition specific pathway, sometimes worked against the objectives of whole-systems integration. One interviewee said that patients preferred a condition-specific approach, rather than a more generic approach to services for people with long-term conditions.

Table 2: Pioneer interventions (as of September 2014)

Pioneer interventions														
	Primary prevention	Self-care/ self-management	Rapid response	Single point of referral/ access	Single assessment	Individual care planning	Redesign of care pathways	Care coordinators/ case managers	Multi-disciplinary teams	Virtual ward	Tele-health/ care	Integrated dementia services	Integrated end of life care	Support for carers
Barnsley	2	2	2	2	2	2	2	1	1	2	1	2	1	1
Cheshire	2	2	1	1	1	1	1	1	1	1	3	2	1	1
Cornwall & Isles of Scilly	3	1	1	2	2	1	1	1	1	3	1	3	3	1
Greenwich	1	1	1	1	1	1	1	1	1	3	2	2	2	1
Islington	1	1	2	3	3	1	1	1	1	1	1	1	1	1
Kent	1	1	1	3	2	2	2	1	1	2	1	1	2	2
Leeds	-	1	2	1	-	-	3	1	1	-	2	3	-	2
North West London	1	1	1	1	1	1	1	1	1	1	3	3	3	2
South Devon & Torbay	-	2	-	1	1	-	2	1	1	-	-	2	2	2
South Tyneside	1	1	-	1	-	-	1	1	1	-	2	2	2	2
Southend	2	3	3	1	2	2	1	2	1	3	2	2	2	1
Staffordshire and Stoke	2	2	2	3	3	3	2	3	3	3	3	1	2	2
Waltham Forest, East London, and City (WELC)	-	2	1	1	1	1	2	1	1	-	-	-	3	3
Worcestershire	1	2	1	1	1	1	1	1	1	1	1	1	1	1

Codes: 1 = Currently 'live'/in operation; 2 = In active planning stage; 3 = To be developed; - = Not applicable

Note: The coding in this table was carried out by the Pioneers themselves. The interventions therefore are as defined by each Pioneer and may refer in some instances to interventions that were already in place or under development in part (or all) of the site before the Pioneer programme was launched.

One emerging issue appeared to be that, while Pioneers were moving towards integrated forms of provision, there was resistance from some groups of patients/service users who were reluctant to move away from condition-specific, specialised services towards a generic long-term conditions model of care.

“This is a transformation programme so we have to find [out] what are the current resources in the system to support people to understand how to live with it [their long term condition]? And the NHS commission very little, or none, of that at the moment. So there is nothing to transform at the moment. We are looking for either new money or transforming the disease specific operating model and making the last bit of it generic. That is going to be a challenge, because professionals don’t like that. And the public have told us – we have done some surveys – and they don’t want generic either. They don’t want to be sitting in groups with someone, is my long term condition HIV, is my long term condition COPD, I don’t want to sit with a gang, I want a choice. But we haven’t got the resource to give you a choice.”

Patient and public involvement (PPI)

Involving patients and the public in the design and implementation of services features to some degree in all the Pioneers. The involvement of Healthwatch is often mentioned, and all the sites referred to the National Voices ‘I Statements’ as informing their vision of integrated care. In some cases, the ‘I Statements’ had been integrated with local activity around engagement, so that one locality described the approach it intended to implement.

“So we've got, it takes a bit of time to build that up, but we've got an action plan, it's called the... [name of plan], which is about making sure we get that engagement and Healthwatch are going to help with that. So that means then that the Healthwatch reps, who are in the working group and the steering group, are grounded in a group of kind of champions in the community. So hopefully we should have that covered. But we haven't done it yet but, I mean, it's early days, but that's the plan.”

PPI was at times well championed during interviews, particularly the involvement of patients/service users (there were fewer references to work with the public more broadly). Pioneers discussed the ways in which the patient/service user voice in particular was helpful in ‘building a case’ for the need to improve the quality of services, which was thought in turn to add weight to the ‘case’ for integration.

“When we started off, we did experimental base design where we got in a company to do some sort of narrative with our patients about what their experience of care was. It was quite eye-opening in terms of some of the horrible things that did happen out in the community to vulnerable people. That was another lever in getting this [Pioneer work] in. That we knew not such excellent things were happening in the community. We’d done lots of engagement with our patients because we have a focus group in [named locality] around what we’re doing around integration.”

Community ‘asset-based’ concepts tended to inform approaches to service user involvement. The intended inclusion of the voluntary sector as well as patient/service users were also key features of many Pioneer sites.

“When we were thinking about having equal partnerships around the table, we always wanted that to include service users as well. I think that was really fundamental ... I suppose it’s kind of, to me, about who is in the room, so all of the partners – including non-professionals and including service users and carers – and it’s also about the approach that one takes. So it’s about not coming to the table with presuppositions about what’s going to happen, not imposing one world view, being very open to the idea of doing things differently and being able to challenge and not being afraid to contemplate things that haven’t been suggested before.”

However, a voluntary sector representative described the challenges in translating the complex and bureaucratic processes and discourses involved in the strategic developments in ways that would lead to meaningful engagement for patients and the community.

“You’ve got three different languages being spoken at Board meetings; you’ve got NHS language and social care language, and then you’ve got Joe Bloggs, the man on the street, which is me, trying to translate that into five key points to feedback to the sector so that they’ll understand it.”

The involvement of the public may also add complexity to the decision-making process, especially where different, and sometimes opposite, positions co-exist within the public itself.

“So actually we’ve got that engagement with the public; the public say yeah, we want joined-up services, but they also want to keep the community hospitals over here. So major challenges in terms of getting people on board with this, both the staff and the population. And the difficulties there in the actual practicalities of it, so for instance we’ve got a locality that maybe wants to close a few community hospitals, let’s say, theoretically, they want to do then something different with that money.”

In a number of instances it was evident that there were efforts to embed the concept of co-production of services into ‘normal ways of working’. However, co-production was made difficult by the demand for long-term strategic plans from NHS England, which did not always fit with the need for reactive and dynamic planning in response to PPI. Locally, it was not always clear what was wanted from PPI and there were different aims for this in different Pioneers. It could also be challenging to do PPI effectively in areas with large numbers of community and voluntary groups. One locality had recognised the scale and nature of the task and responded by setting up paid posts to coordinate the work.

“We’ve started that process so we’ve had various conversations, and what we’re proposing to do now is we’re actually going to create a job role for a voluntary sector representative and a separate one for a social care provider representative, because there aren’t the right umbrella authority organisations to say can we just have someone come and represent everybody because [our locality] is so vast.”

Some interviewees felt that the scope of PPI should be better specified, and that while patient views need to be taken into account, their direct involvement in service design may not always be appropriate.

“Some people’s theory is that we’ll involve patients, patients must design everything. Patients don’t understand how to design things. We interface with the individual when they’re in a stressed environment. The last place you want them to design something is when they’re in a stressed environment because they won’t think clearly, we know that from experience. They are part of the process because they need to be comfortable.”

For others, however, these doubts about PPI were thought to be outweighed by its substantially greater positive effects. Having patients around the table seems to have fostered profound changes about how issues were perceived and addressed by decision-makers and experts, rather than by providing original contributions from non-experts.

“And it’s meant that people who at the beginning were sort of like ‘Seriously? You want like patients to come to meetings where we’re going to be talking about things they don’t understand? Really?’, just had to kind of suck it up and get on with it, and actually it’s completely changed their perception I think, their way of working and their appreciation of what the lay partners bring to the table, so it was lucky that we had such good lay partners!”

Information technology (IT) and information governance (IG)

Information sharing is recognised by all Pioneers as an essential building block in their integrated care models, and all similarly acknowledge the IG issues that hinder sharing patient/service user information between health and social care services. There may also be technical issues (e.g. incompatible IT systems) that make sharing information difficult or impossible.

“The sharing of information across the whole health community is probably the number one thing to solve”

Q: Why was the IT system that was used before abandoned, because that was quite a lot of time and money, as I remember, that went into developing that? A: “Put a million quid into it. It didn't work. The simple message is, ‘You can’t do a bolt-on onto something else for integrated care’. Actually, you’ve got to get your entire IT platform to be about integrated care because there’s a huge amount you need to know and nearly all of it is somewhere else.”

In general terms, the discussion of IT and IG tended to be framed mostly in terms of the barriers and challenges that it presented. In some cases, this was attributable to matters such as deficient and out-of-date IT hardware or software. Problems with IG were reported in a range of contexts, including in relation to risk stratification, where the inability to resolve problems had severely hindered this activity.

“NHS England are saying GPs need to risk stratify and on the other hand, we’ve got the Health and Social Care Information Centre saying ‘No. You can’t do that, we’re going to make you jump all these hoops’. It was difficult because sometimes it feels one part of the system at a very national level is not speaking to the other part and we get caught in the middle, having to fill in lots of forms ... They were stopping us linking our GP data with our acute data set so they were stopping our acute data coming through, which means people will be intervened on who might not be the right patients.”

There were examples of Pioneers reporting progress on IG issues, while acknowledging the difficulties involved in overcoming the challenge.

“We’ve got an information sharing agreement that’s signed by every GP practice and all our key players and patients [the top 1% risk stratified] are consented. It’s really clear they’re sharing information with all out players in the system but that was quite hard to get in and lots of work.”

It was clear that some stakeholders – in particular, the social care sector, the voluntary/community sector and patients/service users – faced greater barriers to being incorporated into initiatives on IT and IG for integrated care purposes. However, some interviewees were keen to stress IT as an important enabler and to deconstruct the idea that IG was an insurmountable problem, and did not want IT/IG challenges to become an ‘excuse’ for inaction. Others noted that, through the BCF, the NHS number has now been mandated to be the single most important patient identifier across health and social care.

“I think the barriers that people often say, like information governance, technology, I don’t think they’re real. They’re not real barriers, a lot of that is myth versus reality, I think. Because actually when you start to push people on information governance they can’t actually come up with what the real issues are. It’s like actually what happens is the staff on the ground don’t necessarily feel confident, so you need to give them training and ‘upskill’ them, but actually the legislation isn’t necessarily stopping us doing what we want to do.”

Pioneers were attempting to devise their own tailored solutions to the IG issue, including shared agreements between organisations, acquiring the status of a safe haven, sub-contracting to accredited providers or other ‘solution focussed approaches’.

“We’ve got honorary contracts for volunteers and voluntary sector workers with GP practices and the GP health organisation and we’re just in the process of agreeing information sharing agreements across all of the partners in [the locality]. We’ve got informed consent that’s agreed by all the partners for each of the participants. It was a challenge but it wasn’t as much of a challenge as it could’ve been.”

Most Pioneers were developing and implementing specific IT workstreams. Some saw the Pioneer programme as a positive way to expand the geographical (across several CCGs) and institutional (across health and social care organisations) scope of the IT system, and several

sites used the Pioneer programme to consider more innovative and ambitious technological solutions, such as developing a platform that would be shared with patients.

“So what Pioneer brings us is it brings us all together and aligns all of our objectives and that we have a shared vision together to deliver it. Things like having a joint shared IT vision, because IT is absolutely the key enabler.”

Overall, it appeared that Pioneers had to try to solve difficulties they encountered at a local level in isolation, either to overcome IG issues, or to identify strategies to achieve interoperability between primary, community, acute and social care IT systems. Several informants lamented that little support had come from national bodies (including the Health and Social Care Information Centre) in terms of clarifying governance rules or providing technical solutions. One interviewee noted that a pilot (in a non-Pioneer) site had developed a web-based integrated care record, and that:

“[it's] really inefficient to reinvent those wheels and so it would be good, if collectively, areas, probably at the sector level, ... would adopt the same sort of solutions.”

All the Pioneers are working on ways to improve information sharing, often with some investment in new systems and with the aim of developing a single system that can be accessed by all relevant staff, including patient access in some sites. For instance, Southend Pioneer has developed a 'Caretrack' information sharing platform which maps the user's journey through health and social care services.

Workforce development

The likely significant future impact of integrated care models on staff and on existing working practices was widely acknowledged, and many Pioneers had workstreams looking at these issues and their implications for training and new ways of working. A few talked about changes in team structures and working patterns and the need for new job descriptions. But more Pioneers referred generally to providing team building exercises or local training for their new integrated care teams.

Interviewees clearly recognised that workforce issues were an important consideration in the drive for successful integrated care activity.

“I think it is a neglected area. I don't think you can do this integrated work without this. You really are, if you're genuinely going to get people working in a different way.”

The changing role of GPs highlighted particular professional development needs in terms of adjusting to their new role within more integrated contexts and understanding the new health and social care economy in order to better manage patient care. It was also regarded as beneficial to equip other professional groups (e.g. senior occupational therapists) to develop local leadership roles to help embed integrated working into local practice. Co-location of staff teams was underway or planned in some localities, although interviewees

cautioned against seeing this as a panacea for overcoming the challenges of integrated working, and that embedding change in working practices was needed.

“When we talk about integration, we talk about, actually, how people work... We talk about culture transformations, so how people think and work differently as a team, across the whole system.”

There were important examples where jointly funded (CCG/local authority) posts were in place and where integrated care navigators/case managers were working. Other innovative roles that were already operational in localities included:

- interface geriatricians (working in acute and community settings);
- rotation nurses (rotating between acute and community settings);
- support workers in intermediate care (trained in nursing, physiotherapy, occupational therapy and social work);
- discharge co-ordinators (based in acute providers);
- baton phone (each day a nominated specialist carries a baton phone to provide specialist advice to community care when needed).

It was noted by a number of interviewees that the development of a new type of workforce, able to work holistically, may be required in order to meet the demands of an integrated care context. Those who had already undertaken it, highlighted the necessity and value of consultation with staff about the changes integrated care was likely to bring. Some interviewees reported that staff who had adopted new roles had found this rewarding in that it enabled them to provide holistic care for a patient. GPs were also said to value having a single point of contact for social care.

Sites which had successfully introduced changes to working practices attributed this to using clinical staff to share learning and focussing on a vision of integrated care from the patient’s experience:

“It wasn’t managers standing up or chief execs standing up and saying this is how it’s going to be. It was frontline workers saying, ‘We did it like this and the outcomes were this.’ All the other staff were saying things like, ‘How did that feel and what were the issues there?’ So the team became the change team, change agents. We did that, communication was absolutely pivotal, and it happened at lots of different levels in lots of forms and it was continual. It created a momentum of its own at various levels.”

“Sharing of the learning and reiterating the vision. I would say now I’m absolutely sure 100% the people here would know about Mrs Smith, but at the early days they didn’t, so you had to keep repeating and emphasising, and the vision was very important because it hooked into people’s values, so it was very value driven.”

While the need for workforce development was referred to, so too were the barriers. Interviewees noted that workforce development was not a short-term process and that to embed this and translate it into changes in practice could take years.

“The other thing we’ve done around workforce is a lot of work [with] frontline staff particularly around our district nurses and community matrons to try and get them to work in a different way and to understand what we’re trying to do here. Trying to change those historical and traditional models of community nursing is hard work. That’s taken a number of years and many workshops with them to really get what we’re trying to do.”

“So, one example is the role of medical consultant. Historically the model is that consultants in the hospital, patients come to them and actually what we need to do is turn it on the head. Turn them into a ...service that goes around and sits in GP surgeries and learn to keep people out of hospital. So negotiating that is quite a difficult process. It’s ...the kind of culture and mindset that they’ve grown up with”.

Some sites reported difficulties recruiting staff. The high level of staff turnover in community nursing in some localities was felt to have a negative impact on the experience of vulnerable people.

“Community nursing remains an unattractive option for most and yet that is where we want more and more patients”

Barriers in workforce development were reported by some to be hindering the ambition of the Pioneers to accelerate integration. For example, one impact of the most recent NHS reorganisation was perceived to have been a deficit in NHS workforce management capacity. Some Pioneers were also concerned that staff may find it difficult to take instruction from managers in different domains and with different professional cultures (e.g. between NHS and social care staff/managers for example).

Some interviewees reported good relationships with the local university that allowed them to align the curriculum for staff training with the objectives of integrated care. It was however noted that the training curriculum authority for some staff groupings was not open to modification by Pioneers to equip them for the new demands of integrated working, as this was often set at the national level by professional accrediting bodies. Also, it was noted that more effective mechanisms needed to be in place to keep staff informed about the developments in integrated working.

“I think we need to be really clear in the vision that we’re articulating and why we are doing this. Because, I guess, misinterpretation in those messages can mean that people perceive it as a threat. And, honestly, for the frontline workforce, hearing about these changes that are coming down the line, people’s initial response is going to be ‘Well what does that mean in personal terms for me?’, that’s absolutely inevitable, so we really need to think about that as well.”

At times, there was disagreement between individuals and organisations about the relative merits of new roles versus better co-ordination of existing professionals. For many organisations, the objective was to reduce the number of different types of staff going into a person’s home. Care was often felt to be too fragmented, with for example, a separate individual visiting a patient simply to administer medication. One Pioneer was addressing

this issue by exploring the adoption of the Buurtzorg model of care, which reverses the trend for using the lowest cost grade of staff by employing qualified nurses who can work autonomously and holistically, and reduce the need for inputs from large numbers of staff.

The tension between a strategy for radical change and scaling up existing initiatives that are working well was highlighted by one interviewee:

“It’s back to the learning. We have all these integrated conversations and I will try and say we’ve got integrated health and social care teams, we’ve had them for 20 years, we could tell you how to do this. But there’s very much a feeling that [Pioneer programme] is going to develop something we’re not doing or couldn’t do. The view of providers generally is there’s too much thinking around let’s do something radically different and not enough look at all the good stuff we’re doing, let’s scale it up. It’s frustrating!”

Financial resources

Financial considerations were a key topic of interest for interviewees and there were a number of significant concerns and questions raised. A primary point made was that the Pioneer programme (initially) attracted no new funding, including no transitional funding, to support moves to Pioneer status, and that all activity had to be based upon existing resources (subsequently £90k was transferred to each site in summer 2014). One site reported that, while they knew that Pioneer status came with no additional money, it would be helpful to have some more flexibility about how they used the money they already had, for example, some flexibility in relation to the regulations that governed the use of surpluses.

There were also severe financial restraints, such as the capping of CCG resources and the significant cost savings to be found by local authorities. Many of the sites had service models based on developing communities and self-care; however, the services that these models relied on (such as befriending services, lunch clubs, peer support, social activities, etc) had frequently been cut.

Concerns about some participants having to contribute more than others emerged as a tension at times. A key concern was also the shift of resources from acute health services to social care/community services. Although this was a goal of integrated care, concerns were raised about the consequences, particularly where hospitals were striving for foundation trust status and being encouraged to strengthen their financial position to achieve this.

“The big challenge that we have got coming up is the issue - and it is an on-the-horizon-issue, but the elephant in the room always is that you can only really take costs out of the system by closing beds. And that will be absolutely the same, it will be common to every Pioneer site, but the challenges around that are... you have to convince your provider to do it, and if their strategy is to increase their income by getting more activity through the door and yours is by reducing it, then you have got a problem.”

While there was a strong presumption that integrated care could help drive out costs in the system, and one Pioneer had undertaken nationally recognised modelling which supported this assertion, it was recognised that the evidence base was deficient and that more work was needed about costs and benefits and how the claims of cost savings might be tested.

“And part of the problem all the way along with this integration is we have no evidence base...we're all just trying it, there's no evidence that says it's cheaper, there's no evidence that says, there's some evidence that says it produces better outcomes, but there's not a lot of that, you know. So actually, and nobody can work out how to get the bloody evidence base either!”

There was scepticism, in particular, that providing care for people in their homes (rather than in a hospital bed) would result in cost savings and a concern that in some cases this could result in inhumane care:

“I saw a case recently, I do work for [name of organisation] out of hours, a call came in in the evening, I went off to see this elderly lady, ‘Oh, she’s got a key safe.’ ‘What’s the number?’ ‘I don’t know. Do you?’ ‘No.’ So half an hour later we manage to do some detective work and we find the number. By this time it’s dark. I get the key, open the door, it’s all dark inside, I go, ‘Hello, hello.’ You hear a little grunt upstairs so you put the light on, go up these stairs into this bedroom and there’s a lady lying in bed with the cot sides up and there’s a catheter in, her home oxygen on, and a table there and a table there and a telly there. She has a carer in 4 times a day for 15 minutes, 4 times a day, and that’s called care at home. She would be far better, I would think, in a residential or nursing home where she gets more interaction through the day, not four 15 minute sessions who are coming in change your catheter and make sure the oxygen’s all right. I was absolutely appalled.”

One interviewee noted that, with an increase in very old people with multiple conditions, an increase in hospital admissions seemed inevitable:

“We’re getting this constant pressure about it locally from all the data coming back to the practice is ‘You have to reduce your urgent admissions.’ ‘Well, tell me I’m sending in inappropriate ones.’ They can’t. We never get any feedback saying, ‘That was inappropriate, you should have done this, you should have done that’, because we’ve done it. We’ve kept people out of hospital, we’ve done everything we possibly can, but people sometimes just need to be in a hospital bed.”

Commissioning and procurement

There appeared to be different approaches to commissioning services between the Pioneers (although this may have been an artefact of the varying level of detail available to the research team at this stage of the project). Most Pioneers said they currently did some joint commissioning (i.e. between the local authority and CCG) or were planning to do so. Much of the joint commissioning pre-dated Pioneer status, and was often related to children’s services or mental health services. For most Pioneers, joint commissioning was an aim or part of a workstream that was examining the options for new approaches to commissioning. Several Pioneers had a joint commissioning lead or function. Some Pioneers did not mention

joint commissioning at all, but instead referred to ‘aligning incentives’, and a few did not consider joint commissioning to be the best way forward (or necessary) to build sustainable integration.

Many sites felt that primary care represented a gap in their commissioning and thus tended to be left out of their plans for health and social care integration. This was most likely a direct reflection of the fact that when the interviews were being undertaken, CCGs had no control over commissioning services from their local general practices since this was the responsibility of NHS England.

Interviewees discussed the potential challenges of procurement in relation to commissioning integrated care services. There were concerns expressed in some sites about the supposedly disadvantaged position of third sector providers in terms of the impact of competition, fragmentation and short contracting cycles on their ability to stay in the market. Also, providers appeared to struggle in some localities to accommodate new commissioning approaches.

Current procurement policy emphasising competitive tendering was thought to be hindering integrated care activity, in part because it was a disincentive to collaboration among provider organisations. Collaboration between organisations required openness and transparency, while competition was thought to promote secrecy.

“If the CCGs say we have to test the marketplace and so does [the local authority] and so does NHS England for all the services that we have provided contracts with them for. We have to go and test the marketplace and it makes every provider want to be more clandestine and secretive ...so when anybody asks us and any other trust, can we have your integrated business plan...we say, no it’s private, it’s commercial.”

“So, if you’re going to really change things, that means taking the money and spending it in a different way. It means having organisations not competing with each other – which is very problematic, considering where we spent the last ten years.”

“All it takes is one of the providers amongst our established providers to decide they’re unhappy with the way things are going, or to feel that their organisational interests are bigger than the others, and they can cause us complete chaos..... So a lack of certainty around what the rules are and are not, it makes it very difficult. And there are very different messages coming out. I mean, the politicians say very different things than the lawyers say, and there’s a big gap between what they say. That creates uncertainty.”

One way commissioners were responding to the need for greater collaboration between organisations was by forming a ‘provider alliance’ and asking the alliance to respond to an integrated care specification which was then put through a non-competitive procurement process. There were also examples of CCG/local authority joint commissioning in operation, with block contracts and new provider partnerships in place.

Implementing such new approaches locally was not without challenges; one interviewee described the resistance encountered to the new approach to developing service innovation in their area.

“We completely disregarded the commissioner- provider split in doing it... And that’s caused some angst from some of the local authorities and from some of the CCGs, saying, ‘You’re running completely roughshod over all our commissioning responsibilities.’ And I’m glad we did because, if we hadn’t, we would have massively constrained what people came up with.”

At least one Pioneer site was working closely with Monitor to develop new contracting and payment systems more consistent with the objectives of whole systems planning.

Funding and payment methods

There were general concerns in most Pioneers that the current payment systems, particularly the payment-by-results (PbR) hospital payment system and central policy requirements regarding the financial position and operation of acute providers (including the foundation trust pipeline and Monitor’s responsibilities for provider sustainability) were often contrary to integrated care objectives. Yet, few Pioneers were at the stage of implementing major changes to provider payment systems to support integration. This probably reflects the fact that integrated service contracting was generally still an emerging issue. Nonetheless, a number of sites reported that they were having discussions about new contracting models, such as the prime contractor model and alliance contracting in which a wide range of providers share financial risk in a bid to ensure openness and effective collaboration.

When asked about specific financial arrangements or innovations that were in place or being developed to support integration, some interviewees said they were not yet at the point where such financial innovations had been developed.

“We’re sort of harvesting a seam at the moment where everyone says, ‘If I had a capitated budget, it would all work.’ So we’re saying, ‘Well, have a capitated budget then.’ So, because people conceptually get what the financial vehicle is going to be, people seem quite willing to play ball with what is all the devil in the detail about how you might go about creating it. But...we’ve spent much more time on ‘What does the care on the ground supposed to look like?’ The [new payment arrangements] will kind of fall out of it really.”

Others expressed awareness of the challenges in setting up new payment systems and were preparing to confront them.

“There would definitely be things in terms of changes that need to happen in terms of the way that GPs were contracted, changes in the way that our contracts were held, payment systems were held and that sort of begins to impact on things such as competition. So I think it was more those bits that we could see as being the barriers that we were going to hit.”

In several cases, Pioneers have used existing financial tools, principally those available to CCGs, to incentivise the provision of integrated care. Interviewees mostly mentioned the Commissioning for Quality and Innovation (CQUIN) payment for quality scheme, but other contracting arrangements were also used to achieve the Pioneers' vision of more integrated services, including the re-introduction of traditional block contracts, in some cases. These tools were used both to promote the reduction of unplanned admissions from NHS acute trusts, and to enable community health services trusts to work in a more joined up way with social care.

"We've used some of the traditional contracting levers, so in terms of CQUIN, we've aligned CQUINs to support the integration. We have contractually shifted the hospital onto block contract for unplanned care, so that was a shift last year. We would like to do that not this year but next year for the management of long term conditions; that's another strategic aim, but [...] the problems of the payment by results contract is that it doesn't really flex in the way that we want it to, now. So we have local variation to that. So we've got some incentives, we've got some kind of, probably, penalties, in that we've fixed the price that we'll pay for emergency admissions, and some of the other levers there."

"We've asked the trust who provide the community staff within the CQUINs to actually say, can you get your community staff to work with one particular town? So, rather than working for three towns, we want to really build the relationships around one town, so that the district nurse really gets to know the social worker, because we believe that health care is based on trust and teamwork. So we're kind of building virtual wards in each of those towns."

"I've got eleven contracts to negotiate for 14/15; I've done nine of them; not one of them is on PBR, even the acute hospitals. So people have come to see PBR isn't the right vehicle. So all of my contracts are block contracts with an incentive payment for delivering out of hospital care, using the IT system, reducing emergency admissions."

The lack of control over primary care commissioning (see above), which appeared to be exacerbated by the low level of involvement of NHS England Local Area Teams in the Pioneers, was frequently cited as a problem. Some Pioneers tried to work around this by using existing financial tools, although in an indirect way.

"Our weakness in it is there's a key part of the pathway missing which is primary care. CCGs don't commission primary care and although they're looking to do that in a co-produced way, it's quite interesting as to how that will work. Area teams' involvement in truly commissioning primary care has been poor. We've just done a piece of research on the community and our most challenged community have identified primary care as an issue and it's kind of so what, who's going to do anything about it."

"First of all, a commitment for us is to use the vehicles that we do have available to us, so CQUINs, the CQUINs system, direct upfront investment by the CCG in services,

in primary care, that helps to release the practices to work differently. So a commitment by the CCG to invest directly in primary care.”

More generally, Pioneer status was said to provide an opportunity for devising, developing and experimenting with new, more ambitious financial arrangements. Pooled budgets were not often explicitly mentioned by Pioneers, except in relation to the BCF specific pooling exercise, or were only mentioned as a long-term objective. More common was the aim to move away from hospital Payment by Results (PbR) or block payments towards outcomes-based commissioning and in a few cases to allocate needs-weighted capitated budgets to integrated providers or groups of providers. Another form of payment being considered or developed was whole care pathway funding (e.g. year of care). Some Pioneers were examining an approach that involved commissioning a lead or prime provider, who would be responsible for delivering the services provided by a range of providers. Any cost savings that might arise would be pooled and split between the providers involved. Several Pioneers mentioned exploring the use of social impact bonds (SIBs) as part of an approach to outcomes-based commissioning and payment for services.

“We’re looking at pooling different commissioning budgets. How does that sit with personal budgets in social care? It’s a very difficult question but I think we really need to be thinking about well actually, if people are receiving state funded social care, that would be a clear personal budget, and that needs to be seen as a key mechanism for choice and control and independence, not just a sideline social care thing that happens.”

Personal health budgets, in particular, were regarded as a powerful tool which could drive far-reaching transformation. Some interviewees pointed out that such a significant change would need a substantial cultural shift on the part of frontline staff and clinicians in order to be fully achieved.

“One of the areas I was keen to have in there was personal health budgets. We’ve put staff into that. [...] I think personal health budgets will challenge the stability of some of the current models, because a large chunk of people with long term conditions in mental health will not choose mental health services that are currently provided by NHS trusts.”

“We had a personal budget regional workshop a week ago. It did have NHS colleagues in the room, but one of the biggest issues that came back is that people said you’ve got to stop the NHS talking about patients. Talk about people and individuals because it’s that power relationship thing. You’ve got to change that. It’s a bit jargon in local government and I don’t like the word, but a citizenship model is about seeing them in a different way.”

However, some interviewees also pointed out that such a transformation could also have an effect on core aspects of the current model of provision, such as the requirement to be able to cost services accurately in order to be able to set a reasonable budget for an individual user. Clinicians and other staff may not be comfortable with this extra challenge.

“I think there is still quite a lot of anxiety around from a clinician’s point of view [...] Health care’s always been free at point of contact, we don’t have to deal with money, and I’ve said ‘But now you’re going to have to because someone, somewhere along the line, is going to have to cost up some support plan and say ‘Well that’s a sensible amount’ or ‘No it isn’t’”, and providers are going to have to get more canny about saying how much services cost because people will want to know before they buy them. So it is a massive, massive change, and there is general anxiety around about it, but it’s about just pitching it at that level, certainly from a long-term conditions and mental health point of view, from an awareness raising level to start with.”

In some sites, pooled budgets already existed, often between community care and social care. In a few cases, these had been tried and had already come to an end, but there was still a commitment to joint commissioning between health and social care. In other Pioneers, existing pooled budgets were being reviewed with the aim of including them within the Pioneer programme.

“So, for example the pooled budget in children’s services a couple of years ago was separated out and that is no longer in existence. Similarly with services for older adults, that was pooled and again separated out a few years ago before the CCG came into existence. So, I’d like to think that there’s opportunities at a commissioning level, to... not necessarily to replicate that, but to reinvigorate joint commissioning and give that some raised profile again.”

“At the moment, we have a learning disability pooled budget. We’re reviewing that at this moment in time, to see whether we kind of... ‘Has that been effective? Is it doing what it needs to do to drive our ambition?’ And the learning disability becomes part of the wider integration work.”

Some interviewees remarked that designing the service model should take priority, and that financial arrangements should follow, in order to avoid the risk that funding, rather than professional commitment, comes to be used as the primary lever to promote change. This risk was mostly mentioned in relation to pooled budgets and the BCF (also see Section 6).

“To talk about integrating and building things together and having a pooled budget, you’ve got to have a lot of things in place before those sort of things can happen. You’ve got to have trust, you’ve got to have workforces that are happy to work in a similar way together. And to just plonk the money in a pot and say crack on and get on with it, I can’t see how that’s going to work and it worries me enormously that we’ll take steps backwards instead of steps forward.”

“So, this is a reflection of me, personally, and therefore, because it’s me, personally, it’s actually partly a reflection of our organisation; we have been consistently resistant against the whole concept of ‘forcing the money together solves the problem’. It doesn’t. It’s about leadership; it’s about creating a different culture; it’s about providing an environment where you ask your staff, ‘What do you need that enables you to work differently?’”

“You can always make the money follow the model if you get the model right. They might be sub-contracting arrangements, there’s lots of different contractual models you can use, but the starting point has got to be where do you want the care.”

Success criteria, monitoring and evaluation

Pioneers shared two broad concepts of success: firstly, the improvement of outcomes, with a particular focus on patient/user experience; and secondly, the shift towards a model of care which is less centred on provision of acute services.

“But obviously, one of the things we expect from the team is to avoid avoidable hospital admissions. Some admissions are absolutely right and need to happen, so that’s one of the hard measures for the teams, which we should be able to track.”

References to the National Voices ‘I Statements’ were frequently made by interviewees, as informing their ideas of person-centred outcomes. This was understood to mean better quality health and social care for the patient/user according to their experience and perception.

“For me, from my point of view, the patient gets the outcomes they need and want.”

“Ideally I’d like to measure success from the patient’s point of view, otherwise why are we all here doing this. Did they get better quality care, the care they needed? That’s how I’d like to define success but that’s quite difficult to measure.”

It was therefore, recognised that patient/user experiences needed to be assessed, and there were some references to local evaluation, but it was clear that this was an area for future development.

“Q: Is the evaluation the main tool that you’re planning to use to assess the success of the individual... [initial implementation projects]? A: ‘I think, at a [name removed] level, probably that would be yes ... I think there will definitely be some strong local arrangements for doing that. But I’m not aware of, at [name removed] level, [planning] for rigorous monitoring. Maybe that’s something we need to think about, going forward, as well.’”

The shift towards non-acute settings of care was often linked with economic goals, and thus presented not only as a means to improve quality of care, but also (and sometimes mainly) a means to promote financial sustainability of the health care system itself. Services were perceived to be under threat so that developing sustainable, cost-effective models of health and social care was seen as a crucial marker of success.

“I think the main criteria that I personally would use would be a sustainable model of health and social care.”

Effectively changing the culture and working practices of stakeholder organisations and patients/ service users was also referred to as important.

“Did it change the behaviours of the people, whether they be staff, or the public? Because we want them to change their behaviours as well. So did it stop them thinking ‘Oh I’ll just tip up at A&E’? Did it change behaviours of staff and the public? Has it changed the attitude of staff and the public? Has it changed the culture now between organisations to work collaboratively?”

While in broad terms, the criteria for success were generally clear, interviewees also reported that it can be difficult to develop long-term perspectives on what success might look-like in the context of a continuously changing public service landscape, especially when the most recent NHS reorganisation was still bedding down.

“Things change so quickly in the NHS. We’ve put all this in place. Whether or not it stays like this, who’s going to remember all this and measure it at the end, that’s a key question. The general election’s coming up next year, we might all change again and no-one will measure it!”

Moreover, different stakeholders might also interpret success differently, according to professional groupings and perspectives.

“There’s lots of other drivers in the system that people perceive as success. The fact we can see less people have gone into hospital and on the CCG’s books, that looks like a saving to us, is that success? My finance director would say ‘Yes’. From the GPs’ point of view, they define success by the fact that the model works and they have greater access for their patients to the other professionals, that’s how they see success. The social workers will have a different view of success than their social care management. Social workers and nurses on the ground really like working in this integrated way because before they didn’t know who to call when they had a social care issue. What I would see as success is, can the model continue and be embedded from a commissioner point of view, is what we’ve done going to have any longevity?”

Most Pioneers are planning a range of monitoring and evaluation activities (e.g. for assessing the performance of their different initiatives). While several Pioneers have already designed a local evaluation protocol and contracted out its implementation, most are still grappling with the issue of what evaluation should be undertaken. Several expressed frustration that their initiatives were progressing, but they had not yet collected baseline data. In addition to advice and expertise on how to undertake local evaluation, sites also said they lacked capacity to carry out the evaluation.

6 The impact of the Better Care Fund

The Better Care Fund (BCF) is a universal mechanism rather than one that is Pioneer specific. However there are important dependencies between the two initiatives that our fieldwork sought to address. In particular, we were concerned to explore how far the BCF was integrated within local Pioneer programmes and assisted them to achieve their goal of extending integrated care at 'scale and pace'. In principle, it was also possible that the BCF might dilute or divert the planning and financial resources available to Pioneers since both activities were likely to be drawing on at least some of the same personnel. In addition, the second round of interviews, conducted in September and October 2014, provided an opportunity to study reactions to the changes in BCF conditions and the requirement to submit revised plans. This section is based on interviews conducted in the summer and autumn of 2014. Table 3 provides an overview of key features of the sites.

Pioneer BCF plans in the wider BCF planning exercise

The submission of final BCF plans was required by 19 September 2014 and could be placed in one of four categories following review by the Nationally Consistent Assurance Review (2014): approved (6 HWB areas); approved with support (91); approved with conditions (49); not approved (5). The NCAR review showed that all but 3 BCF plans within Pioneer areas were placed in the first two categories. They were more likely to be approved with support (82%) than those in other areas (57%) and less likely to be approved with conditions (9% compared with 36%). Of the 5 plans approved nationally without condition, 1 was a Pioneer and, at the other end of the scale, 1 of the 5 not approved was a Pioneer. Overall, therefore, plans in Pioneer sites were more likely to be given a higher status than elsewhere. At the same time, this status was not confined to Pioneer areas. In addition, while 6 of the 22 BCF plans in Pioneer areas were among the 14 accorded 'fast track' status at an earlier stage in the approval process, this figure which had fallen to 1 (Greenwich) out of 5 sites nationally by the end of it.

Eight out of 22 (36%) BCF plans within Pioneer sites pooled funding over the minimum required (mostly London local authorities), which is slightly below the 42% of local authorities pooling funds nationally. Additional monies pooled by Pioneers sites amounted to £53.5 million representing some 7% of the total pooled funded in the 22 Pioneer local authorities, significantly below the average for England (£1.5 billion was added to the minimum of £3.8 billion, representing 28% of the total pooled fund of £5.3m). Overall Pioneer BCF plans accounted for 14.8% of the total BCF pooled funds across England (Table 3).

Table 3: Better Care Fund profiles for Health and Wellbeing Board areas within Pioneer sites

Pioneer	Health and Wellbeing Board (HWB)	Population (HWB)	Target population from risk stratification*	Minimum BCF funding (£ million)	Total BCF funds pooled (£ million)	Above minimal funding	Status approval**
Barnsley	Barnsley	233,700	Not specified	20.3	20.3	no	Approved with support
Cheshire	Chester & Cheshire West	330,000	0.5-5%	24.3	24.3	no	Approved with support
Cheshire	Cheshire East	370,000	1746	23.9	23.9	no	Approved with support
Cornwall	Cornwall	532,300	20,879-31,174 to be further refined	42.5	42.5	no	Approved with conditions
S Devon & Torbay	Devon	750,000	2%	55.7	55.7	no	Approved with support
S Devon & Torbay	Torbay	131,000	2%	12.0	12.0	no	Approved with support
Greenwich	Greenwich	274,950	11.5% (high risk); target 800-1000	19.8	19.8	no	Approved with support
Islington	Islington	215,660	2%	18.4	18.4	no	Approved with support
Kent	Kent	1,500,000	6-7%	101.0	101.0	no	Approved with support
Leeds	Leeds	800,000	2.6%	54.9	54.9	no	Approved with support
NW London	Tri-Borough (3 LAs)	560,00	4%	156.1	193.0	+23%	Approved with support
NW London	Hounslow	250,000	15%	16.9	16.9	no	Approved with support
NW London	Brent	242,000	6500 (2%)	22.4	22.4	no	Approved with support
NW London	Harrow	256,000	16,000 (6.25%)	14.4	14.4	no	Approved with conditions
NW London	Hillingdon	292,000	-----	-----	-----	-----	Not approved
NW London	Ealing	339,300	19,582	24.4	29.2	+20%	Approved with support
S Tyneside	S Tyneside	148,617	773 (very high) +6,961 (high)	13.8	21.4	+54%	Approved with support
Southend	Southend	175,000	3720 (2%)	12.7	12.7	no	Approved with support
WELC	Tower Hamlets	242,000	Very high 1662 (0.5%) + high 11,871 (4.5%)	20.4	20.5	+1%	Approved with support
WELC	Newham	310,460	1008+6411 (Very high + high)	22.6	25.6	+13%	Approved with support
WELC	Waltham Forest	247,503	2959 (very high risk)+8000 (LTC)	17.5	18.6	+6%	Approved with support
Worcestershire	Worcester	584,600	2%	37.2	37.2	no	Approved
All Pioneer sites***	22 HWB	8,225,090	Not applicable	731.2	784.6	6 over minimum (8 if local authority included)	1 Approved 18 Approved with support 2 Approved with conditions 1 Not approved

* From BCF plan 7d. Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them.

** Source: <http://www.england.nhs.uk/wp-content/uploads/2014/11/bcf-ncar-results-analysis.pdf>

***Except for Staffordshire & Stoke Pioneer.

Local context

While it was possible to identify some common themes arising from the experience of the BCF process, local variation was also evident on the ground.

“If you look across the different areas you will find different approaches to the Better Care Fund in different areas, so whether that is driven by localism or financial situation or quality of relationship, it’s probably a mixture of the three, but it would be quite different, so if you ask people their perception of the Better Care Fund it would be quite different in different areas.”

Overall, local authorities tended to be supportive of the BCF process as enabling them to strengthen their engagement in commissioning across health and social care boundaries. On the other hand, NHS providers were more critical of the extent to which they had been included in BCF planning processes. CCGs expressed diverse views about the extent to which the BCF was capable of supporting alternatives to in-patient services and providing a mechanism to promote greater integration. Localities which faced the most challenging financial problems also expressed more concerns about the risks of not being able to deliver the BCF.

Alignment between BCF and ICP strategic goals

Analysis of the BCF plans submitted by local authorities within the 13 Pioneers (i.e. excluding Staffordshire and Stoke) shows a high degree of alignment between activities supported by the Pioneer programmes and the BCF. Similarly, interviewees from these 13 Pioneers generally acknowledged the consistency and interdependence between the BCF and Pioneer programme. Only a minority queried the added value of the BCF, given its degree of duplication with the Pioneer programme.

“I think it just, you know, the way that we’re seeing it here is that the Better Care Fund plan is just a plan. There is no, you know, delivery around it. The delivery is through the Pioneer programme, so it’s very aligned”

While some interviewees said that it was too early to judge, the BCF was generally considered to have been a helpful process so far. It was said to have focussed attention on integrated care, and in areas where integration was largely driven by the NHS, the BCF was seen as a way to get the local authority more involved in, and aligned with, what the CCG was doing. It was considered particularly useful in those areas without existing integrated care pooled budgets.

“My perspective is it’s (the BCF) been helpful in that people have had to establish the structures where they have the conversations around integration, so those structures are in place in most of the areas now and therefore that becomes the forum in which integration gets talked about both in the Better Care Fund and in the wider [system].”

“Through the BCF, I think the relationship between health and social care has got better because we’ve done all these workshops together whereas before around

integration and beds, it was much stronger health led. So BCF has helped the local authority come into the picture.”

Concerns

However, there were a number of tensions and concerns. Interviewees did not always understand the implications of the BCF (e.g. the financial implications for providers). The role of the HWB in relation to the BCF was sometimes thought to be ambiguous, (would it be a scrutiny board or a commissioning body?), although some commented that the second round of BCF helped further strengthen the strategic function of the HWB. In one instance, it was apparent that different stakeholders each thought that the BCF was ‘their pot of money’ and it was not always clear to local politicians that it was not ‘new money’ or that it was health money being transferred into social care. In another instance, there was an expectation by local authorities that the Care Act implementation would be substantially financed by the BCF. There were some general concerns that the BCF was trying to move things too fast, before the necessary structures/ relationships/understandings were in place.

“So there's a fear factor there, you know. Do I believe in an integrated pot? Of course I do! God, I wish we had one of those. But I do think you really need the working relationships established before that happens.”

Several sites suggested, however, that their experience was of the BCF as a parallel plan and that the financial negotiations underlying it had been a distraction from the wider re-design in the health economy as a whole as well as, to some extent, from the implementation of the Pioneer programme itself.

“It's taken over the focus of the programme. I'm not sure that's helpful because we've got into a position of being worried about money because of what's going to happen rather than concentrating on how we practically transform the service.”

Views were also expressed that while the underlying premise of the BCF – transfer of funding from hospital to community care was the right one – it was a significant gamble. In high performing systems, for example, where significant levels of care were already being provided in the community, there may not be high levels of ‘inappropriate’ acute admissions, i.e. the patients who were admitted actually needed to be there. Therefore, reducing acute admissions may not be possible or may impact negatively on care outcomes. In more general terms, there was also the concern that it simply would not prove to be cost-effective.

*“I mean the NHS is giving a massive gift to social care and how are we going to afford it? ... So there's one BCF that hasn't worked in [a part of the locality] – which is not my part of the system so I don't know - but, broadly, we've said, there is some transfer of money from health to social care for nothing in return but the vast majority of it is for a gain for both of us. And, if the gain doesn't happen, we're ****ed because we're now both going to go bust as opposed to just one half of us going bust. But it's obvious the game is there to be had.”*

A further concern was that the BCF was sometimes not well aligned with the nature of some

Pioneer plans, particularly those involving whole system change or where the Pioneer spanned a number of local authorities and where the Pioneer had sought to give higher priority to strategies promoting citizenship, prevention and wellbeing.

“The bit where it hasn’t been helpful, but this is my perception rather than a local perception, is the way the Better Care Fund was set up in terms of the template tends to drive people to think at a scheme-by-scheme level rather than at a ‘how does the whole system need to change?’, so a template that says ‘okay, you’re going to put that scheme in place, it will have that impact, it will do this and then you’ll do that scheme and it will have and that’, that really isn’t our experience. Actually, it’s the combination of things rather than the individual things, so I think that’s where it’s not been helpful.”

Providers’ concerns

Providers generally expressed more concerns about the BCF than other stakeholders, both in terms of the process of developing the plan and of the actual feasibility of delivering the planned activities. Providers frequently reported they had been informed, rather than consulted, during BCF plan development, both because BCF negotiations had been restricted to CCGs and local authorities and also because the BCF timetable seemed highly pressured. Several providers commented on being asked to comment on the draft plan only at a very late stage of the process.

“And you know, there’s a lot being placed on things like the Better Care Fund as an enabler etc, which I think is right, but you do have to have the right people involved in actually determining how that will be utilised. Now that’s the difficulty in that commissioners make those decisions without necessarily talking to providers. So I think there’s a potential difficulty and disconnect there really.”

It was felt by many interviewees that the financial challenges facing health economies were a major constraint on delivering the BCF. This was reinforced by a lack of transition funding to help shift activities out of acute trusts and the difficulties encountered when attempting to alter resource allocations because of complex contracting procedures and the disincentive effects contained in other financial mechanisms like PBR. It was felt that, in a difficult funding environment, organisations were more likely to retrench rather than increase their degree of collaboration.

“No (the BCF assumptions are not realistic) is the short answer. Mainly because of this problem of not being able to control the other factors. I don’t think in () and I don’t think it is different anywhere else, I don’t the scale of the interventions we have in place is sufficient to have the degree of impact on admissions that they have put down on those plans and I don’t think they have accounted for the other factors that will affect that.”

“They (the providers) support the direction of travel but they are concerned by the fact that they need to switch from one system to another, in a context where the demand is increasing. How are we going to switch the demand?”

Process

On a practical level, there were also concerns about the time and energy that had been expended on BCF negotiations. Some interviewees criticised the way the second round of BCF plans was managed, suggesting that the assurance process had been more focussed on process than content.

“We’ve had six months of conversations around Better Care Fund now, and the time and energy, and how much that will have cost all our organisations to come together, nobody ever maps that out.”

In fact, the bureaucratic demands of BCF plan preparation and submission processes were a major point of emphasis in the second round of interviews compared with the first.

7 Barriers, facilitators and central support

Barriers

An important part of our first wave of interviews focussed on identifying barriers Pioneers were encountering in their attempts to integrate health and social care services. Previous studies of integration initiatives (within health and other public services), have similarly identified obstacles to integrated care which closely resemble those described by our Pioneer interviewees (e.g. Goodwin et al 2013; RAND Europe 2012, Frontier Economics 2012, Wilkes 2014), so this ground is well-covered by existing research. However, since descriptions of barriers formed such a large portion of the first wave of interviews, we have included a list (in Appendix D) of the numerous barriers mentioned by interviewees to give a flavour of the types of challenges faced on a day to day basis by staff working on the design and implementation of innovative approaches to delivering health and social care within their local areas. Many of these barriers have already been mentioned or alluded to in previous sections (4 through 6), so below we summarise the barriers under several themes.

The barriers to integrated care, as identified during the interviews, have been grouped into three broad themes (national; organisational/professional/cultural; and local issues), with further sub-groups within each theme.

National issues

Barriers at the national level are important as they are generally perceived as beyond the control of the Pioneers themselves. There were three broad types of issues raised. The first had to do with national policies which appeared to be inconsistent with the goal of delivering improved integration at scale and pace. They included, for example, the perceived role of the Trust Development Authority (TDA) to promote greater activity and growth among acute trusts, whereas one of the key aims of many local integrated care initiatives was to reduce such activity. Most often mentioned, however, were apparent conflicts between choice and competition and the latter's apparent consequences for the fragmentation rather than integration of services. How far such perceptions are correct is perhaps less important than the extent to which they lead in some instances to adoption of a very cautious approach within the Pioneer sites.

The second type of challenge at the national level had to do with the nature and extent of leadership provided nationally. On the one hand, there were complaints that Pioneers were not given sufficient freedom to experiment and try innovative approaches, but this existed alongside the apparently opposed view that there was not a clear national direction. More consistently, however, was the feeling expressed by a great number of Pioneers that there was insufficient support from the centre in dealing with some of these high level barriers (e.g. to do with information governance, competition rules), that there were too many rules and mixed messages emanating from the centre, and that some of the most difficult challenges, such as engaging the public with the need to reconfigure hospitals, were not being tackled effectively.

The third broad theme at the national level related to financial issues, in particular the effect of financial cuts (especially on provision of adult social care services) and the lack of funds to

assist with the development and provision of the new integrated care initiatives (including staff shortages).

Organisational, professional and cultural issues

The first type of barrier in this category had to do with organisational structures, and the types of tensions this could lead to, e.g. whether acute trusts or GP practice federations would take the lead in integrating services and whether different commissioners would be willing to give up control over part of their budget in order to pool resources. Other comments referred specifically to the structure (and workload) of primary care, and how that created challenges for integrating services; this was perceived to be especially problematic in (but by no means limited to) areas with many single-handed GP practices. These structural issues also included the various types of competing demands for different organisations, such as the need for acute trusts to prioritise 4 hour A&E waiting times, which meant integrated care was not always treated with the same degree of urgency by key stakeholders.

The second broad type of barrier referred to professional boundaries, cultural differences between organisations, and the potential impacts of those issues on successfully engaging staff in innovative activities. The most common theme mentioned by Pioneers was of the differences between health care and social care in terms of language, their respective conceptions of health, and their professional ways of working. These factors were reflected at the management level in significantly different systems of accountability within local authority social services and NHS organisations. Similarly, there were difficulties in both removing barriers created by differences in professional roles and responsibilities, and also encouraging staff from different organisations and professions to trust one another and their professional judgements. Even within organisations, there were difficulties motivating staff to become engaged with integration activities. For example, a barrier which was reported within as well as between agencies was the considerable time that it could take to see positive results from integrated care initiatives and the consequent view that 'nothing changes' leading to demotivation.

Local issues

Thirdly, there were local issues, which in some cases are local manifestations of the more general national and cultural issues already described. The effects of financial austerity mentioned under national issues, was clearly identified locally, for example, in the absence of sufficient capacity to manage and implement all Pioneer activities. For the larger Pioneers, the size and complexity of their local health and social care economy created their own challenges, including the sometimes different footprints for local authorities, CCGs and acute trusts, together with their multi-level governance systems. Dealing with such complexities was a significant challenge for local leadership, a challenge compounded if governance structures were insufficiently developed or robust.

In addition, there were various issues to do with securing sufficient or genuine engagement from all the necessary organisations, groups of staff and the public locally. The nature and extent of this difficulty could vary from site to site depending on local circumstances.

Examples illustrating all of these themes may be found in Appendix D. While the list of barriers is a long one, it is important to note that interviewees adopted a practical approach, and viewed such barriers not as necessarily insuperable impediments to their integrated care initiatives, but rather as challenges in need of resolution, which they were in the process of tackling in this early stage of Pioneer activity.

“Every problem is just a challenge, it is just another challenge to solve. I don’t think there is any one that has been particularly problematic, they have all been problematic at different points in the proceedings and they are all barriers, but you just have to find a way of getting round them.”

Facilitators

As well as barriers, the Pioneers identified a wide range of facilitators or enablers of successful integration. While facilitators to integration are also well covered in previous research, to provide some balance to the list of barriers mentioned during the interviews, we have also included (in Appendix D) a comprehensive list of facilitators described by interviewees, following a similar, but simplified, categorisation to the one used for barriers. The facilitators are summarised below by broad theme.

National context

Most important was the advantage of being part of the Pioneer programme, which not only accelerated bringing key local stakeholders to the table, but provided an incentive for them to work together given they felt they were under central scrutiny and, as a result, faced some degree of reputational risk. They also welcomed being part of a wider group of sites that they could speak to and share learning with. The BCF was welcomed in a similar regard, as it brought commissioners and providers together.

Professional/cultural enablers

Every Pioneer emphasised the importance of building good working relationships across organisations and professions. However, difficult to establish and maintain, such relationships were essential in enabling stakeholders to speak frankly, understand one another’s perspectives and move towards shared values and understandings of what the Pioneer initiative was aiming to achieve.

Creating multi-disciplinary teams was also a key enabler, although there were many ways this objective was achieved, some involving a single management structure co-located on a single site, while others were less formal or less hierarchical; what was seen to be important was building trust and shared values among team members. Developing a shared understanding of the patient/service user perspective on integration was identified as one way of facilitating such team building and development.

Local context

Most of the facilitators identified tended to be at the local level, which is not surprising, given that this is the area where staff working on integrated care initiatives have the most control. Having said that, one important factor identified as assisting with integrated care had nothing to do with control, but rather with being fortuitous enough to have a fairly straightforward organisational landscape, e.g. where CCGs and local authority boundaries

overlapped, and perhaps were served by a single acute trust. Other local contextual/historical factors were also important, such as having an integrated IT system across organisations to enable sharing records, having a history of successful integrated care initiatives or having suitable facilities to co-locate teams.

Good local leadership was also identified as critical, at all levels from local authority councillors through to senior and operational managers, together with working within established and appropriate governance structures. Having sufficient resources was also mentioned as an enabler, both in terms of funding (e.g. to 'pump prime' innovation) and, probably more importantly given the current financial climate, in terms of staffing (not only having sufficient numbers of people, but also their continuity in post).

Adequate staff numbers were not sufficient in themselves, of course, especially if they were not sufficiently engaged with the integration agenda. Some of the facilitators identified in securing that engagement included previous success at integration and reassuring staff in the face of what could be perceived as significant change. Perhaps most importantly, a bottom-up approach was considered preferable to imposing changes from the top. Such approaches were based on involving staff in developing the initiatives and encouraging their ownership of the new service models. Favoured strategies for winning over the public and service users followed a similar approach, including ensuring they were fully informed at all stages, and that user representatives were involved in the design of the services, and represented in all key forums.

It should be noted, however, that there was not a uniformity of view among interviewees and that what is considered a facilitator in one area may not be perceived as such in another. To take one example, having co-located teams (e.g. of community health and social care workers) with a single management structure was considered essential by some interviewees, but as unnecessary by other Pioneers or even counter-productive if staff become worried over their position within the new structure.

Advice and support

A key potential facilitator, and one of the benefits sites foresaw when they applied for Pioneer status, was to receive advice and support from national partners and to share learning with other Pioneers. However, there was a general feeling that there was a slow start to the support available to Pioneers from national partners.

"If I'm being honest, I think it's been a bit neutral. So I've not seen a significant level of support coming in nationally."

"It would have been easier, quicker, smoother, pacier, if we'd have been able to get some of those quite challenging issues out there and sorted to start with, or certainly earlier on than now."

Generally, sites reported that, while there was openness to understanding the barriers faced, they had yet to receive timely and responsive support in a way that responded to the needs identified. One Pioneer mentioned that support in solving problems had so far been

limited to an offer to 'put them in touch with other sites', and that they had already done this themselves.

However, it was clear that Pioneers were at different levels of awareness of their support needs, with more time needed in one locality before this would become apparent.

"Have we felt a big impact of it? Not at the moment. They're interested in listening to us to tell them what some of the barriers and obstacles are but I don't think we're getting some of that intensive support to give things a go."

[We're] constantly being asked by partners 'Do we want help with anything?' And it's really hard to work out what you want help with, and part of what you want help with is stop asking us if we want help!"

The main requests for support related to information sharing, contracting and evaluation. Another topic where some sites requested advice was on the evidence in favour of specific interventions, such as rapid response, which they could then use to help develop local services. Sites resented receiving 'sales pitches' from organisations offering commercial solutions.

What they were expecting by way of support from the centre was higher level expertise and skills in solving problems, and one interviewee recounted that they were promised international expertise. Another interviewee from this same site said that what they wanted was not peer expertise, but someone who could mentor and coach.

Frequently, sites said that what they wanted was flexibility around regulations. For example, the flexibility for their acute trusts to delay applying to become foundation trusts if this process was felt to be detrimental to the objective of establishing integrated care in that locality. Where a Pioneer wanted help with particularly difficult issues, they expected to receive this from individuals of appropriate seniority and calibre.

Much of the support on offer was in the form of attending meetings organised for all Pioneers at a central location, often in London. For some sites, the cost of sending staff to attend a London workshop was considerable. Although when they had attended (e.g. the Pioneer Assembly), this was found to be very helpful, particularly the opportunity it gave to meet staff from other sites. It was suggested that these events sometimes be held in parts of the country other than London.

Not all individuals and organisations within a locality had access to advice and support. In some cases, access to support did not extend, in an effective way, beyond the lead organisation or 'core working group'. One provider noted that, not only did they not receive support from the Pioneer programme, they did not have the opportunity to contribute what they had learnt from their successes to national discussions.

There was some indication that access to support was improving in that, at the time of interviewing, a number of sites were anticipating visits from national partners to discuss issues such as contracting and information sharing. In addition, participants who had taken

part in webinars had found the conversations relevant and the sessions well chaired. For example, one interviewee said that:

“...the chair asked good clarification questions such as ‘How were you doing it?’ [and] ‘that there were a good number of people involved so that you felt like you were having a conversation not listening to a conference’.

Receiving assistance was sometimes mentioned as being more important than receiving advice:

“We keep being offered ‘thought partners’. I’ve got more ‘thought partners’ than I know what to do with, but what I don’t have is bums on seats with sleeves rolled up to do the doing, and that is the massive challenge with this, the capacity to do the things that need doing.”

In a related point, a frequent complaint was that the key contact for the Pioneer was inundated with requests for updates and attendance at workshops/conferences. The reporting requirements were felt to be onerous, especially given existing reporting requirements from other national bodies (such as Monitor), and did not add value to the local system. However, the reporting requirements were felt to have decreased over time.

‘If you are a successful organisation, a reduction in reporting would be helpful’.

Sites had already set up their own informal networks with other (often neighbouring) Pioneers, for example holding regular teleconferences, and had found these helpful. All sites valued opportunities to share with other Pioneers, although individuals in the system were not always receiving notifications about events of interest.

There were mixed views on the helpfulness of ICASE. For example, one interviewee felt it had been ‘very helpful’ while others had not used the site at all, feeling they did not have the time to log in. It was generally felt that it was much more effective to have a conversation with someone where you could talk about particular issues or problems, rather than spend a long time searching a site for a document looking for relevant information.

8 Conclusions

Making headway

As we have previously emphasised, it is very early to be drawing firm conclusions about the operation or progress of the Pioneers, individually or collectively. Although Pioneers accepted that the objective was to move at ‘scale and pace’, they also stressed that it might take five years or longer to produce demonstrable impacts, particularly in relation to complex interventions aimed at prevention. Therefore, from this perspective, expectations of evidence of rapid progress were unrealistic and unhelpful, and the overwhelming concern was to encourage realism over the time needed for the Pioneers to bring about major change.

“But the pace, it's defining what that pace is, I mean, we're constantly challenged by the leader over the road, [name removed], in terms of he wants to see things quickly. Department of Health are constantly asking me for updates in terms of what have we, you know, where are we with integration. But actually two months, three months I'm not going to be able to give you a lot of evidence. It's some of that understanding in terms of either we want sticking plasters or we want solutions that are going to last, and I think we've all agreed that sticking plasters no longer kind of work.”

“And of course, the results, you know, the outcomes really won't come for five years down the line, we know this – so from ... this health economy, the introduction of the integrated teams, and the other things we're doing around integration within [Project Name] is a five year programme.”

“If you're investing in self-management, you might not see any benefit of that and any benefit you see might be five years down the track. The NHS does not really think in those timescales so it's a hard conversation to have.”

It was clear that some Pioneers were making considerable headway, particularly at the strategic level, where progress could be identified most strongly in terms of laying the necessary foundations to take implementation forward. This was most clearly articulated in terms of building relationships between important stakeholders and developing (and working through) issues concerned with governance arrangements. There was some concern that this vitally important work should be seen to ‘count’ as progress:

“...relationships are building and are getting better. You can't measure relationships that way.”

“Some of the individual programmes are a success. Putting everybody around the table to challenge them to do something better is a huge step forward.”

However, there was awareness that many challenges still need to be unpicked. Bringing partners around the table to reach agreement about how services should be re-designed, while not always easy, appears to have been tackled to a significant degree by the sites. However, the concrete rolling out of interventions poses a more difficult challenge, and the pace at which this is being implemented did raise some concern.

“To date, yeah, we’re now starting to come up to some really big barriers. We’ve done the easy wins, we’ve got stuff up and running, we’ve got a business as usual, they’re embedded, that’s happened. There’s lots of good stories and a good feel there but the things always on the horizon, the big problems, are now butting up against us so it may be time we need to use more of that.”

“Some of the reasons integrated care doesn’t occur is because we created lots of barriers. There’s a significant challenge to break those barriers down but you don’t get anywhere unless you first identify the barrier and then look to see how you can dismantle it to make it work. [...] So there are positives but when you sit within the process, we don’t think perhaps it’s working quickly or well enough. [...] Somebody once said to me “if you’re doing the right thing but you haven’t got the timing right, change the timing, not the right thing” and that’s always been a very important mantra.”

At an operational level, Pioneers were implementing a mix of the following, often moving on several fronts at once, although there was considerable variation between them:

- continuation of pre-existing integrated care initiatives;
- the roll-out or expansion of pre-existing initiatives into a new service area, population group or over a larger geographical area;
- the implementation of new initiatives proposed in the Pioneer bid and begun since the Pioneer programme commenced.

In fact, many of the pre-existing initiatives should be considered as pilots, and had been implemented in ways that allowed for experimentation with innovative service models. The full-scale implementation of such interventions may require re-design and adaptation when moving to a much larger Pioneer context, and this is the phase that several Pioneers are currently facing. While building a network of relationships among local stakeholders may have been achieved in these sites, the actual implementation of re-designed services represents a more difficult task for many, and may require the removal of barriers that are not within the control of local managers. Assistance to deal with these barriers is likely to become increasingly necessary in future.

“We are getting some of it. The challenge is always going to be that, as a Pioneer, the chances are quite a lot of the ‘lower hanging fruit stuff’ you probably worked through already, so what you are really looking for are thought partners who are going to assist you thinking through some of the more complicated and nitty-gritty issues.”

It was mentioned by some interviewees that integrating care services is a continuously evolving and ongoing process, and it would not be possible to specify an ‘end-point’; for example, did integrated care mean complete and total system integration (as was the aim in some areas), or more modest achievements such as pooled budgets?

Conclusions

As Table C1 in Appendix C demonstrates, the Pioneers are a heterogeneous group of sites which vary widely in, for example, population size, organisational complexity, ambition and

user group focus. Even in very broad terms, what it means to be a 'Pioneer' varies from site to site. For example, some sites appear to define their Pioneer in terms of defined workstreams or interventions, whereas others identify all the integration activities taking place in the Pioneer area as constituting the Pioneer. In some cases, the Pioneer is closer to an ethos linked to a way of thinking about and providing care rather than a specific plan or set of initiatives.

The Pioneers provide a wide range of contexts within which to observe the development of initiatives to promote integrated care and to study the impact of different combinations of what local actors consider relevant facilitators of, and barriers to, progress at 'scale and pace'. The Department of Health and its partners selected the sites through a process of competitive applications and expert assessments. They were not selected to be statistically representative of settings for or approaches to integrated governance and care in England. Nonetheless, the variations highlighted above means that the Pioneer programme offers opportunities to gain insights into the development of integrated care at different levels of planning and service delivery as well as in a variety of contexts, characterised by different combinations of enablers and barriers.

Although Table 2 and Table C1 (Appendix C) provide a profile of the Pioneer programme in terms of key features of the sites and some of their key interventions, they offer little insight into the dynamics of their programmes in terms of the theories of change on which they are planning to operate. As a result, it is difficult to compare and categorise sites according to their approaches to integration. In the next stage of our fieldwork we will seek to construct logic maps for individual sites and consider whether this approach helps us to construct a typology of different approaches to integrated care and governance based on their underlying theories of change.

As has been pointed out in previous evaluations (Cameron et al 2015, Wilkes 2014), facilitators and barriers can, to some degree, be regarded as lying towards opposite ends of various continua, for example, continuity of staff versus high staff turnover (e.g. after a reorganisation), or operating with sound finances versus financial pressures. In addition, we have also identified a tendency for facilitators to be related to relatively 'soft' skills and other characteristics, such as leadership, vision, trust, values and continuity of relationships. By contrast, barriers and obstacles were more likely to be identified with 'harder' features of formal organisational structures and systems (see also Primary Care Network 2010). In practice, this distinction is not absolute (NHS Confederation 2010). In practice, this distinction is not absolute and the two sets of influences are, in some respects, interdependent. Structural reorganisations, for example, disrupt informal relationships and can be responsible for discontinuities of leadership as well as of trust, understanding and commitment between agencies. As we suggest below, however, our observation of differences in the character of facilitators and barriers has implications for central/local roles and relationships.

It would be inappropriate to draw firm conclusions about the Pioneers from this initial stage of data collection and analysis. The Pioneers are also at an early stage in a process that implies embedding significant cultural as well as organisational change. Nonetheless, we

wish to record some initial observations, which appear to be emerging from our evidence to date.

First, our successive data collections in the Pioneer sites is providing a series of snapshots of how the integrated care agenda is being understood and addressed in local care and support systems, all of which are operating in environments characterised by unusually high levels of uncertainty and instability. Our first round of data collection in spring 2014 suggested that the organisational infrastructures and capabilities of the NHS had necessarily been tested by its most recent reorganisation with, in many areas, inevitable consequences for the continuity of relationships with local government. Our second round of interviews (from September to November 2014) suggests that, in general, the new roles, responsibilities and relationships are becoming established within the NHS as well as between it and local government. The nature of our data does not, of course, enable us to draw conclusions about the extent to which the disruptive consequences for inter-agency working of the Health and Social Care Act 2012 have now been overcome and the new arrangements it introduced are enhancing pre-existing capabilities for integrated working. There was a surprising number of references in our first interviews to Pioneer status bringing the right people round the table. Since we did not expect such a basic barrier to exist in Pioneer sites, we have interpreted these reports as indicating the significant extent to which relationships were disrupted by the internal preoccupations associated with such a major restructuring.

Second, a further, and unquestionably continuing, source of uncertainty and instability is provided by local budgetary pressures, which can also encourage an internal focus alongside change in structures and personnel. The position in local government is one of major spending reductions in cash terms and, while that for the NHS is significantly less severe, it still represents the longest period of roughly level spending (after inflation) known in NHS history. The financial environment has implications for integrated care in many different ways. It widens the gap between supply and demand overall. In addition, the asymmetrical nature of spending regimes in the NHS and local government potentially has disproportionate impacts on different parts of whole systems, placing burdens on services which have been relatively protected. For example, at least one Pioneer is seeing cuts in intermediate care spending because the council is having to focus spending on statutory responsibilities. Spending constraints can also undermine longer-term strategies to re-balance service systems by diverting resources to 'fire fight' more immediate pressures. Some interviewees have interpreted the evolving nature of BCF criteria in that light, while also welcoming its contribution to meeting more immediate pressure points at the interface between hospital and community services. Resource pressures also impact on motivations to work collaboratively including incentives to pool, defend and expand budgets. All these factors can work in different directions in different times and places. In addition, and because integrated care appears to be 'process-heavy' (dominated by repeated meetings), that inter-agency working is particularly susceptible to staff reductions and/or increases in workloads. It has been a common observation among our interviewees, for example, that local authorities have found attendance at NHS and joint meetings very difficult to manage during our fieldwork.

Third, and related to the above, we have observed the presence of an ‘integration paradox’. Interviewees suggested that that the current context of growing need and declining budgets becomes an even stronger driver for more effective integration. At the same time, that context is one in which it could (but not necessarily) become more difficult to make progress. If it makes organisations more protective of their budgets and staff or less open to creativity and change, then barriers to integrated care will be reinforced. Equally, as noted previously, organisations under pressure may find their staff stretched too thinly covering internal agendas. In the next round of fieldwork, we will examine how far partners are able to adopt different forms of ‘smart’ working, perhaps by sharing staff and functions or by managing demand. In addition, we suspect it will be important to look in greater detail at the financial barriers to integrated care and the sharing of resources, together with variations in their impact in different settings and circumstances.

Fourth, we have noted some questioning of the extent to which national partners have thus far been in a position to help local sites address those barriers that lie in national policies and systems. The national partners have also been affected by resource pressures and the demands of building new organisations and relationships as a result of NHS re-structuring. Nonetheless, issues around, for example, data sharing, payment systems, procurement, provider viability and the foundation trust pipeline, continue to concern Pioneers. The identification of national sponsors seems to have been recognised as a useful development, though their specific contributions remain somewhat unclear. Interviewees also recognise that the issues above are difficult to resolve, but their concerns might be somewhat allayed if they could see the route map and timescales by which national barriers are being addressed so that their own implementation plans can be developed with more certainty. In the next phase of interviewing, we will be particularly exploring responses to and the uptake of the recently drafted offer of assistance to Pioneers from the centre, which was being discussed as we finalised this report (Pioneer Support Group 2015). This focus is also consistent with a further aspect of the differences we identified between facilitators and barriers in that the latter are more frequently constituted of factors apparently outside the immediate control of local actors and the former are more susceptible to local influence. This observation is consistent with previous survey findings that *“the main factors that promoted integrated working (were) locally determined ... (but) the top factors that respondents felt hindered integrated working (were) nationally determined”* (Primary Care Trust Network 2010). We recognise that this local stakeholder distinction between local and national barriers and responsibilities is unlikely to be a wholly disinterested one. However, it is consistent with one of the core Pioneer programme logics according to which the centre offered to address barriers encountered by Pioneers and for which it was responsible. We will continue to consider the appropriate distribution of responsibilities between the centre and localities in the final stage of our data collection.

Fifth, we noted indications from our initial interviews that the National Voices definition of integrated care as person-centred, coordinated care is helping to frame understandings of both the starting point and goal of Pioneer activity. We also made the observation, however, that it was not the only definition in play, and that the unfolding priorities associated with the BCF (and other cross-cutting agendas) appear to be potentially providing a competing set of resource and activity based objectives. The interviews conducted in autumn 2014 continued to demonstrate the application of person centred approaches to

integrated care and whole person perspectives on needs and outcomes. At the same time, however, there was also evidence of a narrowing of purpose and a focus on pressures in current service systems, most notably at the hospital/community interface. This emphasis reflected the well-known concerns about demand for urgent care and the progressive focussing of the BCF on avoidable admissions. Indeed, it is also relevant that many of the key actors in Pioneer programmes were also centrally involved in developing and securing agreement for local BCF plans. Although the alignment of BCF and Pioneer plans was generally a local priority, the degree of input required to complete BCF processes tended to be considered excessively burdensome and a diversion from the implementation of Pioneer activities.

The re-calibration of BCF plans and national policy priorities was understandable against the background of national resource and winter demand pressures, as well as in the context of the electoral cycle. Strategically, however, these developments might be seen, at least in the short term, as a renewed attempt to repair parts of a 'broken' system rather than begin to implement more fundamental system re-design. It remains to be seen, therefore, how far the vision of transformative change for individuals and organisations, which apparently underlay the Pioneer programme, is being diluted as the vision meets the unforgiving demands of real time implementation. We will continue to explore how far the 2013 national definition of integrated care can be of value in framing integrated care in terms of what is important for individuals (the 'Mrs Smith' approach) rather than what is in the interests of organisations. To the extent that it succeeds, some progress in shifting the focus from systems and processes towards needs and outcomes becomes more conceivable and feasible.

Sixth, one of the ostensible advantages of becoming a Pioneer was not only sharing learning with other sites, but also obtaining access to key decision-makers and receiving advice and support from national and international experts. Access to external advice and support has continued to be perceived as patchy (at best) by many sites. This may be partly due to the nature and manner of the support provided, which is most efficient to provide to Pioneers at the same time, e.g. by way of national conferences or workshops. However, Pioneers tend to be at different stages in their development and struggling with different issues. Therefore, they need advice and support that is tailored to their particular needs at a particular time, rather than the one-size-fits all approach that was initially perceived to have been offered and which may be too early, or too late, for their particular circumstances. Our most recent interviews provided examples of locally tailored support. In one case, for example, bespoke support for local leadership development was seen to be helpful and, in another, the executive team was using external support to promote cultural change at the front line. One of the lessons we draw from these experiences is the importance of space and resources for local managers, with support where appropriate, to determine their own local development needs and fashion locally owned organisational development and advice packages.

We have observed an apparently genuine enthusiasm for, and positive commitment towards, the Pioneer concept and the possibility of making progress towards better outcomes for individuals and communities through integrated care, support and governance. The early stages of high profile initiatives can be expected to be characterised

by such attitudes among those who have been given national recognition and a strong incentive to maintain a leading edge reputation. This climate is arguably one for national partners to maintain through practical, realistic and timely intervention. Generally, Pioneers appear to see barriers to integrated care as problems to be addressed positively rather than insuperable walls that prevent progress, though they are also conscious of the limits of their powers and responsibilities in this respect (see above). Our interviews in autumn 2014 tended to confirm that the environment for whole systems transformation was not becoming easier and underlines the importance of maintaining local ownership of the vision for improved outcomes, which underpinned the Pioneer initiative. We found little if any evidence that the balance between facilitators and barriers had shifted in favour of the former. If anything the balance appeared to be shifting in the contrary direction. This is not to say the Pioneer programme will not make significant progress but the extent to which it is able to do so with, rather than against, the grain of organisational structures and processes remains to be seen.

Finally, it is relevant to note both the expansion of the Pioneer programme to include a further eleven sites with effect from April 2015 and the separate NHS England call for applications to achieve 'vanguard' status as part of the process for implementing the *Five year forward view* (NHS England 2014). The *Five year forward view*, itself, outlined proposals for a number of 'radical new care delivery options' through which the NHS would 'take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care'. These care models included elements of both vertical and horizontal integration, though primarily the former and with little recognition of the place-based horizontal integration strategies evident in some aspects of the Pioneer programme. Nonetheless, the vanguards offer additional opportunities for testing innovative approaches to integrated care and for linking the learning from these and other relevant programmes. The extent to which national and local policymakers are able to learn from these initiatives may be critical not only to achieving the outcomes and user experiences required by the National Voices definition of integration, but also to the sustainability of health and local government services themselves.

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APPENDIX A: Description of Pioneers in government press release on 1 November 2013

The 14 Pioneers were announced in a Department of Health press release on 1 November (<https://www.gov.uk/government/news/integration-pioneers-leading-the-way-for-health-and-care-reform--2>). It included brief descriptions of the 14 initiatives, which are reproduced below.

Barnsley

The aim of the Stronger Barnsley Together initiative is to make sure that the health and care needs of local people are met in the face of an increasingly difficult climate. Population changes, public sector cuts and welfare reforms, have had an impact on how Barnsley delivers these services, and they cannot afford to continue with the existing system as it is. A new centralised monitoring centre has been set up. When the centre is alerted about an emergency case, it is assessed within one of three categories (individual, families, and communities) and the right kind of help is delivered. This will help ensure that the right help is dispatched quickly to the relevant patient.

Patients will receive tailored care to suit their requirements, whether this is day to day support to enable people to stay safe, secure and independent, or the dispatch of a mobile response unit for further investigation. This is vitally important to ensure that patients are seen swiftly and receive the care and information they need – whether this is avoiding a return to A&E, getting extra care support for a child's care needs, or even work to improve the information available explaining how to access to council services.

Cheshire

Connecting Care across Cheshire will join up local health and social care services around the needs of local people and take away the organisational boundaries that can get in the way of good care.

Local people will only have to tell their story once – rather than facing repetition, duplication and confusion. Also the programme will tackle issues at an earlier stage before they escalate to more costly crisis services.

There will be a particular focus on older people with long-term conditions and families with complex needs.

Cornwall

Fifteen organisations from across health and social care, including local councils, charities, GPs, social workers and community service will come together to transform the way health, social care and the voluntary and community sector work together. This is about relieving pressures on the system and making sure patients are treated in the right place. Teams will come together to prevent people from falling through the gaps between organisations.

Instead of waiting for people to fall into ill-health and a cycle of dependency, the Pioneer team will work proactively to support people to improve their health and wellbeing. The

Pioneer will measure success by asking patients about their experiences of care and measuring falls and injuries in the over 65s.

Greenwich

Teams of nurses, social workers, occupational therapists and physiotherapists work together to provide a multidisciplinary response to emergencies arising within the community which require a response within 24 hours. The team responds to emergencies they are alerted to within the community at care homes, A&E and through GP surgeries, and handle those of which could be dealt with through treatment at home or through short term residential care.

Over 2,000 patient admissions were avoided due to immediate intervention from the Joint Emergency Team (JET). There were no delayed discharges for patients over 65 and over £1m has been saved from the social care budget.

Islington

Islington Clinical Commissioning Group and Islington Council are working together to ensure local patients benefit from better health outcomes. They are working with people to develop individual care plans, looking at their goals and wishes around care and incorporating this into how they receive care. They have already established an integrated care organisation at Whittington Health better aligning acute and community provision.

Patients will benefit from having a single point of contact rather than dealing with different contacts, providing different services. Patients will feel better supported and listened to.

Kent

In Kent, the focus will be around creating an integrated health and social care system which aims to help people live as independent a life as possible, based on their needs and circumstances. By bringing together CCGs, Kent County Council, District Councils, acute services and the voluntary sector, the aim will be to move to care provision that will promote greater independence for patients, whilst reducing care home admissions. In addition, a new workforce with the skills to deliver integrated care will be recruited.

Patients will have access to 24/7 community based care, ensuring they are looked after well but do not need to go to hospital. A patient-held care record will ensure the patient is in control of the information they have to manage their condition in the best way possible. Patients will also have greater flexibility and freedom to source the services they need through a fully integrated personal budget covering health and social care services.

Leeds

Leeds is all about aiming to go “further and faster” to ensure that adults and children in Leeds experience high quality and seamless care.

Twelve health and social care teams now work in Leeds to coordinate the care for older people and those with long-term conditions.

The NHS and local authority have opened a new joint recovery centre offering rehabilitative care to prevent hospital admission, facilitate earlier discharge and promote independence. In its first month of operation, it saw a 50% reduction in length of stay at hospital.

Leeds has set up a programme to integrate health visiting and children's centres into a new Early Start Service across 25 local teams in the city. Children and families now experience one service, supporting their health, social care and early educational needs, championing the importance of early intervention. Since the service has been in operation, the increase in face-to-face antenatal contacts has risen from 46% to 94% and the number of looked after children has dropped from 443 to 414. Patients will also benefit from an innovative approach which will enable people to access their information online.

North Staffordshire

Five of Staffordshire's Clinical Commissioning Groups (CCGs) are teaming up with Macmillan Cancer Support to transform the way people with cancer or those at the end of their lives are cared for and supported.

The project will look at commissioning services in a new way so that there would be one principal organisation responsible for the overall provision of cancer care and one for end of life care.

North West London

The care of North West London's 2 million residents is set to improve with a new drive to integrate health and social care across the eight London boroughs. Local people will be supported by GPs who will work with community practitioners, to help residents remain independent. People will be given a single point of contact who will work with them to plan all aspects of their care taking into account all physical, mental and social care needs.

Prevention and early intervention will be central. By bringing together health and social care, far more residents will be cared for at or closer to home reducing the number of unplanned emergency admissions to hospitals. The outcomes for patients and their experiences of care are also expected to increase. Financial savings are also expected with the money saved from keeping people out of hospital unnecessarily being ploughed back into community and social care services.

South Devon and Torbay

South Devon and Torbay already has well-co-ordinated or integrated health and social care but as a Pioneer site now plans to offer people joined up care across the whole spectrum of services, by including mental health and GP services. They are looking at ways to move towards seven day services so that care on a Sunday is as good as care on a Monday, and patients are always in the place that's best for them. The teams want to ensure that mental health services are every bit as good and easy to get as other health services and coordinate care so that people only have to tell their story once, whether they need health, social care, GP or mental health services.

Having integrated health and social care teams has meant patients having faster access to services; previously, getting in touch with a social worker, district nurse, physiotherapist and

occupational therapist required multiple phone calls, but now all of these services can be accessed through a single call. In addition, patients needing physiotherapy only need to wait 48 hours for an appointment, an improvement from an 8 week waiting time. A joint engagement on mental health is bringing changes and improvements even as the engagement continues, e.g. people wanted an alternative to inpatient admissions so we are piloting a crisis house, where they can get intensive support.

An integrated service for people with severe alcohol problems frequently attending A&E is offering holistic support. The service might help sort out housing problems rather than merely offer detox. 84% report improvements. “The people helping me have been my lifesavers. I shall never, ever forget them.” – Patient, alcohol service.

South Tyneside

People in South Tyneside are going to have the opportunity to benefit from a range of support to help them look after themselves more effectively, live more independently and make changes in their lives earlier.

In future, GPs and care staff, for example, will have different conversations with their patients and clients, starting with how they can help the person to help themselves and then providing a different range of options including increased family and carer support, voluntary sector support and technical support to help that person self-manage their care.

In order to do this, there will be changes in the way partners organise, develop and support their own workforces to deliver this and a greater role for voluntary sector networks.

Southend

Southend’s health and social care partners will be making practical, ground level changes that will have a real impact on the lives of local people.

They will improve the way that services are commissioned and contracted to achieve better value for money for local people with a specific focus on support for the frail elderly and those with long term conditions. They will also look to reduce demand for urgent care at hospitals so that resources can be used much more effectively. Wherever possible they will reduce reliance on institutional care by helping people maintain their much-valued independence.

By 2016 they will have better integrated services which local people will find simpler to access and systems that share information and knowledge between partners far more effectively. There will be a renewed focus on preventing conditions before they become more acute and fostering a local atmosphere of individual responsibility, where people are able to take more control of their health and wellbeing.

Waltham Forest, East London and City (WELC)

The Waltham Forest, East London and City (WELC) Integrated Care Programme is about putting the patient in control of their health and wellbeing. The vision is for people to live well for longer leading more socially active independent lives, reducing admissions to hospital, and enabling access to treatment more quickly.

Older people across Newham, Tower Hamlets and Waltham Forest will be given a single point of contact that will be responsible for co-ordinating their entire healthcare needs. This will mean residents will no longer face the frustration and difficulty of having to explain their health issues repeatedly to different services.

Worcestershire

The Well Connected programme brings together all the local NHS organisations, Worcestershire County Council and key representatives from the voluntary sector. The aim is to better join up and co-ordinate health and care for people and support them to stay healthy, recover quickly from an illness and ensure that care and treatment is received in the most appropriate place. It is hoped this will lead to a reduction in avoidable hospital admissions and the length of time people who are admitted to hospital need to stay there.

APPENDIX B: Topic guide for interviews with Pioneer staff

The interviewee

Current role

Past experience (e.g. relevant to integration)

History of integration

How long has (the locality) been doing this sort of thing? Has (locality) been involved in previous integrated care pilots?

(PROMPT: e.g. POPPs, IC Pilots, Year of Care Pilots, WSD, IBSEN, PHB pilots, other regional pilots).

Prior to becoming a Pioneer, what success have you had in integrating care?

(PROMPT: Against what criteria? E.g. structure, process, 'good relationships', user experience, user outcomes etc)

What facilitated success?

What have been the barriers?

What did you learn from previous initiatives?

Given the National Voices definition of integration as 'person-centred coordinated care', what experience did you have of developing and implementing personalised care?

Before becoming a Pioneer, had you seen yourselves as having been a leader in the field of integration? If so in what respects?

Reasons for becoming a Pioneer

Why did you apply to become a Pioneer?

Was there a particular person or organisation behind the decision to become a Pioneer?

Were there any particular local circumstances that enabled the Pioneer to be initiated?

What do you expect Pioneer status to add? (Is there anything specific you thought you might achieve by becoming a Pioneer that you could not do otherwise?)

Did you have any reservations or concerns about joining the Pioneers?

Model of integration

What is the model of (or approach to) integration underlying your application for Pioneer status?

How does it differ from what you were doing previously?

Have you altered your approach to integration since making your application for Pioneer status?

(Additional questions based on reading of application)

What are the key ways in which you expect the Pioneer to improve patient/user outcomes?

How will you define success?

When do you expect to see the desired changes and outcomes appearing?

What do you think will be the most important things that influence 'success' or 'failure'?

Involvement of independent and voluntary sector organisations

How are providers involved in the plan? NHS providers; Voluntary organisations; Other (local government, private sector)

(Details of which organisations are involved in the Pioneer may be available in the plans. Therefore interview questions could focus on how well this is working and how these organisations have contributed.)

What has been your experience in managing the tension between integration and national competition and procurement policy?

Workforce

Does your Pioneer involve any workforce innovations?

(This may be in the plans so the questions can probe how this is going)

Governance

What governance arrangements have been put in place for the Pioneer and for integration more generally? Do these arrangements build on any previous integration initiatives?

Are there any innovative features in your governance arrangements?

How effectively are the (new) governance arrangements operating?

How are you involving users (and carers) and is this different from before?

Information systems

What information systems are in place to support integration?

Are local information systems fit for purpose in terms of supporting integrated care and integrated governance?

What progress have you made in developing integrated information systems?

Can you foresee being able to share information about individuals across organisations and services to support personalised and coordinated care within the next 12 months?

Are there any information governance rules you would like to see altered to improve sharing information?

Financial arrangements for paying providers

What, if any, new financial arrangements have been put in place? (PROMPT: Pooled budgets, incentives for performance etc)

How effectively are these working at present?

What are you planning to change in this area?

Better Care Fund

Were you involved in developing the BCF plan? How did it go?

What do you think of the basic idea behind the BCF?

Do you think that the assumptions on which the BCF is based are realistic in your area?

Is the BCF likely to be helpful in achieving this Pioneer's objectives?

Are you adding other resources to the BCF pool? If so, why and how much?

Do you feel that the national performance criteria for the BCF are consistent with the objectives of the Pioneer?

How has the planning process for the BCF related to that for the implementation of the Pioneer?

How much progress has been achieved with the BCF? PROMPT:

- Plans jointly agreed by CCGs, LAs, HWBs

- Protection for social care services

- 7 day health and social care services to support discharged patients and prevent unnecessary admissions at weekends
- Better data sharing between health and social care
- Joint approach to assessments and care planning
- Agreement on the consequential impact of changes

Overall progress

What have you been focussing on since November 2013 when the selected Pioneers were announced?

Is your Pioneer currently in operation: in whole, in part?

How much of your original Pioneer plan has been implemented so far?

Overall, how would you say things going so far in terms of developing and implementing the Pioneer?

What has changed for patients, if anything, so far?

What factors have promoted progress or slowed progress down?

Are there any particular problem areas affecting this Pioneer?

How can any obstacles be removed or mitigated by you and/or by central agencies?

What do you think is the central government purpose(s) behind the Pioneer initiative?

From your perspective, how far are the central government objectives realistic/deliverable?

Is there anything you would like to add on how you have found Pioneer status so far?

APPENDIX C: Table C1 Key features of the Pioneers

1. ABOUT THE PIONEER	BARNSELEY
1.1 Lead and other organisations involved	Barnsley MBC, Barnsley CCG, acute trust, community trust, police, Healthwatch.
1.2 Overall governance model	Health and Wellbeing Board plus Executive group and programme boards.
1.3 Pioneer catchment area	Barnsley metropolitan district.
1.4 Target population	Whole population with an explicit focus on children and families.
1.4.1 Inclusion criteria	Whole population with emphasis on 'inverting the triangle' while also meeting needs of most vulnerable.
2. INTEGRATION PROCESS	
2.1 Vision/general aim of programme	Whole system with particular emphasis on three building blocks: strength in partnership and governance; innovation in practice; and whole systems transformation. Three pronged approach: 'inverting the triangle' (e.g. focus on prevention, early intervention); joint transformation programme (e.g. integrated pathways, care services); fast track enablers at individual, family and community levels.
2.2 Breadth of integration	Whole system including community and voluntary sectors.
2.3 Types of services involved	Barnsley Council (including schools and academies), acute, community health, primary care, mental health, police.
2.4 Patient and public involvement	Healthwatch is member of HWB. Strong citizenship and community foci, especially in LA. Emphasis on 'Barnsley I statements', community development and better information to support co-production of health and wellbeing.
2.5 Timelines (priorities/targets)	Timetable in bid as follows: Phase 1 2013-14: underway as described. Phase 2 2014-16: to achieve medium term objectives including evaluation of cost savings, embedding personalised budgets and results delivery on fast track enablers. Alignment of joint programmes and delivering key impacts including improved self-direction and independence at individual, family and community level and better all-round service experience. Phase 3 2016-18: achieve whole systems transformation, better outcomes and sustainable costs.
3. INFRASTRUCTURE AND ENABLERS	
3.1 Technical	
3.1.1 Shared electronic patient/client records (IT)	One of first local authorities to secure governance clearance for connection to spine.
3.1.2 Risk stratification	Focus on 'inverting the triangle' while still meeting needs of most vulnerable.
3.2 Workforce	
3.2.1 Workforce development	Local authority has a high performing training and development function to support workforce and organisational development across the local authority, NHS and independent sector providers.
3.2.2 Integrated working (e.g. joint staff, co-location)	Health and Wellbeing Development Manager: post jointly funded by members of HWB to manage its work.
3.3 Financial	
3.3.1 Joint commissioning /pooled budget	Overarching joint vision, but not necessarily all activity to be jointly commissioned and/or provided. Three categories referred to in bid: single agency activity; activity for collaboration; joint activity (categories not further defined).
3.3.2 Financial arrangements	Exploration of reward sharing model with Turning Point for reductions in emergency admissions and reducing LOS. HWB conducting review to identify gap between committed spend and expected income.
3.3.3 Integrated personal commissioning (personal budgets)	Involved in all major personalisation pilots nationally and committed to progressing integrated personal budgets.
4. MEASURING SUCCESS	
4.1 Internal evaluation/ monitoring	The Stronger Barnsley Together initiative will be subject to an external evaluation, with four key objectives: 1. To what degree has Barnsley Stronger Together facilitated person centred care? Has this delivered improved outcomes, including better experiences for patients and people who use the services? 2. How successful has the integration of services been? Has this improved patient outcomes and experience? To what extent have local cultural and organisational barriers been tackled and how? Has this realised savings and efficiencies for reinvestment? 3. Have the fast track enablers successfully facilitated behaviour change across each of the three levels? To what extent have the fast track enablers accelerated the rate and scale of any change which has been found to have taken place? 4. Has the Barnsley Stronger Together initiative increased social capital amongst service users and their families? Metrics defined by October 2015; interim evaluation report autumn 2017; final report spring 2018.
4.2 Expected outcomes/ targets	The first stage of the evaluation will be a six month scoping exercise to establish specific metrics for the programme. Will build on the National Voice 'I statements' and using PPI methods to establish further measures.

1. ABOUT THE PIONEER	CHESHIRE
1.1 Lead and other organisations involved	Cheshire West and Chester Council, Cheshire East Council, NHS Eastern Cheshire CCG, South Cheshire CCG, Vale Royal CCG, West Cheshire CCG.
1.2 Overall governance model	A Pioneer panel comprises chairs of HWBs, all CCGs' accountable officers, 4 CCG chairs. Cross Cheshire Pioneer director.
1.3 Pioneer catchment area	All of Cheshire (Cheshire West and Chester Council, Cheshire East Council).
1.4 Target population	Older adults with chronic conditions and individuals with mental health issues representing 210,000 people (30% of the overall population); complex needs families (1100 families).
1.4.1 Inclusion criteria	People who are, or are likely to become, part of the target groups.
2. INTEGRATION PROCESS	
2.1 Vision/general aim of programme	Collaboration across Cheshire with a focus on: integrated communities; integrated case management (people with complex needs); integrated commissioning; integrated enablers (information sharing, joint performance framework, joint workforce development).
2.2 Breadth of integration	Mostly horizontal through integrated health and social care teams; in mid-Cheshire, vertical integration of secondary care clinicians and GPs (geriatrics).
2.3 Types of services involved	Health and social care including intermediate care, reablement, mental health services, drug and alcohol support, housing.
2.4 Patient and public involvement	Delivering joint investment plan for the voluntary community; time banks to attract volunteers; patient involvement programme in East Cheshire linked to the service reconfiguration.
2.5 Timelines (priorities/targets)	2014 developments: development and implementation of across Cheshire enablers workstreams such as information sharing, new commissioning and funding models towards outcomes based commissioning; developing learning modules for integrated teams; all three sites will continue to roll-out their specific services.
3. INFRASTRUCTURE AND ENABLERS	
3.1 Technical	
3.1.1 Shared electronic patient/client records (IT)	Specific workstream to develop a single information system across Cheshire; information sharing agreement between GP practices and community services in WC is currently operational and integrated records to be launched in November 2014.
3.1.2 Risk stratification	Focussing on most intensive service users.
3.2 Workforce	
3.2.1 Workforce development	Developing specific learning set modules for integrated teams with University of Chester.
3.2.2 Integrated working (e.g. joint staff, co-location)	Pioneer lead position is funded by all partners and rotates between all CCGs. Director of integrated care in Central Cheshire is funded by all 7 local partners. Joint commissioner post for mental health and learning disabilities across LA, WC and Vale Royal CCGs. Co-located integrated multi-disciplinary teams in West Cheshire. Learning disability teams in West Cheshire are co-located at the Countess of Chester Health Park.
3.3 Financial	
3.3.1 Joint commissioning /pooled budget	Already active for some services: community equipment service, children in care, disabled children, drug and alcohol, coalition to co-ordinated care, integrated wellness service. Joint commissioner post for mental health and learning disabilities. Additional joint commissioning planned.
3.3.2 Financial arrangements	A funding and contracting model is being scoped to move towards outcome based commissioning; existing programme budgeting for mental health with prime providers model; new funding and contracting model planned to shift from acute to community (e.g. capitation).
3.3.3 Integrated personal commissioning (personal budgets)	Personal health and social care budget planned to be rolled out.
4. MEASURING SUCCESS	
4.1 Internal evaluation/ monitoring	In progress, dashboard being developed (outcomes, process evaluation, monetising of improvement outcomes, RCT and logic chain evaluation).
4.2 Expected outcomes/ targets	Hospital admissions (25% reduction). Reduced cost of admissions/services in acute/community/mental health trusts/residential care etc.

1. ABOUT THE PIONEER	CORNWALL
1.1 Lead and other organisations involved	Age UK Cornwall & Isles of Scilly, Age UK national, Cornwall Council, Cornwall Partnership Foundation Trust, NHS Kernow, Peninsulocal authority Community Health, Royal Cornwall Hospitals Trust, Volunteer Cornwall.
1.2 Overall governance model	The HWB oversees the programme and the Joint Strategic Executive group is responsible for delivery.
1.3 Pioneer catchment area	Cornwall and the Isles of Scilly.
1.4 Target population	People who are, or are likely to become, high users of health and social care services.
1.4.1 Inclusion criteria	Currently people with at least 2 LTCs or with a social care package, but planned to expand to include other cohorts during 2015.
2. INTEGRATION PROCESS	
2.1 Vision/general aim of programme	Shape whole system around the person to drive decision making; start with a conversation with the person to understand their aspirations and goals; expanding the role of the voluntary sector is at the heart of the programme; everyone buying or supplying care and support will work to a shared plan.
2.2 Breadth of integration	Whole system: local integrated team of health, social care and voluntary sector, with shared processes, budgets, management, information and governance.
2.3 Types of services involved	Health and social care, mental health, end of life care, voluntary sector services and informal community/voluntary services.
2.4 Patient and public involvement	Cornwall Healthwatch supports engagement and consultation; GP practices have patient participation groups; piloting a People's Commissioning Board to develop patient role in commissioning; each locality has a local people, local conversation group made up of local people, community groups and organisations.
2.5 Timelines (priorities/targets)	2015 developments: developing workforce; creating online resources; IT portal; shared outcomes framework. Integrate commissioning functions; explore new payment arrangements; evaluation of Penwith pilot; delivery and evaluation of East Cornwall; roll out to three more sites; develop integrated care community governance model.
3. INFRASTRUCTURE AND ENABLERS	
3.1 Technical	
3.1.1 Shared electronic patient/client records (IT)	Working with BT to develop shared clinical portal to provide access to health and social care record at point of care.
3.1.2 Risk stratification	Risk stratification used to help GPs identify suitable people for the Living Well approach.
3.2 Workforce	
3.2.1 Workforce development	Currently designing new workforce roles, and a values based recruitment, development and improvement programme.
3.2.2 Integrated working (e.g. joint staff, co-location)	Director of Pioneer is CEO of Age UK Cornwall & Isles of Scilly, and is jointly appointed by CCG and LA. Living Well practitioners are located with district nurses, GPs and social workers and move round offices to ensure communication, feedback and trust and relationships are built and maintained. Currently exploring the option of locating practitioners within local authorities' one stop shops as well to support the localism/devolution agenda.
3.3 Financial	
3.3.1 Joint commissioning /pooled budget	Currently exploring options for integrated commissioning across CCG and local authority.
3.3.2 Financial arrangements	Currently exploring alternative options for contracting the Living Well approach including alliance contracts and social impact bonds.
3.3.3 Integrated personal commissioning (personal budgets)	Approved to be part of the early national pilot.
4. MEASURING SUCCESS	
4.1 Internal evaluation/ monitoring	Outcomes and metrics for project co-designed by all partners and people and agreed, using Triple Aim: improved health and wellbeing; improved experience of care and support; reduced cost. A range of evaluations planned or in process, including: Nuffield Trust looking at utilisation and costs for Penwith patients; Univ of Exeter looking at the role of the volunteer, and how the programme works in practice; a survey of practitioners by the CCG; and others.
4.2 Expected outcomes/ targets	Over 50+ measures have been developed looking at the Triple Aim. The Pioneer expects improved or maintained ability to manage LTCs, social care needs, independence, improved QoL, improved staff satisfaction. There should be reduced costs for acute and community admissions, social care support, residential care, primary care, etc.

1. ABOUT THE PIONEER	GREENWICH
1.1 Lead and other organisations involved	Greenwich LA, Greenwich CCG, Oxleas NHS FT, Healthwatch, Greenwich Action for Voluntary Services, Lewisham and Greenwich NHS Trust, primary care in Greenwich.
1.2 Overall governance model	Greenwich Co-ordinated Care (GCC) Project Board, linked with HWB, oversees strategic direction and is the delivery vehicle for integration and the Better Care Fund. GCC Project Board currently developing Delivery Plan closely aligned to the priorities in the HWB Strategy. Each organisation continues to deliver services into GCC from within their own governance systems, while working with the shared approach underpinning the GCC Board. Local Community Based Care Transformation Steering Groups for LTC, mental health, unscheduled care, primary care, planned care and children.
1.3 Pioneer catchment area	Greenwich local authority area.
1.4 Target population	Older adults with complex or chronic conditions and individuals with mental health issues. Currently considering widening the approach to other populations.
1.4.1 Inclusion criteria	People who are, or are likely to become, part of the target groups (high users).
2. INTEGRATION PROCESS	
2.1 Vision/general aim of programme	Focus on integrating services across the whole system to enable people to manage their own health and wellbeing. Extend the current integrated rapid response and intermediate care model to more patients with complex needs through providing better coordinated care earlier in the pathway (phase 2). Strategy is to 'build a team around the person' by focussing attention on primary care and better co-ordinating services already available including mental health. The model is being tested with clusters of GP practices to create a 'community of practice'.
2.2 Breadth of integration	Mostly horizontal through integrated health and social care teams; involvement of third sector.
2.3 Types of services involved	All local services: primary and community, acute, mental health, social care and voluntary sector.
2.4 Patient and public involvement	No specific user group but has access to other existing patient groups. Model focusses on the narrative from National Voices and previous local involvement events. Healthwatch are part of the Project Board and are involved in the evaluation and feedback from the patients/service users' perspective.
2.5 Timelines (priorities/targets)	2014 developments: continuation of the 'Test and Learn site' activities in Eltham. Start a new 'test and learn' (October 2014) in Woolwich and Thamesmead to test the model in a deprived geographical area with complex problems such as drug and alcohol misuse and mental health issues.
3. INFRASTRUCTURE AND ENABLERS	
3.1 Technical	
3.1.1 Shared electronic patient/client records (IT)	Not currently operational but the care navigator service has access to community health and social care records, including mental health, on different systems. Care navigators will have access to a combined community/mental health record from summer 2015.
3.1.2 Risk stratification	Risk stratification partly used to identify high risk cases. Others are referred based on health and social care professionals identifying need for the service.
3.2 Workforce	
3.2.1 Workforce development	Cultural change management and action learning approach taken to model design and building integrated teams supported by Institute of Public Care, Oxford Brookes University. Integrated workforce development workstream being developed as part of the Delivery Plan. HESL to fund bid to look at roles of care navigators across SE London.
3.2.2 Integrated working (e.g. joint staff, co-location)	Joint management appointments, but staff contracts stay with original organisation; integrated teams (if the lead is a social worker, the second in command is a health care worker). Co-located teams of nurses, physiotherapists, OT, social workers and care managers already in existence. The care navigator service is located in the community and includes social workers as well as a health professional as the lead. The mental health services have been fully integrated and managed by the community/mental health provider (Oxleas NHSFT) for many years.
3.3 Financial	
3.3.1 Joint commissioning /pooled budget	Greenwich has long established mature arrangements for joint commissioning of services for all mental health services and for adults with learning disabilities. No additional joint commissioning planned.
3.3.2 Financial arrangements	Financial and commissioning decisions are coordinated between partners; to be developed, notably in terms of alignment of incentives.
3.3.3 Integrated personal commissioning (personal budgets)	Aim to develop integrated personal budgets to maintain independence alongside a commitment to implement personal health budgets.
4. MEASURING SUCCESS	
4.1 Internal evaluation/ monitoring	In progress, dashboard being developed for monitoring. Patient study conducted by Healthwatch. Staff survey has been conducted.
4.2 Expected outcomes/ targets	Reduced cost of admissions/services in acute/community/mental health trusts/residential care etc. Shift 55% of acute activity to community; avoid 30% of non-complex non-elective acute admissions; 40% reduction in admissions for LTCs.

1. ABOUT THE PIONEER	ISLINGTON
1.1 Lead and other organisations involved	Islington CCG, Islington LA, Whittington Health NHS Trust, Camden and Islington Mental Health FT, UCL Hospital NHS FT, UCL Partners (academic). Healthwatch
1.2 Overall governance model	IC Board includes clinical leads, IC director, director of commissioning, director of adult social care, provider partners, Healthwatch and a patient representative, etc. The IC Board reports to Strategy & Finance Committee in Islington CCG. The local authority reports to HWB.
1.3 Pioneer catchment area	Islington local authority and CCG area (which are coterminous).
1.4 Target population	Two focuses: 1) population health-wide approach; 2) improving the health of those that need to receive targeted interventions.
1.4.1 Inclusion criteria	For (2) above - intensive service users, i.e. those with more than one LTC, half of whom are 75+ years. People with mental health problems, >30,000 patients.
2. INTEGRATION PROCESS	
2.1 Vision/general aim of programme	To develop a whole system approach to service planning and delivery to support the wider population and better coordinate care for intensive users. High levels of deprivation require whole population based approach to integrated care. Aim to reduce inequalities and poverty as set out in Islington Fairness Commission.
2.2 Breadth of integration	Mostly horizontal through MDT with focus on primary care, mental health professionals, community nursing and social workers. Islington has an ICO (Whittington Health NHS Trust) that provides vertically integrated acute, community and primary care.
2.3 Types of services involved	Primary and secondary care, mental health services, nursing and housing.
2.4 Patient and public involvement	There is 1patient/service user representative on the Integrated Care Board. Involvement from Healthwatch.
2.5 Timelines (priorities/targets)	<p>2014/15 Understand the local system through risk stratification, systems resilience planning, collaborative work and a robust BCF plan; develop new ways of working including proactive ambulatory care, an integrated community ageing team, proactive work with care homes, an integrated psychiatric liaison and assessment team, locality navigators and community paediatric nurses; link personalised health and social care budgets, co-production, collaborative care planning and self-management; learn from local pilots and 8 'test and learn' sites; develop enablers including integrated IT, a CEPN; develop new commissioning approaches, e.g. value-based commissioning for diabetes and psychosis.</p> <p>2015/16 Develop a full locality offer, including: a focus on prevention; services that are person centred and support self-management; community health and care wrapped around primary care; proactive, rapid responses, with interface between hospitals and the community; develop a single point of access.</p>
3. INFRASTRUCTURE AND ENABLERS	
3.1 Technical	
3.1.1 Shared electronic patient/client records (IT)	Procuring an integration engine that will enable the development of shared patient records.
3.1.2 Risk stratification	Risk stratification tool used with MDTs.
3.2 Workforce	
3.2.1 Workforce development	Islington became a Community Education Provider Network (CEPN) in April 2014. This has overseen a number of workstreams including: piloting the Care Certificate to improve training for Band 1-4 staff (includes reception staff, healthcare assistants, domiciliary care etc); developing placements in primary care for undergraduate nurses; workforce modelling.
3.2.2 Integrated working (e.g. joint staff, co-location)	Considering potential to share premises and co-locate as part of locality offer.
3.3 Financial	
3.3.1 Joint commissioning /pooled budget	Joint commissioning since 2002, when the local authority and PCT pooled budgets. Experience with pooled budgets for mental health care through the Camden & Islington FT. BCF has expanded this.
3.3.2 Financial arrangements	In discussion. Looking at how levers can be built into contracts to support change. Developing value based commissioning for diabetes and mental health for 2015/16.
3.3.3 Integrated personal commissioning (personal budgets)	Using 'Making it real' to work with users to co-produce the implementation of personal budgets. Over 20 personal health budgets to date. Joint arrangements with local authority, and working on local offer for personalised budgets.
4. MEASURING SUCCESS	
4.1 Internal evaluation/ monitoring	Used the logic modelling approach to develop an evaluation framework.
4.2 Expected outcomes/ targets	4 high level outcomes: improved patient/user experience; improved health and care outcomes and reduced health inequalities; a sustainable health and care system with an efficient locality-based model of care and a lean acute provider sector; a system that can manage growing demand so residents receive the right care, in the right place at the right time. Islington has developed a local iteration of the 'I Statements'.

1. ABOUT THE PIONEER	KENT
1.1 Lead and other organisations involved	Kent County Council, all seven CCGs in Kent (Dartford Gravesham and Swanley, Swale, West Kent, Ashford, Canterbury and Coastal, South Kent Coast, Thanet). Kent Community Health NHS Trust, East Kent Hospitals University NHS FT, Kent and Medway NHS Social Care Partnership Trust and Commissioning Support Unit. Maidstone & Tunbridge Wells NHS Trust, Darent Valley Hospital.
1.2 Overall governance model	Kent Integration Pioneer Steering Group is a working group of the HWB to support partners in delivery. Existing governance arrangements retain accountability. The Group reports to the joint CCG/Social Directorate Management Teams, the HWB and other relevant groups as required.
1.3 Pioneer catchment area	Kent local authority area.
1.4 Target population	Adults with long term conditions and older people. Children and transition to adult services to be considered in future.
1.4.1 Inclusion criteria	Older adults and people with long-term/multiple conditions. Based on risk stratification and social care eligibility criteria.
2. INTEGRATION PROCESS	
2.1 Vision/general aim of programme	Make health and social care services work together to provide better support at home and earlier treatment in the community to prevent emergency care in hospital or care homes. The vision is citizens to be at the centre, with services wrapped around what's important to them. Residents can expect: better access; increased independence; empowerment for citizens to self-manage; improved care at home; rapid community response particularly for people with dementia; to live and die safely at home; access to control electronic information sharing; better use of information intelligence.
2.2 Breadth of integration	Whole system integration, across the entire health and social care economy.
2.3 Types of services involved	Health and social care, mental health, community and voluntary sector.
2.4 Patient and public involvement	Integration Pioneer signed up to Think Local Act Personal action plan. Action plan for engagement, linked to personalisation and 'I statements'. Local area implementation groups had public representatives included as members.
2.5 Timelines (priorities/targets)	Pioneer aims to build upon existing integration at a faster pace. Main areas of progress have been developing the local vision and objectives and developing the leadership and governance arrangements. Also some operational developments of care pathways and integrated teams. Completion by 2018.
3. INFRASTRUCTURE AND ENABLERS	
3.1 Technical	
3.1.1 Shared electronic patient/client records (IT)	Aim is for an IT integration platform to enable clinicians and others, including the patient, to view and input information so that care records are joined up.
3.1.2 Risk stratification	Risk stratification of patients takes place across Kent to inform MDTs. Public health leads developing approaches for risk stratification to inform commissioning. They cross-match pseudonymised data with social care and health provider records in order to provide comprehensive analysis.
3.2 Workforce	
3.2.1 Workforce development	Key workforce needs being identified within CCG areas and development of local implementation plans.
3.2.2 Integrated working (e.g. joint staff, co-location)	Some joint posts established for delivery (South Kent Coast and Ashford and Canterbury). Co-location in North Kent, with potentially more co-location as plans are implemented.
3.3 Financial	
3.3.1 Joint commissioning /pooled budget	Integrated commissioning to be informed by all key stakeholders including patients, district councils and housing. Year of Care model being developed.
3.3.2 Financial arrangements	Procurement model: alliance, lead provider, key strategic partner, industry contracts. Aspiration for pooled budget BCF plan 2014-16.
3.3.3 Integrated personal commissioning (personal budgets)	NHS Kent and Medway completed two Personal Health Budget (PHB) pilots. Going Further Faster integrated personal budgets are being piloted, and Pioneer accelerated pace of roll-out.
4. MEASURING SUCCESS	
4.1 Internal evaluation/ monitoring	A number of performance measures are in place using the BCF, Year of Care and the HWB assurance framework as well as local CCG area measures. Work is taking place to combine these to a coherent set of outcome measures. Evaluation workstream established working with partner universities in Kent.
4.2 Expected outcomes/ targets	The aim is to develop outcome measures based on the 'I Statements'. BCF measures as follows: emergency admissions – 3.5% reduction in non-elective admissions; admissions to care/residential homes – 7.4% reduction in permanent admissions to residential and nursing care; effectiveness of reablement – increased proportion of older people still at home 91 days after discharge; transfers of care - 22% reduction in delayed transfers of care for 2015/16; Patient/service user experience - increase percentage of those in last 6 months who had enough support from local services or organisations to help manage long-term health condition (from GPPS); reduction in admissions due to falls.

1. ABOUT THE PIONEER	LEEDS
1.1 Lead and other organisations involved	Leeds City Council, Leeds North CCG, Leeds South and East CCG, Leeds West CCG, Leeds Community Healthcare NHS Trust, Leeds Teaching Hospitals NHS Trust, Leeds and York Partnership FT.
1.2 Overall governance model	Leeds Health and Social Care Transformation Board which reports to the HWB.
1.3 Pioneer catchment area	Leeds local authority area.
1.4 Target population	All adults and children.
1.4.1 Inclusion criteria	
2. INTEGRATION PROCESS	
2.1 Vision/general aim of programme	Rather than focus on structural solutions, the approach is developmental and iterative, focussed on finding ways for staff from different organisations and backgrounds to work together with service users, families and carers to find solutions that best meet their needs and deliver the best experiences, outcomes and use of collective resources. Our vision is that Leeds will be a health and caring city for all ages, where people who are the poorest will improve their health the fastest. People who use care and support, as well as their families and carers, have told us they want 'support that is about me and my life, where services work closer together by sharing trusted information and focussing on prevention to speed up responses, reduce confusion and promote dignity, choice and respect'. Through our Pioneer programme, we aim to improve quality of experience of care and health outcomes for the people of Leeds in line with this vision.
2.2 Breadth of integration	Horizontal.
2.3 Types of services involved	All.
2.4 Patient and public involvement	Well championed and represented at Board level. Formed basis of metrics of patient experience.
2.5 Timelines (priorities/targets)	Five year vision for high quality and sustainable health and social care system. Year 1: Leeds Innovation Health Hub established; adoption of 'Leeds £'; new operating model rolled out Year 3: Hub expands across sectors; Cost benefit analysis and predictive model fully populated across Leeds Year 5: Choice, control and personalisation fully established across all ages
3. INFRASTRUCTURE AND ENABLERS	
3.1 Technical	
3.1.1 Shared electronic patient/client records (IT)	The Leeds Care Record is currently in development by Leeds Teaching Hospital. It will provide a 'view' access to clinical information from primary and secondary care via a single portal. There is a plan to roll-out the LCR to all GP practices, LYPCFT, LCH and some neighbourhood teams.
3.1.2 Risk stratification	Leeds has a system of risk stratification already in place to identify patients at high risk of hospital admission. In future the tool will be used to identify the top 2% of high risk patients from each practice. These will have a named accountable GP who will be responsible for developing a personalised care plan. The plan will also specify a care coordinator, who will be the most appropriate person from within the MDT.
3.2 Workforce	
3.2.1 Workforce development	In discussion. A key strategic ask of the Pioneer programme.
3.2.2 Integrated working (e.g. joint staff, co-location)	Currently with integrated health and social care community bed unit and Early Start Service. 12 integrated neighbourhood teams across the city, staffed by a mix of adult social care and healthcare professionals.
3.3 Financial	
3.3.1 Joint commissioning /pooled budget	Joint Health and Social Care Transformation Board and 'the Leeds £'.
3.3.2 Financial arrangements	Pooled funds.
3.3.3 Integrated personal commissioning (personal budgets)	Yes.
4. MEASURING SUCCESS	
4.1 Internal evaluation/ monitoring	Have developed a Leeds Integrated Health and Social Care Outcome Framework with the University of Birmingham. Will use 'caretrak' (an innovative product which tracks patient populations across the health and social care system based on use of NHS Number) to ascribe both clinical and financial value to an intervention.
4.2 Expected outcomes/ targets	Developed 'I statements' (now used by National Voices). Innovative approach using third sector to train researchers to conduct interviews. Bespoke informatics including longitudinal studies of individuals. Framework developed with university partner. Aligned with national outcomes framework and joint health and wellbeing strategy. Avoidable emergency admissions, readmissions, differences in life expectancy. Reducing number of children coming into care safely and appropriately. LOS, long term care placement bed weeks. Particular focus on impact on the broader system including the economy. Ability for multiple organisations to act as 'one' for Leeds.

1. ABOUT THE PIONEER	NORTH WEST LONDON
1.1 Lead and other organisations involved	31 organisations from North West London (NWL) including eight CCGs, seven Local Authorities, NHS England and community, health, mental health and acute providers.
1.2 Overall governance model	Governance structure in place across NWL and for local early adopters (EAs). Integration Board brings together senior leadership from partner organisations across NWL. Working groups at programme level to take forward workstreams across NWL. Programme coordinated by Strategy & Transformation team which is jointly funded by 8 CCGs. S&T team works closely with partner organisations including local authorities and providers. Local EA steering groups.
1.3 Pioneer catchment area	Eight NWL local authority areas.
1.4 Target population	Potentially whole population of 2 million from eight London LAs. Work to segment the NWL population into 10 groups based on similarity of need. From next year, local EAs will focus primarily on older people with one or more LTCs but it is intended to extend the approach to other population groups as proof of concept is achieved.
1.4.1 Inclusion criteria	All EA projects have identified target group e.g. 75+ and healthy, 75+ with one or more LTC.
2. INTEGRATION PROCESS	
2.1 Vision/general aim of programme	Strategy consists of vision, 3 pillars, 10 steps to achieving integrated approach across the system. Vision is to support carers and families, empower and support people to maintain independence and to lead full lives as active participants in their community. 3 pillars: 1) People empowered to direct their care and support and to receive the care they need in their homes or local community; promote the long-term, sustainable wellbeing of the whole person. 2) GPs at the centre of organising and coordinating people's care. 3) Systems that enable, not hinder, the provision of integrated care, e.g. payments for outcomes not activity; information sharing; providers accountable for outcomes and demonstrable efficiencies. Partner organisations work together and with lay partners to co-design new approach, which culminated in launch of NWL toolkit to support implementation. Local development and planning to implement vision for integration, initially through nine EA projects to prepare for subsequent roll out (one EA per local authority plus one mental health programme across all LAs). EAs to develop locally appropriate integrated commissioning and integrated provider models.
2.2 Breadth of integration	Whole systems working is core concept, meaning integrated commissioning budget and integration between providers of health and social care. Understandings of scope of 'whole systems' continues to develop.
2.3 Types of services involved	CCGs, local authorities, acute, community, primary and mental health providers, third sector, community organisations, lay partners.
2.4 Patient and public involvement	Co-production involving lay partners has been growing force over the past 6-12 months. Now a continuing process which has had impact on nature of debates between stakeholders and content of toolkit and EA OBCs. Lay partner model becoming embedded into 'usual' way of working but not without challenge.
2.5 Timelines (priorities/targets)	A clear path forward with new models of integrated care being implemented in 2015/16 supported in some areas by shadow capitated budgets, based on experience from EAs (staged and timetabled process provides route map).
3. INFRASTRUCTURE AND ENABLERS	
3.1 Technical	
3.1.1 Shared electronic patient/client records (IT)	Core principle and currently being developed. A core requirement as EAs move towards maturity.
3.1.2 Risk stratification	Plans for further stratification based on need within each of the ten population groups.
3.2 Workforce	
3.2.1 Workforce development	Recognise importance of cultural change among front line staff; linked to other transformational initiatives including Shaping a Healthier Future (acute services) reconfiguration, seven day services, PM's Challenge Fund. Ealing is site for national Home Truths workforce initiative.
3.2.2 Integrated working (e.g. joint staff, co-location)	Plans for providers to pool staff into integrated care teams in the EAs initially and more generally subsequently.
3.3 Financial	
3.3.1 Joint commissioning /pooled budget	Plans for pooled budgets across health and social care out of which capitation payments will be made, focussed on target population groups.
3.3.2 Financial arrangements	CCGs pooling 2.5% non-recurrently for transformation activity and shifting funding between above and below target areas; capitated funding is anticipated to be rolled out across all settings and commissioners. At least five CCGs said to have moved from PBR to block plus reward payments this year.
3.3.3 Integrated personal commissioning (personal budgets)	Some interest at EA level in taking forward this concept.
4. MEASURING SUCCESS	
4.1 Internal evaluation/ monitoring	Formative evaluation commissioned across NWL, partly with responsibility to suggest indicators and metrics (available May 2015). High level NWL wide person-centred outcomes framework being planned to support EAs.
4.2 Expected outcomes/ targets	NWL wide outcomes framework being developed. Modelling in Triborough as part of national community budgets pilot adopted and developed through Pioneer to identify cost effectiveness of out of hospital services (and seen as national model).

1. ABOUT THE PIONEER	SOUTH DEVON & TORBAY
1.1 Lead and other organisations involved	South Devon and Torbay CCG, South Devon Healthcare NHS FT, Torbay and Southern Devon Health and Care NHS Trust, Torbay Council, Devon Partnership NHS trust.
1.2 Overall governance model	Joined Up Board includes all system leaders from health and social care (CCG, social care, acute, community, mental health and hospice providers).
1.3 Pioneer catchment area	South Devon and Torbay CCG.
1.4 Target population	Whole population.
1.4.1 Inclusion criteria	
2. INTEGRATION PROCESS	
2.1 Vision/general aim of programme	Making a person's journey through the system as simple and seamless as possible. Extending existing model of integrated care for frail elderly across the whole community.
2.2 Breadth of integration	Vertical and horizontal.
2.3 Types of services involved	Adults, children, mental health, learning disability, end of life.
2.4 Patient and public involvement	CCG Strategic Public Involvement Group. Selected their own members from within their networks, and selected their own chair and vice chair. Two Healthwatch organisations.
2.5 Timelines (priorities/targets)	Integrated community hubs (frail elderly and young people's services) and joined-up IT programmes under development.
3. INFRASTRUCTURE AND ENABLERS	
3.1 Technical	
3.1.1 Shared electronic patient/client records (IT)	E-prescribing, e-booking, VitalPAC (bedside vital signs monitoring). An inter-operability portal to share information between different systems is under consideration.
3.1.2 Risk stratification	Predictive modelling to identify patients most at risk of admission.
3.2 Workforce	
3.2.1 Workforce development	Currently have health and social care co-ordinators in community health and social care (trained in nursing, physiotherapy, OT, social work) and support workers in intermediate care (broader range of training). Considering further workforce redesign.
3.2.2 Integrated working (e.g. joint staff, co-location)	Community hubs.
3.3 Financial	
3.3.1 Joint commissioning /pooled budget	
3.3.2 Financial arrangements	Pooled budget.
3.3.3 Integrated personal commissioning (personal budgets)	No.
4. MEASURING SUCCESS	
4.1 Internal evaluation/ monitoring	In discussion.
4.2 Expected outcomes/ targets	Self-harm metrics to be agreed with service users; alcohol use - personal goals set with individuals, experience against NV measures; dementia metrics to be agreed with service users; patient survey for 7 day services. 7 day services has staff survey, recruitment. 7 day services - SHMI mortality indicator. 7 day services - readmissions, LOS. Reduce self-harm attendances by 10%/year; 0% increase in alcohol related hospital admissions; reduce frequent attenders to secondary care with medically unexplained symptoms by 10%; reduce dementia hospital admissions by 10%/year; increase number of people supported to die at home; reduce hospital deaths by 10%/year; 25% reduction in LOS for patients in last two weeks of life. Developing evaluation framework for children's hub and frailty hub.

1. ABOUT THE PIONEER	SOUTH TYNESIDE
1.1 Lead and other organisations involved	South Tyneside Council, South Tyneside CCG, South Tyneside FT, Tyne and Wear FT.
1.2 Overall governance model	Pioneer is a workstream of the Integration Board. (As of December 2014 this situation has changed, so that principle of Pioneer self-management will be embedded across all integrated care workstreams.)
1.3 Pioneer catchment area	South Tyneside local authority area.
1.4 Target population	Whole population with focus on people who could benefit from initiatives on prevention, wellness promotion and self-care.
1.4.1 Inclusion criteria	
2. INTEGRATION PROCESS	
2.1 Vision/general aim of programme	Strengthening self-care.
2.2 Breadth of integration	Horizontal.
2.3 Types of services involved	Self-care and early help.
2.4 Patient and public involvement	Asset based approach to public consultation. Representation of users in staff workshops. Engagement strategy.
2.5 Timelines (priorities/targets)	Early focus on 111 access, improved pathways for high hospital users, integrated diabetes services, new Change4Life service, employment prospects for young people.
3. INFRASTRUCTURE AND ENABLERS	
3.1 Technical	
3.1.1 Shared electronic patient/client records (IT)	
3.1.2 Risk stratification	Yes.
3.2 Workforce	
3.2.1 Workforce development	Training for staff to promote self-management.
3.2.2 Integrated working (e.g. joint staff, co-location)	Yes.
3.3 Financial	
3.3.1 Joint commissioning /pooled budget	
3.3.2 Financial arrangements	Exploring 'main contractor' model.
3.3.3 Integrated personal commissioning (personal budgets)	No.
4. MEASURING SUCCESS	
4.1 Internal evaluation/ monitoring	In development.
4.2 Expected outcomes/ targets	Developing measures of people's experience of self-care.

Note: In autumn 2014, South Tyneside Pioneer plans had changed to embed the principle of self-management in all their integration workstreams. This will be reflected in the final report for the early evaluation (summer 2015).

1. ABOUT THE PIONEER	SOUTHEND
1.1 Lead and other organisations involved	Southend Borough Council, Southend CCG, Southend University Hospital NHS FT, Southend Association of Voluntary Services, South Essex Partnership University NHS FT.
1.2 Overall governance model	A Pioneer Joint Executive Group (JEG) with all partners provides programme direction. It is directly accountable to Southend HWB for delivery. Each of the five workstreams has a management group which meets regularly and reports, through the programme manager, to the JEG.
1.3 Pioneer catchment area	Southend local authority area.
1.4 Target population	Whole population with focus on high service users. Initial phase of the operations work stream to focus on adults with physical disability and older people. Second phase to include mental health, learning disability and children.
1.4.1 Inclusion criteria	Primary Care Hub pilot will include development of a risk stratification approach to intervention. Voluntary sector involved in the development of early intervention.
2. INTEGRATION PROCESS	
2.1 Vision/general aim of programme	Overall aim is to develop a model of integration which can be rolled out across Southend. This involves better integrated services and better access (co-design with patients, more choice and community care, integrated teams, single point of access); better integrated information (integrated dataset, uncomplicated pathways); better understanding of residents and their experiences; focus on prevention and individual responsibility (telecare, telehealth, housing, individual budget); better use of resources through joint planning and commissioning. A Primary Care Hub pilot with GPs as the central focus will be developed to act as the first Hub around which current MDT's will be further integrated.
2.2 Breadth of integration	Mostly horizontal through integrated health and social care teams, including the third sector.
2.3 Types of services involved	Developing a broader 'all ages approach' to integration, engaging and mobilising a wider range of partners. Explore options to improve joint working from learning disabilities and services working with frail elderly.
2.4 Patient and public involvement	Deliberative sessions, direct engagement, 'come and tell us' events, consultation and focus groups. National Pathfinder for Patient & Public Involvement. Plans to co-design services with users (e.g. consult on strategy for older people). A series of workshops involving all stakeholders has been held with further events planned.
2.5 Timelines (priorities/targets)	In 2014, five workstreams were signed off by the JEG: prevention and engagement; commissioning; operations; information and technology; communications.
3. INFRASTRUCTURE AND ENABLERS	
3.1 Technical	
3.1.1 Shared electronic patient/client records (IT)	'Caretrack' information sharing platform: jointly commissioned by health and social care to enable both risk stratification and pathway redesign. Patient data shared on a pseudonymised basis. Phase 2 to include community services data. Issues with IG have slowed progress.
3.1.2 Risk stratification	Planned but facing information governance issues.
3.2 Workforce	
3.2.1 Workforce development	In a scoping phase.
3.2.2 Integrated working (e.g. joint staff, co-location)	Planned a joint commissioning lead for integrated care. The structure for joint commissioning has been developed and the job description for a joint post has been developed. Single point of referral team is co-located. Co-location of staff is being discussed between CCG and LA. Primary Care Hub pilot will include co-location of front line staff.
3.3 Financial	
3.3.1 Joint commissioning /pooled budget	The commissioning workstream is well under way and a memorandum of agreement between the local authority and the CCG has been signed. A joint commissioning structure is being developed and a joint commissioning post agreed. A mental health joint commissioning group is in place to develop a joint commissioning process.
3.3.2 Financial arrangements	Plan to develop, shadow and monitor a currency for patients with LTCs and develop a contracting and commissioning framework for local use. Plan to test the RRR concept to establish whether funds can be liberated from within national tariffs (HRGs) to support rehabilitation and reablement services.
3.3.3 Integrated personal commissioning (personal budgets)	Plan to develop personal health budget. Increased used of personal (social care) budgets reported. Greater use of personal budgets (health and social care) is expected through the Primary Care Hub pilot.
4. MEASURING SUCCESS	
4.1 Internal evaluation/ monitoring	Plan to monitor service performance; joint planning to apportion costs and benefits across the whole system; cashable savings generated. An evaluation working group has been formed which will develop the process for monitoring performance and will include both qualitative and quantitative data (including for evaluating users experience). Plans to align with BCF.
4.2 Expected outcomes/ targets	Improve the service user experience, increasing community resilience and personal responsibility, and improve health and social care sustainability (reduction of hospital admission and admissions to care homes).

1. ABOUT THE PIONEER	STAFFORDSHIRE AND STOKE
1.1 Lead and other organisations involved	Macmillan cancer support, North Staffordshire CCG, Stoke on Trent CCG, Cannock Chase CCG, Stafford and Surrounds CCG.
1.2 Overall governance model	Programme Board and delivery subgroups. Staffordshire County and Stoke-on-Trent City Council are represented in the Programme Board, which reports back to CCG Boards. The programme is led by independent management, while the Programme Board chair is Chief Officer in two of the four CCGs. Programme Board also includes Specialised Commissioning, Public Health and GP representatives, together with CCGs and Macmillan.
1.3 Pioneer catchment area	Population served by the 4 CCGs.
1.4 Target population	Patients receiving cancer care and patients receiving end of life care (all LTCs). All cancers patients are expected to be included over the 10 year duration of the contract, but initial focus is on patients with breast, lung, bladder and prostate cancer. Patients in the last year of their life.
1.4.1 Inclusion criteria	Diagnostic criteria for cancer patients and tools to identify patients eligible for end of life care to be developed by the Service Integrator.
2. INTEGRATION PROCESS	
2.1 Vision/general aim of programme	Redesign of pathway for cancer and end of life care, bringing together specialist with community/primary care. Integration of cancer care and end of life care will be delivered by a Service Integrator, according to the prime provider model. Two separate contracts will be made for cancer and for end of life care.
2.2 Breadth of integration	Horizontal and vertical. All health care commissioned by CCGs for patients with cancer and patients in their last year of life. Specialised care commissioned by NHS England and social care commissioned by local authorities will be included.
2.3 Types of services involved	Preventative, primary, acute, specialised, community and social care.
2.4 Patient and public involvement	30 patient champions have been recruited and trained to evaluate bids, and their views have been put at the heart of the programme.
2.5 Timelines (priorities/targets)	Aim is to appoint Care Integrators for cancer and for end of life care by April 2015; procurement process started in summer 2014. During the first two years of the contract, the Service Integrator will analyse the current arrangements in order to devise their re-organisation of care pathways. During this time, existing contracts with the providers will sit with the current commissioners, and the Service Integrator will be funded by Macmillan. After approximately 18 months from appointment, the Care Integrator will submit a set of commissioning intentions to the commissioners, about the changes they want to make over the next years of the contract. These intentions will need to be approved by commissioners. From the third year on, the Service Integrator is expected to finance itself through improved system efficiencies.
3. INFRASTRUCTURE AND ENABLERS	
3.1 Technical	
3.1.1 Shared electronic patient/client records (IT)	Current level of record integration is deemed unsatisfactory, and is identified as a crucial priority that the Service Integrator(s) will need to tackle.
3.1.2 Risk stratification	To be considered and possibly developed by Service Integrator(s).
3.2 Workforce	
3.2.1 Workforce development	Workforce development is identified as a key step towards integrated working, especially for end of life care, and the expected shifts in services to the community/closer to home. Workforce will be reviewed by working with LETB, CCGs and LOCAL AUTHORITY commissioners, and local Deanery.
3.2.2 Integrated working (e.g. joint staff, co-location)	Determining aligned workforce strategies across health and social care commissioners is also identified as a key step.
3.3 Financial	
3.3.1 Joint commissioning /pooled budget	Agreements exist between the CCGs and the local authorities and NHS England that specialised services and social care are part of the pathway. Financial arrangements to be developed in order to include these services within Service Integrator activity.
3.3.2 Financial arrangements	The prime provider model will be applied and the commissioning will be outcome based. The Service Integrator(s) will develop their purchasing arrangements with possible further providers.
3.3.3 Integrated personal commissioning (personal budgets)	To be considered and possibly developed by Service Integrator(s).
4. MEASURING SUCCESS	
4.1 Internal evaluation/ monitoring	Outcome monitoring essential to programme management. Current plan is to choose a manageable number of indicators, to cover the following areas: patients' and clinicians' satisfaction; clinical outcomes, likely to be survival rates; activity indicators, e.g. volume of key processes, identified as beneficial; resource utilisation.
4.2 Expected outcomes/ targets	Key metrics still need to be identified in detail. Targets will be set according to data collected during the first two years of contract by the Service Integrator, which will provide a baseline to measure future progress.

1. ABOUT THE PIONEER	WALTHAM FOREST, EAST LONDON AND CITY (WELC)
1.1 Lead and other organisations involved	Waltham Forest, Newham, Tower Hamlets CCGs and LAs; Barts Health NHS Trust; East London NHS FT; North East London NHS FT; UCL Partners.
1.2 Overall governance model	Integrated care board in each LOCAL AUTHORITY includes commissioners and providers; central Programme Management Office (PMO) oversees workstreams; Executive Group with managers from CCGs, local authorities and the PMO oversees the PMO and LOCAL AUTHORITY boards; Integrated Care Management Board provides overall strategy and guidance; the programme reports to each LA's HWB, and each LOCAL AUTHORITY reports through normal governance structures; each LOCAL AUTHORITY retains accountability. The governance structure is being reviewed pending outcome of discussions about governance for the Transforming Service Together programme.
1.3 Pioneer catchment area	Waltham Forest, Newham and Tower Hamlets local authority areas.
1.4 Target population	Population at risk of a hospital admission within next 12 months.
1.4.1 Inclusion criteria	Top 20% at risk of hospital admission in next 12 months. Use risk stratification, starting with top 5% (very high and high risk), and moving over time to including the remaining 15%.
2. INTEGRATION PROCESS	
2.1 Vision/general aim of programme	Model of integrated care that looks at whole person – physical health, mental health and social care needs – and focusses on empowering individuals by providing responsive coordinated and proactive care, and ensuring consistency and efficiency. Evidence-based model of care adapted to local population needs.
2.2 Breadth of integration	Secondary and primary care, health and social care services; focus on mental health services; primary care networks; greater involvement of voluntary sector.
2.3 Types of services involved	Model of care covers supported discharge, care planning and coordination, mental health liaison and rapid assessment and discharge; self-care and specialist support in the community with key enablers of primary care networks, information sharing, technology, alignment of financial incentives, payment on outcomes, OD and workforce.
2.4 Patient and public involvement	PPI central to development of services in local authorities and CCGs; community representatives on HWBs and local integrated care boards; users involved in co-production of services; workshops held for users.
2.5 Timelines (priorities/targets)	Implementation started in Q2 2013 for 'very high risk' patients for care plans, care navigation, rapid response, discharge support; 2014/15 will include 'high risk' patients (e.g. self-care, discharge support); 2015 on will expand to include 'moderate risk' patients.
3. INFRASTRUCTURE AND ENABLERS	
3.1 Technical	
3.1.1 Shared electronic patient/client records (IT)	Investing in IT to link health and social care records.
3.1.2 Risk stratification	Aim to identify top 20% of population at risk of hospital admission in next 12 months. Risk stratification currently varies between the three LAs, but moving towards a common programme-wide approach. Will use linked GP and acute hospital records, and mental health will be embedded in risk profiling.
3.2 Workforce	
3.2.1 Workforce development	Care navigation training being commissioned specifically to support new roles. OD framework for integrated care also under development. Providers are being challenged to think about new roles and working practices and provide training etc to support integration.
3.2.2 Integrated working (e.g. joint staff, co-location)	PMO funded by CCGs; several joint appointments in the three areas.
3.3 Financial	
3.3.1 Joint commissioning /pooled budget	
3.3.2 Financial arrangements	Providers agree in principle to moving to payment on outcomes. Developing capitation model over next 2-3 years. Provider development work is supporting development of local consortia/alliances/new model of care committed to working together to deliver an integration specification. Incentives are developing around a share of the savings achieved through successful delivery.
3.3.3 Integrated personal commissioning (personal budgets)	Personal health budgets will be offered to eligible patients.
4. MEASURING SUCCESS	
4.1 Internal evaluation/ monitoring	Steering group looking at metrics and evaluation at Pioneer level. UCL Partners have researcher-in-residence for two years.
4.2 Expected outcomes/ targets	Metrics for use of services, care outcomes and staff experience are under development. User experience will be measured using the 18 DH/Picker questions. All providers are developing these into local existing and new mechanisms to collect data. CCGs are investigating the use of PAMs and also taking part in the Aetna PROM development pilot. Savings are being tracked via the CCG QIPP schemes. Integration function metrics (emergency admissions, avoidable admissions, total bed days and readmissions at 30 days) are being actively tracked as part of the 14/15 CQUIN schemes, baselines agreed in Aug 2014.

1. ABOUT THE PIONEER	WORCESTERSHIRE
1.1 Lead and other organisations involved	Worcestershire Acute Hospitals NHS Trust, Worcestershire Health and Care NHS Trust, Worcestershire County Council, Redditch and Bromsgrove CCG, South Worcestershire CCG, Wyre Forest CCG, NHS England, Healthwatch, representatives of the voluntary and community sector.
1.2 Overall governance model	Through HWB and Strategic Partnership Group (SPG) which includes the CEOs and clinical leaders of all partner organisations including provider GPs.
1.3 Pioneer catchment area	Worcestershire local authority area.
1.4 Target population	Whole population with primary focus on older people and people living with long-term conditions.
1.4.1 Inclusion criteria	Based on risk and activity stratification.
2. INTEGRATION PROCESS	
2.1 Vision/general aim of programme	Improve user experience. Provide care and support that addresses individual needs using a whole-person approach. Invest in prediction, prevention and early intervention. Offer more care in community hospitals, the wider community and in people's homes. Improve health in communities and groups where health is poorest.
2.2 Breadth of integration	Collaborative cross-sector approach based on clinical & service integration (not organisational integration). Primary, community, social and secondary care; involvement of voluntary sector and increased emphasis on self-care.
2.3 Types of services involved	Primary and secondary health care, voluntary, ambulance, social care, housing.
2.4 Patient and public involvement	Communications and engagement workstream. Engagement events held throughout 2013 and 2014.
2.5 Timelines (priorities/targets)	Developing new models of care and improving patient flow. Workstreams include clinical and professional leadership, shared accountability, ICT and information sharing, performance indicators, aligned incentives, workforce development and involvement, engagement and communication. Developing integrated commissioning plans based on outcomes and use of capitated budgets.
3. INFRASTRUCTURE AND ENABLERS	
3.1 Technical	
3.1.1 Shared electronic patient/client records (IT)	GPs use EMISweb, which allow shared data between primary, community and secondary care to give access (with patient consent) in A&E, medical assessment units, and out-of-hours service, with aim to roll out to other services (e.g. community hospitals, community teams, prisons). Can extend to social care with user consent. Technical issues emerging about integration of records between primary and community care. Data governance for secondary use proposed (e.g. stratification and capitation) also represents a barrier, which needs unlocking from central level.
3.1.2 Risk stratification	For older people with co-morbidities.
3.2 Workforce	
3.2.1 Workforce development	Workforce curriculum and training development is supported by Worcester University and discussions are on-going with LETB. Agreement to countywide workforce planning process.
3.2.2 Integrated working (e.g. joint staff, co-location)	The Pioneer director is jointly funded by LOCAL AUTHORITY and CCGs. For services that are jointly commissioned (e.g. mental health and learning disabilities) there is single line management structure in which staff employed by social care and health work in single teams. Timberdine Nursing and Rehabilitation is jointly commissioned by CCGs and LOCAL AUTHORITY and provided by the LA, employing social care staff, nurses and other health professionals.
3.3 Financial	
3.3.1 Joint commissioning /pooled budget	Existing joint commissioning of some services (e.g. substance misuse, children's community paediatrics, sexual health, CAMHS and adult mental health, learning disability, etc) through section 75 agreement (value c.£175m). Programme Director also accountable for delivery of BCF.
3.3.2 Financial arrangements	Interested in Year of Care payment and new contractual models. Aligned incentives workstream is addressing the commissioning, contracting and financial flexibilities that can support integration across stakeholders. Pilot for the use of SIBs. Plans to use the BCF to create a capitated budget to contract care for high-cost patients with multiple chronic diseases. Contractual vehicle still to be identified. Participants in the Monitor-led Pioneer group exploring new options for integrated care payment methodology.
3.3.3 Integrated personal commissioning (personal budgets)	All social care clients have a personal budget, 25% of them receiving this through direct payment. CCGs working on personal health budgets and opportunity to synergise with social care PB.
4. MEASURING SUCCESS	
4.1 Internal evaluation/ monitoring	One CCG developed specific measures of integration. Targets specified in the five Year Health and Care Strategy include integrated care.
4.2 Expected outcomes/ targets	User experience is central measure of integration: 1) improve user experience of care and services received; 2) improve access to services that support people in looking after themselves and each other; 3) provide timely access to relevant user information for those delivering services. Provide better overall VfM. Reduce emergency admission by 15%; reduce Admission Composite Indicator in the 3 CCGs; reduce permanent admission of over 65s to residential and nursing care homes, from 594.7 to 547.5 per 100,000 within the next 5 years.

Note for Table C1 for all Pioneers: Each Table was completed by a member of the research team in liaison with the Pioneer. Interpretations of the categories and decisions about what was relevant to include in the Table may differ slightly between sites.

APPENDIX D: Barriers and facilitators

As indicated in Section 7, dozens of ‘barriers’ were mentioned by interviewees during data collection. A list of the barriers mentioned are paraphrased in this Appendix to give a flavour of the issues which Pioneers have raised and need to confront and overcome. These vary greatly in their significance and whether or not they are generalizable to more than one site or specific to a particular Pioneer. The barriers have been categorised by the research team according to a number of headings and sub-headings. It should be noted that other categorisations are of course possible, and that the groupings provided are not mutually exclusive; many of the barriers could be included in more than one category.

Barriers

I National policy framework/contextual issues

A *Mixed agendas/objectives at national level*

Discrepancies between different national bodies

- Where TDA objectives promote growth and more activity to reach FT status, local systems seek to shrink the acute sector.
- Different demands, expectations and reporting cycles placed on the NHS and on local authorities place barriers in how they can work together.
- Difference in approach, with DCLG trusting more locally devolved responsibility, while DH/NHS England adopts a ‘command and control’ attitude.

National policies on choice and competition conflict with integrated care

- Providers have a lot of specialist expertise, but won’t tell you their ideas for making improvements, if those ideas will then be used by commissioners for a competitive tender.
- Similarly, even providers who want to work with commissioners to integrate care, if they say something that commissioners don’t like, they may be threatened with going out to tender, which is very unhelpful for integration. This can lead to tensions/lack of trust between commissioners and providers.
- Reforms introduced under the Health & Social Care Act increased fragmentation for some sites, which adds complications and considerable management resources, and has also required time for the new organisations to become established.
- Local commissioners have no control over the commissioning, recruitment, distribution, or performance management of GPs, which lies with NHS England.
- In order to design integrated care (not just the services, but also the outcomes and how you measure them), you need providers around the table, which could lead to accusations of collusion.

- The competition rules are unclear, and you get different messages from the centre, and since people are risk averse, it is difficult to take things forward.
- The commissioning landscape has become very fragmented since the reforms, so that one provider said that services previously managed by four contracts now required twelve contracts.
- Procurement regulations mean having to tender for newly redesigned services, rather than changing contract terms for existing providers.
- Too many rules about how money can be spent (e.g. Pioneer can't decide just to hire more GPs, even if they think it is necessary in their area).
- National targets/performance indicators may not be relevant to local initiatives, but force them in particular directions.

Issues integrating mental health services

- Mental health services are underfunded and historically not a priority.
- This is reflected in a lack of interest in learning from mental health services and what they have accomplished because they are considered a Cinderellocal authority service.

B National leadership on integrated care

Pioneers not being given enough freedom

- People don't feel empowered enough to try really innovative things/don't feel able to breach what may be current legal requirements (even if these are outdated).
- Central control of NHS does not allow for local flexibility.
- Policies that could lead to significant change (e.g. personal health budgets) are not being pushed at the national level.
- The reconfiguration of hospitals has to be debated nationally, but politicians don't take this on.
- The Health and Social Care Information Centre reportedly preventing the linking of GP and acute data.
- Ongoing problems with information governance.

Inconsistent messages/priorities/demands from the centre

- Multiple transformational agendas (integrated care, 7 day care, cost cutting) and other disconnected pilots, along with other issues that consume considerable time and energy which cannot be spent on integrating care. It also makes it difficult for leaders to keep a focus on everything that may be going on. Continual requests for devising new plans diverts efforts into planning rather than delivering change. Also, there is a danger that the different initiatives could end up going in different directions.
- Changes to BCF guidance and planning in 2014.
- There is a lack of clear national direction.
- Complex rules and bureaucracy can 'suck the life out of the system'.
- The considerable reporting requirements of multiple national bodies, sometimes referred to as constantly 'feeding the beast'.

- 2015 general election may give people an excuse to not do anything.
- Competing priorities divert attention to the urgent (e.g. A&E waiting times).
- The desire and encouragement to co-design services with local residents can conflict with the need to provide NHS England and others with 5 year plans.
- The incentives within Payment by Results for acute providers to increase activity work against providing more care outside of hospitals.
- CCGs and local authorities have responsibilities, targets and deliverables that sometimes clash.

C *Financial austerity/funding issues*

Effect of financial cuts

- Financial austerity has a number of impacts. For example, cuts to local authority services mean that community services are being closed that are essential to providing integrated care. Cuts to acute services means that more people are presenting to GPs or A&E. Organisations tend to look inwards when faced with great financial difficulty. Significant time and energy is required to redesign services to cope with financial cuts, which detracts from Pioneer initiatives.

Lack of funding to manage transitions/invest/keep up with demand

- Lack of finance results in shortages of staff/capacity to plan or implement change.
- There is not enough money to try large scale change, so often you need to try new initiatives on a small scale, but then you can't determine whether or not it is really having an impact because it is just too limited.
- What's often needed initially is extra start-up funding, so the community services can be set up to relieve acute services, before cuts are made to the latter.
- Difficulties in reallocating resources between different organisations (e.g. from acute to community care), particularly in a time of austerity, without destabilising the providers or creating tensions between organisations.
- The consultant contract reportedly makes it very difficult to move to 7 day working because paying for 'anti-social' hours can be prohibitively expensive.
- Demands on community services are increasing, but funding is not increasing to keep pace. Double running is needed while services are being developed to keep patients out of hospital.
- 'The cake can be cut into different slices, but it needs to be bigger.'
- The need for large scale capital investment to modernise the local acute provider.

II Organisational, professional and cultural boundaries

A Organisational structure

Organisational boundaries

- The NHS is structured around current organisational boundaries and to operate in particular ways and puts its own 'needs of survival' first, and finds it difficult to work more flexibly or to envisage how a new model of integrated care might work.
- Health care and social care have different sources of funding and different regulatory environments which makes integration complex.
- Expecting GPs to share/give up part of their budget to the local authority.
- Patients/service users of most concern to social workers are not necessarily the same as the patients of most concern to GPs. Similarly, social care cannot always look after/provide for patients that GPs identify, as social workers are not funded to care for these individuals.
- Tension between local foundation trusts and GP federations as to who will take the lead on integration. In other areas, there are tensions between GPs and the local authority, with GPs saying they will be prime provider.
- Tensions between different provider partners when planning the future and talking about who will be providing what services.
- Budgets need to be pooled, so commissioning organisations need to accept giving up complete control over their own budget in order to have influence over a larger budget, which is a 'big ask', especially with the number of commissioning bodies increasing.

Structure of primary care

- GPs should provide the leadership for integrated care in England, but the structure of primary care means it is not capable of providing that leadership.
- GPs are often key to integrated care initiatives, but some GPs are quite remote and disengaged from the initiatives.
- GPs being worried that the changes could mean a lot of extra work on top of already very busy workloads.
- GPs may not be aware of all the options open to them, and because they are so busy fall back on default options.
- GPs being risk averse/concerned with risk management may not always lead to patient-centred solutions or to the wrong solution for patients.
- The primary care landscape, for example, Pioneers with many small GP practices found it difficult to implement integration. Single-handed GP practices are too small to accommodate MDTs. Also, GP practices are reportedly struggling to play a strategic and developmental role in the face of increasing demands for clinical services.

Engaging providers

- Integrated care is not a priority for providers who have so many other competing demands, e.g. local emergencies (e.g. meeting 4 hour waiting time A&E targets) which detract resources from integration initiatives.

- Providers are not always invited to be on the inside and part of the conversation, which leads to tensions and lack of trust.
- Providers sharing risk and reward is a very radical departure from the current system of each provider trying to gain as much reward and avoid as much risk as possible.

B Professional, cultural and political issues/accountability

Cultural differences

- Cultural differences between local authorities and the NHS. For example, the impact of working with different decision-making structures and systems of leadership, i.e. local politicians (local authorities) versus senior level professional managers (NHS), and integrated care risks 'politicising the health agenda', which the NHS is not used to.
- Differences between the health and social care sectors in terms of language and conceptions of health and wellbeing, and professional cultures and working practices.
- When organisations try to collaborate, it often means working to the most conservative, risk averse procedures rather than the more innovative ones.

Professional boundaries

- Professional territorialism and being held accountable to your own organisations leads to duplication of effort (e.g. by carrying out multiple assessments of the same patient) by staff from different organisations.
- Existing approaches to training professionals does not support integration. There is a need for a new 'holistic' workforce, prepared for working in an integrated context.
- National professional bodies were felt to be a barrier to integrated care by:
 - reinforcing disciplinary boundaries which were 'not about patients';
 - imposing rigid training programmes;
 - regulations (such as nurse prescribing).

Engaging staff

- The challenges of engaging front-line staff with the Pioneer vision: the need for a change in mind-set from 'what matters to me, not what's the matter with me', yet staff are trained and socialised so that they are orientated to the latter.
- Staff scepticism about NHS initiatives that had previously been seen to 'come and go'.
- Actual change taking longer than, or not living up to, staff expectations (e.g. their job not changing as much as they may have been led to expect) makes it more difficult to engage staff and can lead to demoralisation.
- Staff tend to be risk averse and would rather not try to change than to 'go for it'.

Pressures to achieve

- There can be too much pressure at an early stage to prove the success of new initiatives, in order to keep them funded/running, but it may be too early to demonstrate success.
- Being overly ambitious to start with creates challenges.
- Collating the data/evidence (or lack of evidence) to help demonstrate that the new model is a better way of doing things.
- Merging acute, community and social services in one organisation takes time, 2-3 years for everything to settle down.

III Local issues

A *Local context/boundaries/history*

Local context

- The size and nature of the local health and social care economy, particularly in large geographies with complex, multi-level governance systems.
- NHS and local authority boundaries not coinciding complicates planning and providing patient care. Similarly providers working across CCG and local authority boundaries with different expectations and needs in each area, leads to complications.
- In London, there is a clash of geography, with 33 local authorities, but acute trusts operating across local authorities, so finding a way to blend the local with the multi-borough is challenging.
- Physically co-locating teams can be problematic, especially in London.
- Incompatible IT systems makes sharing records difficult.

Lack of resources/capacity

- Since most Pioneers consisted of only small teams working on integration, lack of time was underlined by most sites, which can be exacerbated if key staff members leave.
- For the more complex Pioneers, work at a higher level (e.g. across a number of CCGs and/or local authorities) has diverted resources from the local level where real differences can be made.
- Key partners cannot all contribute the same amount of staff time/resource, so its difficult to keep up the pace of change.
- When relying on volunteer input, there may be difficulties in recruiting sufficient numbers.
- Too many meetings to attend. For providers especially, it is difficult to get involved in all the integrated care meetings because of the pressure to deliver patient care.
- High staff turnover or shortage of staff (e.g. GPs, clinicians, community nurses) to carry out the work arising from the new initiatives.

B *Governance/leadership issues*

- The governance structures set up specifically for the Pioneers in some sites do not have authority to make decisions, nor do they have the resources, and are reliant on partners in the CCG and local authority.
- Meetings not being attended by senior enough people (who could make decisions), so the meeting could only deal with scenarios and possibilities.
- Working in partnership requires more governance, which takes time and energy away from implementation.
- Local leadership not having the relevant skills and/or capacity, especially given the often ambitious timelines.
- Acute trusts are not represented on the local HWB, so cabinet members can't see the linkages with acute trusts when e.g. planning for more out of hospital care.
- Lack of awareness/local knowledge between NHS and social service staff (e.g. services available, managers not knowing one another).
- There are poor pockets of primary care, and even with new GP federations, there is a question whether they will be able to improve those areas of poor primary care.

C *Financial issues*

- Have a good understanding of health care costs, but not social care costs.
- Where there is no tariff mechanism, working out prices/tracking the money is complex.
- There are carrots, but not sticks, to incentivise providers, but the carrots are very small in relation to their total budget.
- Pooling budgets before established working relationships are in place is a step backwards.

D *Engaging stakeholders*

- If acute trusts or social services are having other problems, getting their engagement in integrated care activities is more difficult.
- Getting voluntary sector organisations to work together could be useful, but is harder than getting NHS organisations to work together, especially as they are often competing against each other to provide (social) services.
- There is not much interest of local acute trust in mental health services, but they should be integrated.
- Previous experiences of integrated care that have not worked well (e.g. pooled budgets, joint commissioning) have affected working relationships between individuals and organisations.

E *Engaging the public*

- Getting the public signed up to some of the changes, e.g. the unpopularity amongst the public and thus reluctance amongst politicians of closing community hospitals.

- Trying to integrate through commissioning does not have public support and is risky by attempting to transfer all risk to the prime provider. It also leads to provider resistance rather than partnerships among local partners.
- The struggle to communicate the Pioneer vision effectively to the public, especially where sites are seeking to introduce self-care.
- Patients are deferential to clinicians, and need to take more responsibility about managing their own care.

Facilitators

As well as identifying barriers, the first wave of interviews were also concerned with identifying facilitators or enablers that support integrated care activities. These are often the obverse of the barriers, and are paraphrased below under the same broad themes (albeit with a simplified categorisation since fewer facilitators were mentioned).

I National context

- Being part of the Pioneer programme is a facilitator, for several reasons: the status of being ‘a Pioneer’; the ‘buy-in’ of all key local partners that is needed to achieve Pioneer status; the Pioneer sites are ‘under the microscope’ which makes people more inclined to work together; and the ability to share learning with other Pioneer sites (and within a single Pioneer for the larger sites).
- The BCF brought commissioners (from local authority and CCG) together.
- Supportive legislation (e.g. the Care Act).
- Pioneer status broadened focus from thinking locally to looking at international initiatives/models.
- Ignoring the commissioner/provider split opened up wider opportunities to innovate.
- Freedom to try things out, not having a ‘culture of blame’ if things go wrong, and piloting new initiatives and sharing the learning before rolling-out.
- Combining the NHS, which has cash but not enough people, with the local authority, which has people but not enough cash.

II Professional/cultural enablers

- Relationships and trust were the first and foremost facilitators of working together to solve problems, agree system-wide plans and deliver on these. A considerable amount of skill, effort and goodwill went into building, maintaining and continually reinforcing relationships and facilitating productive, frank conversations between different stakeholders.
- Getting all key partners, including local commissioners (CCG and local authority), around the same table, talking frankly, increases understanding of others’ perspectives and can lead to a new shared perspective.

- Staff in all sectors (secondary, primary, community) recognising the necessity to integrate services for long-term sustainability and each organisation/group of professionals recognising there are benefits for them as well.
- Integrating the health and social care workforce into a single management structure and building integrated co-professional teams with shared values.
- Creating a real team, without the hierarchy that exists in medicine to facilitate working together and sharing tasks.
- Joint approaches to training and career development, so staff can move between health and social care.
- Being 'patient/service-user-centred' so that all professionals are thinking about what the patient/service-user needs as the main focus, and looking at things from their perspective helps break down the barriers and tensions between different groups of professionals (e.g. between clinical and social care staff) and can contribute to a common language and shared values.
- Creating a shared culture across different professional groups, based on shared values.
- 'Wake-up moments', when a clinician starts thinking more deeply about patient-centred care/what a patient really needs.
- A 'can do' culture.

III Local issues

Local context

- Areas that may be small or, even if large geographically, had (largely) coterminous organisations. Areas with smaller health and social care economies often attributed their ability to move quickly on implementing innovations to the simplicity of their organisational landscape and their ability to implement and communicate change more easily.
- Having an integrated IT system/an electronic integrated health and social care patient record that can be easily shared, and an information sharing agreement between key partners and patients.
- Pioneer activities being further developments of thinking or initiatives already under way, rather than something completely new.
- Reconfigure the acute sector first before attempting to integrate services that provide more out of hospital care.
- Co-location facilitates communication between different professionals.

Local leadership

- Having the correct leadership and governance in place, representing all key partners and ensuring system leadership includes those at a sufficiently high level to have a strategic overview and are able to take difficult decisions.

- For local authorities, having the councillors on board, providing leadership, liaising with local communities.
- Local champions to push and progress the work and 'win hearts and minds'.
- Having a 'network model' of GP practices, as they pressure others within the network to improve performance.

Resources: funding, staffing

- A sound financial position provides freedom to innovate and the funds that are needed to 'pump prime innovation' and 'to invest to save'.
- Pooling budgets gave 'added value' and allowed activities to be funded that otherwise would not have been. With pooled budgets, patient need is at the fore, as there are no concerns over whether the funding is coming from the health or social care budget.
- Provider(s) in a secure financial situation and contractual certainty.
- The lack of funding has meant that NHS and local authorities have had to work more closely together (e.g. to decide who funds what).
- Sufficient resources in terms of staff as well as funding.
- Continuity of staff, particularly in the context of the aftermath of the NHS reorganisation.

Engaging stakeholders and the public

- Historical success, which gives confidence upon which to build, and examples to draw on, is particularly useful for engagement.
- A bottom up, organic approach with staff driving change and developing the framework rather than it being imposed from the top.
- Staff 'ownership' of clinical/social service models.
- Reassuring staff so they 'feel safe' in the face of change.
- Willingness to include the voluntary sector as equal team members.
- Collecting the right information/indicators so that impact/success can be measured and visible to staff, patients and the local population.
- Managing communication, ensuring a consistent message.
- Involving patients/service users in the design of services, having patient/service user representatives attend project board meetings to ensure patient/user viewpoint is available at all stages.
- Patient/service user expectations for more personalisation of services.

It should be noted, however, that what is considered a facilitator in one area may not be perceived as such in another. To take one example, having co-located teams (e.g. of community health and social care workers) with a single management structure was considered crucial by some interviewees, but as unnecessary by others or even counter-productive if staff become worried over their position in the new structure.



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