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Early evaluation of the Integrated Care and Support Pioneers Programme
Final report

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PIRU POLICY INNOVATION RESEARCH UNIT

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Preface

This final report of the 'early' evaluation of the Integrated Care and Support Pioneer programme develops and expands on the findings presented in the February 2015 interim report and is intended to provide a description of (roughly) the first eighteen months of Pioneer development. The interim report may be found on PIRU's website: www.piru.ac.uk/assets/files/Early evaluation of IC Pioneers, interim report.pdf. It incorporates findings from fieldwork undertaken over the spring and summer of 2015, since the publication of the interim report. However, since the research team has subsequently been commissioned by the Department of Health to carry out a longer-term evaluation over the next five years (through June 2020), in some respects, this report may be considered as another interim report of the Pioneer evaluation. Some of the features of the early evaluation, however, will not be repeated during the longer-term evaluation, in particular, the extent of in-depth qualitative interviewing that was carried out within each of the first wave Pioneers, and which provided a detailed insight into the priorities, processes and thinking within the 14 sites. While covering the 11 wave two Pioneers as well as the 14 wave one sites, the longer-term evaluation will involve a mix of quantitative and qualitative methods, and will be much more focussed on evaluating the cost-effectiveness of particular initiatives within selected sites. In-depth qualitative work will be primarily devoted to understanding how and why these initiatives bring about any changes identified quantitatively. Further details of the longer-term evaluation may be found on PIRU's website: www.piru.ac.uk/projects/current-projects/integrated-care-pioneers-evaluation.html.

As mentioned in the February report, it is (still) early in the process of Pioneer development to expect Pioneer status to be associated with delivering many substantial changes that were not already in train before the start of the programme. The details included in this report may still be considered a description of the Pioneers' plans and objectives, how these have developed over the course of the first 18 months of the programme, and some of the key factors which have affected the development of 'whole system integration'. The report should also prove useful for developing the next stage of the longer-term evaluation of the Pioneer programme.

This report has 10 chapters, a Summary and 5 Appendices. Chapter 1 provides brief background information and context on integrated care and on evaluations of earlier initiatives, along with a framework and logic map for understanding and analysing integrated care. Chapter 2 sets out the objectives and methods used for this early evaluation. Chapters 3 to 9 present the findings from the early evaluation. Finally, chapter 10 provides some concluding remarks.

Since the interim report was completed in February 2015, the research team carried out a second round of interviews with the Pioneers in spring and summer 2015. The results provided in this report are based on an analysis of this second round of interviews along with the initial round of interviews carried out between April and November 2014. Pioneer documents, including their initial proposals and Better Care Fund (BCF) plans, were also examined. This final report took as a starting point the text of the interim report. While much of the text has been retained, some sections have been dropped, some new sections have been added, and others have been updated/re-written (including the conclusions). Despite considerable overlap between the interim and final reports, they are complementary, and reflect the research team's views at two different points in time (winter 2014 and summer 2015).

Contents

Summary

1.   The Pioneer programme

1.1   The Integrated Care and Support Pioneer programme was initiated nationally 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 compared with previous integrated care initiatives 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 were the focus of an early evaluation commissioned by the Department of Health covering approximately the first 18 months of the programme. A second wave of 11 Pioneers was announced in late January 2015 and officially started in April 2015.

1.5   Over a period of at least five years, the Pioneers are being given access to in-kind expertise and support from the national partners and international experts. Only minimal additional funding was provided initially (£20,000), with an additional £90,000 made available to each first wave Pioneer in June 2014.

2.   The Better Care Fund

2.1   The Pioneers are operating in the context of 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 during the early period of the Pioneer programme was the Government's 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 their Health and Wellbeing Boards (HWBs).

3.   Early evaluation

3.1   The early evaluation ran from January 2014 to July 2015. It aimed to describe the vision, scope, objectives, plans, interventions, underlying logic and implementation of the first wave Pioneers in the context of the BCF. It did not include the second wave Pioneers.

3.2   The study was largely qualitative, with the principal data drawn from 140 interviews undertaken between April and November 2014, and 57 further interviews undertaken between March and June 2015. Interviewees included staff from CCGs, NHS provider organisations, local authorities and the voluntary sector involved in their local Pioneer.

4. Characterising the Pioneers

4.1 The vision for the future of health and social care of the Pioneers was of a 'transformed', 'whole system' of integrated care involving all the local bodies and all professional groups in which holistic services would be organised around the needs of the individual and her/his carers. Other features of the vision included giving people a greater voice, and affording them dignity, respect, choice and control over what happens to them. All Pioneers saw better integrated care as a crucial means of improving care quality and patient experience in a context where need and demand were increasing more than the resources available. Such a goal was thought to be achievable by reducing acute hospital admissions through better managing patients with multiple conditions in non-acute settings and by maintaining people's independence and wellbeing as long as possible.

4.2 The Pioneers largely shared the same broad vision for the future of the health and social care system, were deploying many apparently similar initiatives and service developments, and targeted similar patient and client groups (particularly, overlapping groups variously described as frail older people, people with multiple long-term conditions (LTCs), high service users, or high risk groups (e.g. people at high risk of hospital admission). Comparison of the Pioneers' logic models (theories of change) failed to differentiate between them sufficiently clearly to generate a typology of Pioneers. This was most likely because the Pioneers had all agreed to pursue the same user-centred definition of integrated care endorsed by the national agencies that formed the Integrated Care and Support Collaborative.

4.3 However, in two important respects they varied. First, they differed in terms of the structural complexity of the organisational relationships involved (partly due to the population scale at which they are working), which varied significantly from the relatively simple (e.g. Barnsley or Southend, where there is one CCG, one local authority and one NHS acute trust with largely overlapping boundaries), to the relatively complex (e.g. North West London where there are 8 CCGs and 7 local authorities involved covering a far larger population). Second, they differed in terms of the breadth of integration, which ranged from relatively narrow to relatively broad in terms of the number of organisations that were intimately involved in the Pioneer's activities during the first 18 months (which of course may change during the course of the 5-year Pioneer programme).

4.4 What it meant to be 'a Pioneer' varied between sites and between individuals within sites. At various times it was apparent that Pioneer status meant one or more of the following:
- a 'badge' for a locality signifying national recognition of innovation and progress in integrating care
- an enabler of the existing local plan for transformation
- a particular governance arrangement, for example a Board that brought all system leaders and their organisations around the table
- a collection of discrete workstreams, characteristically covering a combination of different groups of users and infrastructure projects (for example, information sharing, workforce development, etc.)
- a specific new integrated service, such as a frailty service
- an ethos or way of thinking about and providing care, rather than a specific plan or set of initiatives.

Most saw the Pioneer programme as a way of building on their past experience and maintaining progress towards a more integrated health and care system that had already been underway before they became Pioneers. These differences in interpretation of the meaning of being a Pioneer complicate attempts to evaluate the Pioneers.

4.5 Pioneer governance arrangements primarily involved project boards without formal authority and powers reporting to HWBs or separately to CCGs and local authorities. Board members were typically senior managers from the CCG, local authority, local NHS providers and occasionally the Third Sector. The ultimate decision-making power remained with the formally constituted governing bodies. As a result, it was reported that, on some occasions, the Pioneer board struggled to get the formal governing bodies to take decisions necessary to progress the Pioneer.

4.6 Involving patients, service users and the public was seen as important in all of the Pioneers. The extent and nature of patient and public involvement (PPI) varied in different localities from extensive and well-developed to under developement. Larger Pioneers with more complex geographies and governance arrangements faced a bigger challenge coordinating PPI but also had greater resources to devote to it. PPI methods included a wide range of activities such as: the involvement of Healthwatch; action research projects; involvement of citizen's panels; consultation events; and representation on strategic and decision-making bodies including for procurement. Activities to engage the wider public were less frequently discussed as was the involvement of carers.

4.7 Project boards were usually supported by a small programme management team, which oversaw progress, and by specific working parties. Costs of the programme management team were often shared between partners and could include jointly funded appointments.

4.8 Generally, one of the organisations involved in the Pioneer was identifiable as the 'lead' either explicitly or de facto. Overall, provider organisations were less likely to be centrally involved in driving the Pioneers compared with commissioners of health and social care. In some cases, there were tensions between commissioners and providers within the Pioneer. The role of Health and Wellbeing Boards was central to many Pioneers, although this generated some tension at times since local providers were not represented on HWBs.

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 on a geographic basis.

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/service 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 relatively ambitious schemes to:
- provide more care in the community, thereby directly reducing the demand for hospital services; and
- promote 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, Pioneers prioritised around three population sub-groups, though five Pioneers described their focus as the whole community. Most frequently, they described their main focus as older people with multiple long-term conditions, particularly frail older people, high service users, or people at high risk of hospital admission. A few were prioritising mental health problems, people with learning difficulties, or families and children. Staffordshire and Stoke was unique in focussing on cancer exclusively.

6.3   Many apparently similar initiatives appeared in Pioneer plans, though terms like 'multi-disciplinary team' or 'rapid response' could well conceal different ways of implementing and operating such schemes (see Table 6.1, page 60).

6.4   Programmes tended to include 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   There were signs of a lowering of the level of ambition between the two rounds of fieldwork and emphasis on a more limited set of initiatives over time, at least under the rubric of the Pioneer programme, particularly, use of care navigators, locality-based multi-disciplinary teams, care planning, and a single point of access.

6.6   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 for three reasons: to allow health and social care professionals to coordinate and manage care for individuals; for risk stratification (i.e. to identify those most in need and who would most benefit from coordinated care); and to be able to track health and social care costs to enable the development of pooled, capitated budgets. In most cases, information technology and governance were presented as barriers to progress. While technical problems (e.g. incompatible IT systems) were identified as making information sharing difficult, these were not seen as insurmountable. More problematic were issues of information governance, particularly in relation to accessing general practice data. In general, the regulatory framework appeared confusing. This led to local actors receiving contradictory advice which highlighted the risks of taking decisions to make progress in this area. However, a minority of respondents argued that the barriers to integration posed by information systems had been overstated and that there was more flexibility in the system than was commonly perceived or expressed.

7.2 In spite of the difficulties, the Pioneers were working at local level 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. Some of the 'work arounds' described seemed to be highly inefficient.

7.3 Most of the Pioneers wanted concerted strategic leadership from national government (that went beyond the issuing of guidance) to solve the problems of information governance.

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 across health and social care were working. Other innovative roles that were already operational included:
- interface geriatricians (working in NHS acute and community settings)
- rotation nurses (rotating between NHS acute and community settings)
- support workers in intermediate care (trained in nursing, physiotherapy, occupational therapy and social work)
- discharge co-ordinators (based in NHS acute hospitals working with social care)
- baton phone (each day a nominated specialist carries a baton phone to provide specialist advice to community care when needed).

8.3 Sites which had successfully introduced changes to working practices attributed this to using professional staff to share learning and focussing on a vision of integrated care from the patient's point of view.

8.4 Pioneers noted that workforce change was a long-term process requiring wider changes in the system to be successful. They highlighted 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. However, some interviewees reported good relationships with the local university that had allowed them to align the curriculum for local staff training with their objectives for integrated care. Other localities had introduced their own in-house training and development courses for staff.

8.5 There was some disagreement between interviewees about the relative merits of developing new occupational roles, flexing existing roles or simply improving the co-ordination of existing professionals. For many organisations, the objective was simply to reduce the number of different types of staff going into a person's home (e.g. by using the Buurtzog model of care, which reverses the trend towards using the lowest cost grade of staff by employing qualified nurses who can work autonomously and holistically, thereby reducing the need for inputs from larger numbers of staff).

9. Progress towards implementation of plans

9.1 Pioneers typically had very broad and ambitious views of what would constitute success defined in terms of: the improvement of outcomes, particularly in terms of patient/service user experience; and the shift towards a more cost-effective model of care much less centred on the hospital. Many referred to the so called 'Triple Aim' of improving health and wellbeing, improving experience of care and support (usually defined in terms of the National Voices 'I Statements'),

and reducing the per person cost of care and support. However, the vision of success 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.

9.2 Pioneers were aware that many challenges still needed to be tackled to bring about service change. 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.

9.3 Some challenges were outside the control of local managers and assistance from central government agencies was likely to become increasingly necessary in future.

9.4 Operationally, Pioneers were often moving on several fronts at once through the:
- 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 planning and implementation of new initiatives proposed in the Pioneer bid and begun since the Pioneer programme had started.

9.5 Although Pioneers accepted that the purpose of the programme was to move at 'scale and pace', they also generally stressed that it might take five years or longer to produce demonstrable impacts, particularly in relation to complex interventions aimed at prevention. In addition, the Health and Social Care Act 2012 had brought about major upheaval at local level that was only just beginning to subside. As a result, most Pioneers also emphasised the importance of measuring process and intermediate outcomes, such as improvements in workforce morale and job satisfaction associated with better quality care.

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 inpatient 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 than others. There was evidence that the Pioneers' BCF planned spending on social care tended to mirror the extent to which local social care spending had been reduced previously due to local authority budget cuts.

10.3 Analysis of the Pioneers' BCF plans showed a high degree of alignment with Pioneer activities. This was corroborated by most interviewees who acknowledged that the BCF was broadly consistent with the goals of the Pioneers, though a minority of the more complex Pioneers suggested that the BCF had been a distraction from their wider service re-design objectives. The BCF was generally seen as more bureaucratic than usual Pioneer work. Some Pioneer leaders where the Pioneer comprised multiple CCGs, felt that the BCF requirement for each CCG to make its own BCF plan undermined the ability of the Pioneer as a whole to develop a coherent service and financial strategy.

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 seen as substantial obstacles to BCF implementation.

11. Barriers to integration

11.1 The identification of barriers formed a large part of many interviewees' accounts in the first round of interviews. Many of the barriers identified were familiar from previous research into health and social care integration. It was too soon in most cases to identify significant progress made in removing key barriers. The outstanding issues tended to be the most complex and resistant to easy resolution and many barriers required national attention (e.g. the legal framework for contracting/commissioning, information governance).

11.2 **National barriers**
a) National issues outside Pioneer control
- These included disruptions arising from the reorganisation of health care following the Health and Social Care Act 2012 and 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 were 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 guidance about how far they could 'flex' the system to bring about change, lack of protection when taking risks and too little policy coherence from government and national agencies.
- 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.
- The support was perceived as having been slow to emerge and needed to be pitched at a high level of expertise to be valuable. Pioneers did not want performance management but rather robust, constructive challenge. Areas where support was especially needed were information sharing, commissioning/contracting and evaluation.

c) Financial issues
- Pioneers reported that in the absence of any additional funding associated with Pioneer status, they were limited in their ability to bring about major service change, particularly given restrictions on how they could use their available funds. Ideally, Pioneer status would have attracted 'hump' funding to ease the transition between the status quo and a rebalanced health and social care system.
- The local government situation, in particular, 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) 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.

11.3 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.
- Different organisations in the local system faced different imperatives, 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

- Health care and social care continued to be separated by 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.

11.4 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 local health and social care economies created challenges for the larger Pioneers, which often had to work with different boundaries for local authorities and CCGs, acute trusts serving different populations, and multi-level governance systems.

c) Dealing with such complexities placed even higher demands on leadership and governance across organisations.

11.5 At the first round of data collection, interviewees tended to view the long list of barriers not as insuperable, but as challenges in need of resolution, and which they were trying to tackle where they could. By the second round of interviews, however, dissatisfaction at the lack of support from the centre at tackling these barriers was more frequently expressed.

12. Facilitators of integration

12.1 The facilitators reported were generally the obverse of the barriers and their prominence varied between Pioneers. However, facilitators received considerably fewer mentions than barriers in interviews.

12.2 National context

a) Most important to participants was the perceived advantage of being part of a national Pioneer programme, which provided an impetus for local professionals to work together to improve care locally. The National Voices 'I Statements' behind the Pioneer programme were perceived as particularly valuable in bringing a shared vision and narrative to Pioneer work.

b) Being part of a national programme was perceived as bringing 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 by bringing commissioners and providers more closely together.

12.3 Professional and cultural enablers

a) Every Pioneer emphasised the benefit 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 at the service delivery level was a specific key enabler in this respect, although there were different approaches to teams, 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 salience of professional demarcations and sensitivities in the interests of more integrated working.

12.4 Other local factors

a) Most of the facilitating factors mentioned 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/service 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 perceived to be 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 were described as positive for implementing integrated care.

f) Perhaps the most important factor articulated was staff involvement in developing integration initiatives and encouraging their 'ownership' of new service models. Winning over the public and service users followed a similar approach, while ensuring they were fully involved in the design of the services at all stages.

13. Learning from the first 18 months of being a Pioneer

13.1 The most common piece of advice that first wave Pioneer staff had for the second wave was the need to invest in relationships locally, particularly with frontline staff and especially in general practice and local authority social services, and to build these relationships with the long haul in view.

13.2 Other advice to new Pioneers focussed on fostering a 'bottom up' approach to strategy and suggested that a 'top down' strategy had little chance of success. It is unclear what evidence participants had for these pieces of advice.

14. Conclusions

14.1 By the summer of 2015, most of the 14 first wave Pioneers were still in the relatively early stages of implementing their plans. After only 18 months, we are cautious to draw conclusions too firmly about their progress. For example, it is too soon to reach definitive conclusions about whether they might provide role models for other parts of the country to learn from. There is considerable diversity in progress between the 14 Pioneer sites. 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 specific changes to services and professional behaviour. While most Pioneers have agreed locally how most services should be re-designed, for the majority of sites, much remains to be done to put this in place. There is limited evidence so far of change in service delivery, despite the expectation that Pioneers would be able to get into delivery mode quickly.

14.2 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.

14.3 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 development and information governance. Some 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 agencies.

14.4 From the perspective of participants, the environment for whole system transformation was not becoming easier. There was little evidence that the balance between facilitators and barriers had shifted in favour of the former during the first 18 months. 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'. 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 health and care system provided a competing set of pressures.

14.5 By the conclusion of our fieldwork, 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. The majority of Pioneer programmes appeared to be converging towards a set of specific interventions for older people with substantial needs, such as care navigators, care planning, risk stratification, single points of access and, in particular, multi-disciplinary teams organised around primary care. These are consistent with the emphasis of much national policy over the past two years at a time of both growing demand and the need to reduce immediate pressures on acute hospital services.

Convergence of this kind would represent a narrowing of some of the broader original ambitions in relation to early intervention and attempting to intervene in the social determinants of health envisaged by the Integrated Care Collaborative for the Pioneers. The BCF, Vanguard models and location of responsibility for the programme in NHSE were among the factors identified by interviewees as associated with this narrowing of focus.

14.6 On one scenario, the Pioneers could be seen as laying the foundations to make rapid progress and start sharing learning. On another, the barriers and difficulties they have experienced to date could prevent just such progress. We currently have little evidence to support the first scenario. Indeed, the most recent interviews suggest that the journey to integrated care is not getting easier.

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 description of integrated care from the perspective of service users was developed by National Voices following a commission from NHS England on behalf of the Integrated Care and Support Collaborative. Together with its accompanying narrative on person-centred, coordinated care, the statement 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, its adoption 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 within and 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 (2014). 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 et al 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 and lessons have been identified on how to deliver successful integrated health and social care from these initiatives (including Nolte and McKee 2008, Wistow 2011, Goodwin et al 2012; Knight 2014; Kings Fund 2014). Representative of this approach is the synthesis by Ham and Walsh (2013 p.2) of the lessons learned over time by the King's Fund about what is required 'to develop integrated care at scale and pace'. The authors emphasise that 'there are no universal solutions or approaches that will work everywhere' and that approaches will need to vary according to local contexts and challenges. Nonetheless, they offer 16 lessons from experience as a comprehensive set of steps through which the spread of integrated care can be enhanced (Figure 1.1).

Figure 1.1 Lessons from experience

1. Find common cause with partners and be prepared to share sovereignty
2. Develop a shared narrative to explain why integrated care matters
3. Develop a persuasive vision to describe what integrated care will achieve
4. Establish shared leadership
5. Create time and space to develop understanding and new ways of working
6. Identify services and user groups where the potential benefits from integrated care are greatest
7. Build integrated care from the bottom up as well as the top down
8. Pool resources to enable commissioners and integrated teams to use resources flexibly
9. Innovate in the use of commissioning, contracting and payment mechanisms and use of the independent sector
10. Recognise that there is no 'best way' of integrating care
11. Support and empower users to take more control over their health and wellbeing
12. Share information about users with the support of appropriate information governance
13. Use the workforce effectively and be open to innovations in skill-mix and staff substitution
14. Set specific objectives and measure and evaluate progress towards these objectives
15. Be realistic about the costs of integrated care
16. Act on all these lessons together as part of a coherent strategy

Barriers to integrated care

Cameron and her colleagues (2003 and 2012) have conducted two systematic reviews of the integration literature to identify barriers as well as enablers to the development of integrated care. They found a 'significant overlap between positive and negative factors, with many of the organisational factors identified in research as promoting joint working also being identified as hindering collaboration when insufficient attention is paid to their importance' (Cameron et al 2012 p.1). Their initial review grouped these factors into three broad categories: organisational issues; cultural and professional issues; and contextual issues. Additional factors were identified in their second review but they were accommodated within the original three categories, which were found to provide a useful continuing framework for organising barriers and enablers reported in the literatures reviewed. The individual barriers within each category are listed below together with examples of each (Figure 1.2).

Waring et al (2007, 2015) also highlight the significance of cultural barriers. Drawing on insights from organisational theory, they suggest such barriers stem from social and cultural differences between individuals and organisations including those in:

- **Knowledge:** The way that actors perceive, make sense of and understand their work, including the different forms of knowledge that are seen as legitimate, for example, tacit knowledge based on experience vs that which comes from the laboratory or from Cochrane reviews.
- **Organisation:** The formal aspects of service or work configuration, such as task allocation, division of labour and shift patterns.
- **Power:** Forms of status, hierarchy and influence such as those that exist between health and social care, and between acute and community sectors.

Figure 1.2 Factors hindering joint working

Organisational issues:
- Aims and objectives: insufficient shared understanding and purpose
- Roles and responsibilities: lack of clarity; confusion and protectionism
- Organisational difference: competing visions, leaderships and operational policies
- Communication: difficulties leading to discontinuities of care
- Information sharing: incompatible IT systems; concern about sharing individual data
- Co-location: absence impeded coordination of care
- Strong management and professional support: absence left individuals feeling unsupported
- Involvement: in design of services affected commitment to and understanding of them

Cultural and professional issues:
- Negative assessments and professional stereotypes: strategic and operational level barrier
- Different professional philosophies: social model undervalued; attitudes to risk
- Trust, respect and control: distrust of others' assessments and reluctance to refer
- Joint training and team-building: limited nature undermined joint working
- Role boundaries: team working as threat to professional identity

Contextual issues:
- Relationship between agencies: complexity undermines effectiveness
- Constant reorganisation and lack of coterminosity: adds to complexity and distracts from aims
- Financial uncertainty: inadequate levels and short-term availability of funds
- Labour market: recruitment difficulties

The NHS Confederation and Association of Directors of Adult Social Services made a different kind of attempt to identify barriers and facilitating factors through a survey of PCT Chief Executives and Directors of Adult Social Care (NHS Confederation 2010). One aspect of the findings (Figure 1.3) is the contrast drawn in the analysis of the factors reported to promote and hinder joint working at local level. Thus, the top factors that respondents considered to help integrated working were described as 'locally determined' – local leadership, vision, strategy and commitment. Conversely, those identified as hindering integrated working were predominantly interpreted as 'nationally determined' – performance regimes, funding pressures and financial complexity. Even the hindering factor the survey considered to be an exception to this general pattern (changing leadership) can be seen to be strongly nationally influenced to the extent that it coincides with local responses to nationally mandated reorganisations or national performance management pressures. This analysis led the report to suggest two interpretations of its findings: first that the centre might have 'more capacity to do harm than good'; and second that its role in respect of integration might be 'defined as an enabling rather than delivery one – to develop a framework of policy for use with local interpretation' (p.3). In brief, we would interpret these findings as implying that an important function for local government is to clarify how far national policies and influences create a local environment that positively promotes and enables integration while modifying influences which do not have that effect.

Figure 1.3 Factors that help and hinder joint working

Table 1. Factors helpful to and hindering local integration[4]

Helpful factors*	Hindering factors*
Friendly relationships (35)	Performance regimes (40)
Leadership (31)	Financial pressures (34)
Commitment from the top (26)	Organisational complexity (30)
Joint strategy (24)	Changing leadership (26)
Joint vision (24)	Financial complexity (22)
Co-terminosity (20)	Culture (19)
Additional funding (16)	Commissioning (15)
Patient and user focus (14)	National policies (14)
Front-line staff commitment (13)	Local history (14)
Joint commissioning (13)	Data and IT (14)
Central guidance (13)	Planning (12)
Joint appointments (11)	Workforce (11)
History of success (11)	Other (3)
Other (5)	

4. Presentation on 'snapshot of integrated working' survey to ADASS Spring Seminar, March 2010.

Reproduced from NHS Confederation (2010)

Evaluation and assessment of integrated care

Understandings of the nature and impact of barriers to integrated care are, however, restricted by limitations of initiatives and their evaluation. It has typically been the case that integrated care 'pilots' and/or evaluations have not covered a sufficient period of time to draw firm conclusions about the consequences of such barriers together with the impacts of service change 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

It was against this background that, in the spring of 2013, a collaborative of national partners[1] called for expressions of interest from the 'most ambitious and visionary' local areas to become integrated care Pioneers capable of driving 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 May 2013). Each Pioneer was 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 May 2013).

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 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 implementation of the BCF in 2015/16 (Local Government Chronicle 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

[1] Association 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.

some £400m will be held back as performance-related payments which will depend on local areas' ability to reduce 'avoidable' 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.

During the course of our fieldwork, a number of further initiatives has been announced which have implications for the development of integrated care. Although the implementation of some is at an early stage, they are indicative of the environment of continuing policy development in which the pioneers are located. For example, in the summer of 2014, the government 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 May 2014). NHS England announced a pilot programme for integrated health and social care personal budgets to begin in 2015/16 (NHS England September 2014). 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.

The evaluation also took on an additional dimension following the announcement in January 2015 that a second wave of eleven Pioneers would start in April 2015 (Department of Health 2015). Although no data have been collected from that group of pilots in the early evaluation, they will form part of the longer-term evaluation of the Pioneers that the PIRU team has been commissioned to conduct from 2015-2020 (see PIRU website: www.piru.ac.uk/projects/current-projects/integrated-care-pioneers-evaluation.html). One of the second wave Pioneers is in Greater Manchester and, as such, is a substantial element of the DevoManc initiative under which budgets and resources, including those for the NHS, are being devolved to the 12 Greater Manchester metropolitan councils under the leadership of an elected mayor and Cabinet. A similar initiative (without an elected mayor) has been signalled in Cornwall and it is possible that others will be announced at the time of the forthcoming Autumn Statement by the Chancellor of the Exchequer.

In a 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 Partners October 2014, NHS England December 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, and 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 December 2014). In January 2015, NHS England called for local proposals to become 'vanguard' areas to prototype some of those models (NHS England January 2015). Twenty-nine vanguard sites were announced in March 2015, and a further eight 'urgent and emergency care vanguards' were announced in July 2015 (NHS England March and July 2015). Three of the vanguard sites (partially) overlap geographically with the first wave Pioneers. Figure 1.4 provides a timeline highlighting some of these key events over the past 2½ years.

Figure 1.4 Timeline for early evaluation and key events: May 2013 – September 2015

Pioneer Early Evaluation
- Start (Jan 2014)
- First Round of Interviews (Apr 2014 – Dec 2014)
- Interim report completed (Feb 2015)
- Second Round of Interviews (Mar 2015 – Jun 2015)

Pioneer Programme
- Call for applications (May 2013)
- Applications Deadline (Jun 2013)
- 1st Wave of 14 announced (Nov 2013)
- Ministerial launch (Dec 2013)
- 2nd Wave of 11 announced (Jan 2015)

Better Care Fund
- Launch (Jun 2013)
- Revised Guidance (Jul 2014)
- BCF Plans deadline (Sep 2014)
- Delivery of BCF Plans (Apr 2015)

Other initiatives related to integrated care
- Proactive Care Programme launched (Jun 2014)
- IPC pilots launched (Jul 2014)
- IPC guidance published (Sep 2014)
- 5 Year Forward View Published (Oct 2014)
- Devo Manc Announced (Nov 2014)
- IPC Applications deadline (Nov 2014)
- Vanguard Applications deadline (Feb 2015)
- 29 Vanguards announced (Mar 2015)
- 9 IPC pilots announced (Apr 2015)
- 8 Vanguards announced (Jul 2015)
- 13 Vanguards announced (Sep 2015)

Understanding and analysing integrated care

As noted in the Background section, 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 enabling 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, as the literature indicates, integrated care is more multi-levelled and multi-facetted than that (Nolte and McKee 2008, Wistow 2011, Valentijn et al 2013, Goodwin et al 2013). Other aspects of integrated care need to be captured if different approaches and models are to be analysed and compared. For example, Goodwin et al (2014) combine the concepts of integration types (Nolte and McKee 2008) with that of integration levels (Valentijn et al 2013) to create a framework for comparing seven cross-national models of integrated care. 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 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 realist 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 they provide, 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. 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 1.5). 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 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 1.5 Components of an intervention logic map

Context	Input	Output	Outcomes	Impact
Issues addressed and context in which it is taking place	What is invested, e.g. money, skills, people, activities	What has been produced?	Short and medium term results	**Long-term outcomes**
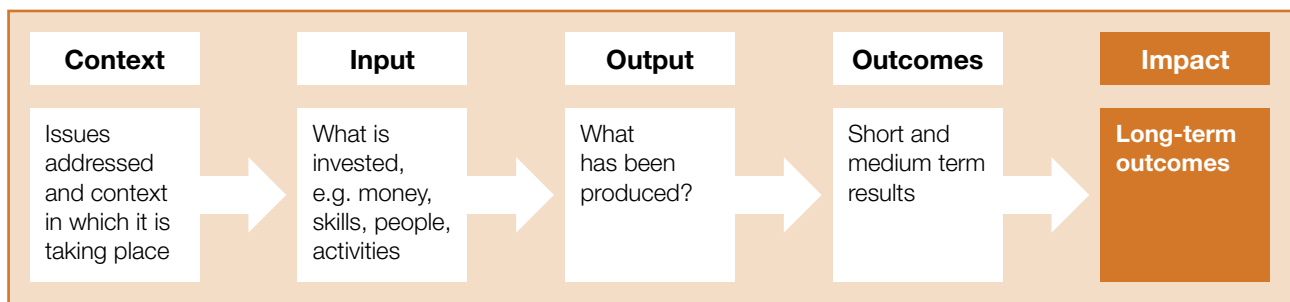
Reproduced from Figure 1 in Hills 2010

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, Fisher 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 1.6 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. 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 1.6 Logic map for integrated care and support Pioneer programme

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

2. 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 PIRU to carry out 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 report was published on PIRU's website in April 2014 (www.piru.ac.uk/assets/files/IC and support Pioneers-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 (Raleigh et al 2014).

The second short-term project, to which the current report relates, was to undertake an early evaluation of the first 18 months (January 2014 through June 2015, with reporting in autumn 2015) of the Pioneers in order to identify and describe their objectives, 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 Pioneers selected at the first wave;
- 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;
- 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 focuses 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 15-18 months in relation to their initial integration objectives;
- distill and 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; aims of the programme and whether these have changed in the first year; services and models of integration; 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); learning points from the first year; local evaluation and measures of success;

- 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 Delivery Service Managers (DSMs) who keep in regular contact with the Pioneers (and who originally were based in NHSIQ, but subsequently moved to NHS England);
- 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. A second template was designed to illustrate the logic model of the programme at both national and Pioneer levels; the logic models for the 14 wave one Pioneers are included in Appendix E.

The main focus of the analysis in this report is the semi-structured interviews carried out in two waves – April to November 2014 and March to June 2015 (as highlighted on the timeline in Figure 1.4) – by five members of the research team working to a shared topic guide (included in Appendix B). The number of interviews per site varied depending on the complexity of the site. Contact was initially made with the coordinator in each Pioneer, who was also typically the first interviewee. The coordinator then identified other key managers to be interviewed within their site, and the research team would try to ensure that at least one person was interviewed from each local organisation involved in the Pioneer. The vast majority of interviewees were middle and senior managers (up to Chief Executives) involved in the strategic direction of the Pioneer, or in the design and management of services, with very few involved at an operational level. Most interviews were carried out face-to-face, but several 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 June 2015 is given in Table 2.1 and the host organisation of interviewees is shown in Table 2.2. (Some interviewees were joint appointments, usually between the local authority and clinical commissioning group; these individuals were categorised according to which organisation held the person's contract.) The number of individuals interviewed is slightly greater for local authorities than CCGs (68 and 64 respectively); there were another 49 interviews with staff from other NHS organisations involved in the local Pioneers (including primary care, acute, community and mental health providers).

Table 2.1 Individuals interviewed per Pioneer

	Individuals interviewed	
Integrated Care Pioneer	**April – November 2014**	**March – June 2015**
Barnsley	11	3
Cheshire	18	7
Cornwall	7	3
Greenwich	5	4
Islington	4	3
Kent	10	7
Leeds	15	6
North West London	13	8
South Devon and Torbay	16	2
South Tyneside	5	2
Southend	9	2
Staffordshire and Stoke	6	3
Waltham Forest, East London and the City (WELC)	12	5
Worcestershire	9	2
Total	**140**	**57**

Table 2.2 Host organisation of interviewees

	Individuals interviewed	
Host organisation of interviewees	**April – November 2014**	**March – June 2015**
Primary care provider	5	–
Clinical Commissioning Group	44	20
Acute hospital	17	8
Community/mental health services	16	3
Local authority	49	19
Voluntary sector	7	5
Other	2	2
Total	**140**	**57**

To ensure comprehensiveness and rigour, a thorough and systematic approach to analysis of the interviews was employed. All interviews were recorded verbatim and transcribed, aside from two, where notes were taken during and immediately after the interview. Each transcript was reviewed and coded 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. 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 considered 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 chapters (3-10), selecting rich and descriptive illustrative examples from the transcripts, which were then commented upon by the entire team.

This pragmatic approach to analysing the qualitative material was well suited to this highly applied context, being both rigorous and feasible for working with a large dataset with relatively little time available for analysis.

3. Becoming a Pioneer

The following chapters of the report (chapters 3 through 9) present the main findings from the early evaluation. Our findings are based mostly on analysis of the two rounds of interviews undertaken at Pioneer sites (the first between April and November 2014, the second between March and June 2015), but also on documentary analysis of Pioneer proposals, plans, etc. Chapter 3 covers issues to do with becoming a Pioneer; chapter 4 provides an overview of Pioneer aims, objectives and activities; chapter 5 describes how Pioneers will judge whether their programmes have been a success; chapter 6 describes key features of the Pioneer sites, including their governance arrangements, integrated care strategy/models, workforce development, etc; chapter 7 summarises some of the barriers and facilitators to integrated care, how barriers have been overcome, and what steps are needed to help with remaining barriers; chapter 8 describes their Better Care Fund plans in the context of Pioneer activities; and chapter 9 outlines progress within the first year of the Pioneer programme and lessons they have learned during the first year.

Pre-Pioneer history and context

One of the selection criteria for Pioneer status was a 'proven track record' in successfully delivering 'public sector transformation at scale and pace'. Several Pioneers described having 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 informed current activities and approaches.

> "It's never something that we've woken up one 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." (Local authority)

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 when the Pioneers were announced; there were examples of integrated care activity where NHS organisations and local authorities had been engaged in joint commissioning or joint appointments, which established a context for collaboration before becoming a Pioneer. Involvement in previous pilot programmes was mentioned by several interviewees as providing essential experience that the Pioneer programme built on.

> "Part of [our inheritance] is from the [previous pilot] work because everyone did it collaboratively …" (CCG)

A history of collaborative working led to the perception that Pioneer 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. This corresponds with the explicit intention of the architects of the Pioneer programme. Moreover, the strength of historical relationships already established provided a stable framework for integrating care in a context where the system reform process had frequently and recently 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] … when the CCGs came together, we came together … with an agreed principle that we would have two CCG federations that were collaborative … with a joint financial strategy [across Pioneer areas] which allows us to use the money more effectively." (CCG)

One impact of the Pioneer process was that it was perceived as often allowing 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 taken place.

> "[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 … you hear people … go out and evangelise about the networks as the best thing ever. At the time there were some hard fought battles." (CCG)

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'. More positively, the Pioneer programme was seen as not just 'another pilot' but as a genuine 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." (CCG)

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 and, instead, a new model was to be introduced.

Reasons for becoming a Pioneer

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

> "[This] is not a rich [local authority] ….One of the key drivers was that we could see people were going into hospital when they could have 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." (CCG)

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 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?' ….And then you look at the demographics, which in five years' time [our area's] over-65 population will have doubled ….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."
(Non-acute provider)

It was frequently reported that Pioneer status provided localities with an attractive opportunity to scale-up and develop their prior integration work. Some interviewees went further by suggesting that Pioneer status would provide an opportunity to proactively push the agenda on integration, to innovate, 'barrier-bust' and take risks. There was also a conviction that integration was the recognised way forward in improving quality of care and user experience by providing services that were 'joined-up', consistent and user-focussed. However, questions remained as to 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?" (CCG)

In some Pioneers, it was hoped that integrated care would help address inequalities by bringing consistency of service provision across localities and communities.

"The biggest commissioning issue that got raised 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 [Local Authority]. So I suppose we've kind of made that happen." CCG)

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 similar initiatives meant that key stakeholders were already on board. Pioneer status was a way to maintain existing commitments to integrated care and keep momentum going, particularly because of the perceived added interest and scrutiny that Pioneer status was likely to bring.

"… 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 … when challenges get tough and providers tend to retreat back into their own organisations, actually the Pioneer focus is quite helpful." (Voluntary sector)

This value of Pioneer status was also remarked on by those areas whose plans were controversial 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 … being part of a national programme, it gives them a reason for being and a reason for staying, because this programme … is quite controversial." (CCG)

There was also an expectation that Pioneer status would bring national kudos and recognition for work that was already in place, as well as 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 particular sites as well as provide opportunities for local leaders to feedback their perspectives.

> "What I think it has brought us is ... 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." (Non-acute provider)

This was related to the hope that Pioneers might attract additional resources, although it was clear that there was not going to be substantial additional funding available for Pioneer support and development. In this regard, some interviewees mentioned the offer of additional in-kind advice, help and support, as well as permission to challenge policies seen as barriers to integration, as making 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." (CCG)

Access to other Pioneers, sharing information and disseminating learning between localities was also an important driver. The opportunity to network was identified as a strength of the programme, and interviewees highlighted the value of sharing experiences and learning, and of being aligned with a larger group.

> "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 …." (Voluntary sector)

Concerns about becoming a Pioneer

Becoming a Pioneer was not without concerns, in particular the risk of reputational damage to the locality if the initiative failed. This was particularly salient for Pioneer areas with a long history of integrated care initiatives with, in some cases, nationally recognised successes in the past. This reputation 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 could ask yourself 'Do we need it'?" (Non-acute provider)

Another concern was of the increased workload and bureaucracy that Pioneer status might bring, along with additional demands for information from the centre, and requests for advice and demonstrations of good practice from other localities. Such demands were deemed capable of outweighing the benefits, so that Pioneer status might actually slow down the local integrated care process more than support it.

> "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." (CCG)

The idea of formalising the local integration process through becoming a Pioneer raised some concerns in larger Pioneers where there might be substantial variation in performance across services and localities. 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 … and there is a risk … 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." (Local authority)

There were also concerns about adding additional complexity to what were in many cases already complicated health and social care economies, and questions were raised about whether the additional demands that Pioneer status might make were worth the benefits, particularly as there were no extra financial 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 many 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.

4. Overview and aims of the Pioneers

This chapter first provides an overview of the vision for integrated care articulated by interviewees. This is followed by a brief description of each of the 14 wave one Pioneers.

Vision for integrated care

The vision for nearly all the sites refers to 'whole system' integrated care, or 'transforming' the whole health and care system, or integrating care services around the person, or adopting a 'whole person approach'. From the start, interviewees were able to articulate a strong sense of the vision for their Pioneer programme. However, it was often perceived as challenging to translate this vision into concrete strategies and action plans, and in some sites, much of their first year as a Pioneer was focussed on developing their plans.

The features of integrated care were typically specified from a patient/service user's perspective, but the issue the Pioneers were trying to address was how to turn 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." (Local authority)

Within some Pioneer sites, there were 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/service user, considering their health and social care needs holistically, giving people a greater voice, coordinating care around their needs, and affording them dignity, respect, choice and control.

> "That the patient, that the citizen would feel, this is one of my catchphrases, would feel safe to live and safe to die at home ….That we met their needs in 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…. 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." (CCG)

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.

> "We are adamant that 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 is about weaving together a whole fabric of local services, including the voluntary sector." (CCG)

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." (Non-acute provider)

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 wider vision of integrated care as a crucial means of improving care quality and patient/service user 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 and by maintaining independence and wellbeing. Nonetheless, as the following section shows, 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." (Acute provider)

> "In terms of [our] Pioneer, the first thing to say is it's very different ….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 ….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." (Voluntary sector)

In contrast to sites that were focussing on provision or commissioning, other Pioneers were more concerned with the need to reduce demand by strengthening capabilities around self-care, or by focussing more attention on prevention and 'wellness', or by increasing resilience within communities.

Overview of the Pioneers

This section provides an overview of each of the 14 first wave Pioneers. The descriptions that follow were largely drafted by the Pioneers themselves and provide their own account of their vision and activities with some information provided by the research team. These descriptions were initially drafted for inclusion in the previous interim report, and thus largely reflect the situation towards the end of 2014. (The initial descriptions of the Pioneers that were included in the government press release announcing the 14 initiatives are included in Appendix A.) Progress made in implementing local initiatives, whether the sites consider themselves on track, and whether there have been any significant changes to their overall aims and objectives are described in chapter 9.

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 catchment and the 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 preventive approach to service delivery.

The principal projects include: a Universal Information and 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: telehealth; 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 across the whole of Cheshire serving 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 four 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 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, aligned to GP surgeries and virtual MDTs are 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 a hospital at home project in West Cheshire; support to carers; programme to tackle isolation; promotion of self-care models; and telehealth.

Cornwall and 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 purposeful activity in later life. 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 to enable 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 wellbeing. 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. Towards the end of 2014, it was being tested in Penwith, west Cornwall, where the Living Well approach was supporting 800 people, and in East Cornwall supporting 250 people. Living Well has been rolled out across other parts of Cornwall and the Isles of Scilly during 2015.

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

The Pioneer is also 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 well-established integrated health and social care teams, with shared management arrangements, in all parts of the care 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 developing more services, the emphasis is on better utilisation and co-ordination of all existing health and care 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 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 coordinated 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 health conditions.

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 services to the public and to assist in handling referrals.

As Islington is taking a life course approach to this work, the health and wellbeing of children is integral to all workstreams. 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 trust, acute trusts 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 place 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 other assistive technologies.

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

Leeds

In Leeds, the Pioneer programme underpins plans for transformation of the effectiveness 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:

- 13 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 communities. GPs are 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: payments for outcomes not activity; information sharing; and 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

The slogan '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 an enhanced social fabric. The young people's service includes design of a weight management programme by young people, and builds 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 to enable staff to have different conversations with their patients and clients, starting with how they can help each 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. South Tyneside is planning to embed the Pioneer principle of self-management within all its 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 to services (co-designed with patients/service users, with more choice and community care, integrated teams and a 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); and better use of resources through joint planning and commissioning.

Interventions that are being developed include: single assessment and care planning; MDTs aligned with a primary care hub footprint; seven day services in acute hospital and in the community; pooled budgets which follow the patient/service user across health and social care; a 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 brought about by joining existing health and social care teams; and pilots of new pathways for stroke rehabilitation and intermediate care beds.

The development of GP practice level co-located multi-disciplinary teams and integrated locality teams is under way. This is based on developing the existing multi-disciplinary teams and forms the model for rolling-out integrated care 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 services 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 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, the service integrator will manage a fixed budget for providing care (calculated on current expenditure) and will be expected to finance any increases from efficiency savings. The tendering process is expected to be finalised by early 2016.

Waltham Forest, East London and City (WELC)

The Waltham Forest, East London and City (WELC) Integrated Care Programme is about putting the patient/service user 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 health care 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 on 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; and discharge support from acute to community.

While working towards a capitation model in the next few years, an interim contracting model promotes integrated services by contracting with a 'provider consortium' 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 collaboration between Worcestershire County Council, all NHS organisations with responsibility for Worcestershire including NHS commissioners and providers, Healthwatch and the voluntary sector. It is aimed at refocussing care from acute hospitals into the community by 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 their length of stay in acute settings, by means of integrated sub-acute, community and social care. The programme is built upon the significant tradition of integrated care in Worcestershire, and its vision includes both enhancing existing initiatives to operate at a larger scale and greater 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; and future lives.

Each programme encompasses several re-designed or new projects and activities that will be developed at 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, such as the provision of telecare/telehealth, form part of the strategy aimed at increasing choice and control by patients/service users, and reducing the need for long-term health and care services.

Logic models

Appendix E includes the logic models that the research team developed in spring 2015 for each Pioneer based on their original proposals, other available documents, and interviews with key staff. Draft logic models, along with an explanatory note on their purpose and format, were sent to the Pioneers for comment, and amendments made when comments were provided. The main rationale for developing logic models – i.e. to make explicit how proposed interventions are expected to produce the desired outcomes – was described in chapter 1, which also included a logic model for the Pioneer programme as a whole, derived by the research team from national statements about the programme (Figure 1.6). The logic models in Appendix E make explicit the investments and activities being undertaken at the level of each Pioneer, and the outputs, outcomes and impact expected as a result. There are many underlying similarities between the 14 logic models, and they generally align well with the national logic model (Figure 1.6). The inputs often refer to shared governance arrangements between the local authority and the CCG; investments in the workforce, IT/IG systems and in primary and community care services; providing improved information and access to the population; co-design of services with patients/service users and/or the public; and occasionally pooled or integrated budgets. Similarities in outputs were notable, and typically included: risk stratification; neighbourhood or multi-disciplinary teams; care planning and care co-ordinators/navigators; various prevention initiatives; tele-health/tele-care; reablement; rapid discharge schemes; reduced emergency admissions; etc. The Pioneers were all aiming for similar outcomes and impacts (although with slight differences in classification between 'outcomes' and 'impacts'), including: more person-centred care; improved quality of life/wellbeing at the individual and population levels; more people living (and dying) at home than in care homes (hospitals); improved quality of life/wellbeing of carers; greater involvement of volunteers/community in care planning/provision; more joined-up, seamless services; improved staff morale; resources moved from acute to community/primary care settings; more cost-effective service models; improved value for money; lower per person health and social care costs; demand pressures managed and a more sustainable health and care system.

Another reason for developing logic models was to help the research team devise a typology for categorising the Pioneers which could be used later to see which approaches to care integration were more or less successful. Various approaches have been taken in the literature to developing a conceptual framework and/or typologies, in order to describe and understand different approaches to integrating care (e.g. Valentijn et al 2013, Fulop et al 2005, Lewis et al 2010). Most of these typologies distinguish integration initiatives along a number of dimensions including: type of integration; breadth of integration; degree of integration; and process of implementing integration (Nolte and McKee 2008). Such dimensions were used to inform the templates of key features of the Pioneers included in this report in Appendix C.

However, we did not find that these dimensions, or the logic models, were especially helpful in classifying Pioneers into different types: firstly, because of many similarities in terms of their target groups, activities, and logic models (all had agreed to pursue the same user-centred definition of integrated care endorsed by the national partners forming the Integrated Care and Support Collaborative); and secondly, because none of the existing typologies took account of a major dimension we identified for the Pioneers, namely the structural complexity of the organisational relationships involved (partly due to the scale at which they are working), from the relatively simple (e.g. Barnsley or Southend, where there is one CCG, one LA and one NHS acute trust with largely overlapping boundaries), to the relatively complex (e.g. North West London where there are eight CCGs, seven LAs and multiple NHS acute trusts).

Efforts to categorise the Pioneers into an existing or modified typology will continue as the longer-term evaluation progresses.

Overview of target groups

Most commonly the target groups for Pioneer interventions were described as frail older people, or people with multiple long-term conditions (LTCs), or high service users, or high risk groups (e.g. people at high risk of hospital or care home 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. Other groups targeted by the Pioneers included people with mental health conditions or people with learning disabilities. A smaller number of Pioneers were prioritising families and children. Several sites say their target group is the whole community, which is typically the case for preventive interventions. Staffordshire and Stoke is unique in focussing on cancer patients.

In identifying high risk groups, Pioneers have had to develop their own approaches to risk stratification, and some interviewees mentioned the challenges of designing a suitable methodology, including using an appropriate algorithm, identify a cost-effective risk threshold, and defining a manageable 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?" (Local authority)

Overlapping policies on integration

As mentioned in chapter 1, in the recent past there have been many policy initiatives aimed at developing and delivering greater integration between health and social care, and more widely, such as Whole-Place Community Budgets. Many of the 14 Pioneer sites have participated in these past initiatives and this has contributed to shaping their activities.

Since the launch of the Pioneers, there have been further developments in national policy and new programmes which target similar populations and plan similar activities as those of the Pioneer programme, although they may differ in scope and specific objectives. Recent policies include:

- the Better Care Fund (see chapter 8)
- the Pro-active Care programme (NHS England May 2014) to support CCGs

to manage a cohort of patients identified through risk stratification, and to shift funding into primary care and community health services with a view to bringing about a step change in the quality of care for frail older people and other patients with complex needs

- establishing effective seven-day services within existing resources, which is included in the BCF guidance as a requirement for local areas to confirm how their plans will provide seven-day services to support patients being discharged and to prevent unnecessary admissions at weekends.

Other recent programmes include:

- 'Vanguard' sites for the New Care Models Programme, one of the first steps towards delivering the Five Year Forward View (NHS England October 2014) and supporting improvement and integration of services (NHS England March and July 2015)
- the Integrated Personal Commissioning (IPC) pilots, which will for the first time blend comprehensive health and social care funding for individuals, and allow them to direct how it is used (NHS England 2015)
- Social Impact Bonds (SIBs) that are meant to unlock private investment to provide funds for organisations to tackle social problems on a payment by results basis (Cabinet Office 2013).

In addition, there are a number of initiatives that aim to strengthen local capacity in order to support the delivery of specific Pioneer activities. These include the National Technology Fund (phases 1 and 2) that aims to strengthen technological capacity in some sites to deliver integrated care more effectively; and the Prime Minister's Challenge Fund, which aims to improve access to general practice and stimulate innovative ways of providing primary care services. There is full or partial geographic overlap between the Pioneers (both 'first wave' and 'second wave') and the sites where these newer programmes are being implemented (Table 4.1 and Appendix D).

Table 4.1 Number of Pioneers involved in other government programmes aimed at integrating health and social care[6]

	Vanguard[1]	Vanguard[2]	Vanguard[3]	IPC pilots	Social Impact Bond (SIB) trailblazers[4]	Prime Minister's Challenge Fund[5]
First wave Pioneers	–	3	–	5	2	9
Second wave Pioneers	3	3	4	–	1	3

1 Integrated primary and acute care systems
2 Multispecialty community providers
3 Enhanced health in care homes
4 Not all SIBs have been agreed
5 Three Pioneers received more than one award
6 The overlap between Pioneers and Vanguards is likely to increase with new Vanguard sites expected to be announced, e.g. for acute care collaboration and for urgent and community care

Generally, Pioneers that are also involved in other programmes have valued how they reinforce their integration activities.

Interviewees generally felt that Pioneer aims were consistent with those set out in the Five Year Forward View and the goals of the Vanguards, and that the Five Year Forward View had helped Pioneers gain more focus and political clout, as well as provide a means of diffusing more widely the innovative models piloted by the Vanguard sites, which tended to be geographically smaller than some Pioneer areas.

> "I think that when the Five Year Forward View came out, it absolutely puts integration on the agenda." (Local authority)

There were nevertheless concerns that the plethora of recent initatives could be confusing or might divert attention from the original aims of the Pioneers as well as about effectively aligning activities and resources between the Vanguards and Pioneers, especially given the less central role of local government in the Vanguard models. Some interviewees, mainly from local authorities, expressed worries that the Vanguards could overshadow the Pioneers, which would become a 'sideshow', especially since they had financial resources attached to them (unlike the Pioneers).

Finally, where Vanguard status was awarded to only part of the full Pioneer area, some interviewees expressed disappointment that the whole area had not been designated a Vanguard.

> "Well, I think this is one of the problems with the whole of it, we've got far too many named things and there's support for everything. So as far as I can see, and this relates, the Vanguard is part of this, there's BCF which is a small part of integration. There's the Vanguard site, I guess that's part of integration, there's integration Pioneers, what exactly does that mean?" (CCG)

5. Measuring success and progress

Introduction

The logic models (in Appendix E) include for each Pioneer a list of:

- 'outputs', i.e. products of activities including service types and targets
- 'outcomes', i.e. changes in participants' behaviour, skills, level of functioning
- 'impacts', i.e. wider changes in organisations, communities or systems (intended and unintended).

Ideally all these should be measured directly or indirectly in order to determine if Pioneer interventions and activities have been successful in meeting their aims and objectives. Whereas outputs often include very short-term measures of process, outcomes include results in the short- and medium-term, and impact refers to much longer-term results.

Given that the Pioneer programme was no more than 18 months old when data collection stopped for the current report, the focus so far has largely been on measuring outputs, which are often expressed as a specific target to be met (e.g. more patients/ service users being given care plans, a reduction in emergency hospital admissions by a specified percentage, etc). All the Pioneers collect their own Key Performance Indicators (KPIs), which are usually derived from routine data, in order to monitor performance in relation to their specified outputs.

Measuring outcomes and impacts can be more difficult, often requires the use of indirect measures, and may not be expected to materialise until several (sometimes many) years after the start of the intervention (e.g. increased healthy life expectancy, reduced health inequalities, a sustainable fit between needs and resources).

Potential indicators for measuring the quality of integrated care was the subject of a PIRU report published in April 2014, available on PIRU's website: www.piru.ac.uk/ assets/files/IC and support Pioneers-Indicators.pdf. Each Pioneer has been developing its own list of indicators to monitor outcomes relevant to its own initiatives, and is developing its own local evaluation to examine specific aspects of its programme. Aside from the five nationally defined indicators used to assess progress in the implementation of the BCF, there is no agreed set of indicators common to all Pioneers that can be used to look at how progress and outcomes are being met across sites. However, the development of such a list will form part of the longer-term evaluation (www.piru.ac.uk/ projects/current-projects/integrated-care-pioneers-evaluation.html). Such indicators will usually be routinely collected, either as part of an administrative system or as part of an existing national health or social care survey. Moreover, in order to provide baseline data against which progress can be measured, the administrative/survey dataset needs to be collected (for at least one year, but ideally for several) before the intervention began. Before a common set of performance indicators is collated and analysed as part of the longer-term evaluation of the Pioneers, we confine ourselves to reporting participants' own definitions of 'success' in the remainder of this chapter and their informal assessments of how their Pioneers are progressing in chapter 9.

Pioneers' views of success

Pioneers typically had very broad and ambitious views of what would constitute success. Many of the sites referred explicitly to the 'Triple Aim', which is a framework developed by the Institute for Healthcare Improvement in the US (www.ihi.org/ Engage/Initiatives/TripleAim/Pages/default.aspx). This involves designing initiatives which aim simultaneously to pursue three goals:

- improving health and wellbeing
- improving experience of care and support, and
- reducing the per person cost of care and support.

While interviewees recognised that it was essential to balance these three goals, precisely how they were to be balanced was also recognised as important.

> "… although we talk about having the triple aim in balance, actually, we know if you do the first two things you get the third, but if you focus just on cutting contracts or … on increasing volume, and you try and do that in a contractual way rather than in a relationship way, you very rarely get the first two …" (Voluntary sector)

While some Pioneers did not refer explicitly to the Triple Aim, they largely shared the same overall objectives. For example, one interviewee identified 'four strands' for measuring success, two of which were qualitative and two quantitative: the first two related to the views of patient/service users about their experience of integration along with staff views; and the second two were related to the efficiency of the system and the impact on demand. But all four strands needed to be looked at as a package.

> "There's a number of dials that we're watching to basically see, is any impact being made? … they can all translate into a pound sign, but we're trying to look at it in the round, not just the financial impact, but the impact on social outcomes, the impact on the outcomes on the individual, the impact on the workforce." (Local authority)

When looking at outcomes, interviewees often referred to the National Voices 'I Statements' as informing their ideas of person-centred outcomes. This was usually interpreted to mean better quality health and social care looked at from the patient/service user perspective.

> "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?" (CCG)

One of the primary means of reducing the per person cost of care was to shift resources away from expensive acute settings to more community-based care, in order promote the financial sustainability of the health and social care system. 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." (Local authority)

However, some interviewees expressed caution over what integration could realistically achieve financially, in particular that it might not provide the expected cost savings many were anticipating.

> "I don't think that there is any good evidence anywhere that costs are saved. I think the best case that can be made is that growth of costs is reduced or mitigated to some extent." (Acute provider)

While the most common view of success was to look at the quality of life and experiences of the patients/service users who were subject to Pioneer activities and interventions, some interviewees referred instead to improving the health of the local population, or of particular groups within it (e.g. older people, frail or vulnerable people, etc.). For example, in one site, the Health and Wellbeing Board was not interested in …

> "… the 30 odd indicators that we're using to measure the impact of the program. Their interest is 'What difference does it make to the whole population?' ….So they've created a list of 10 [indicators] which engage everybody, from police to voluntary sector, to commissioners of health and social care, to private sector organisations, to insurance companies, that then measure the impact across the population." (Voluntary sector)

This highlights that different stakeholders can have different interpretations of success, which may vary according to professional background and position in the system.

> "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 … social workers will have a different view of success than their social care management ….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?" (CCG)

Other measures of success were sometimes mentioned, such as having a 'happy workforce', who feel …

> "… really valued, being able to collectively do the jobs that they want to do and that is sort of supporting and providing the best sort of health and social care … if you've got a group of people who really feel valued, value in what they're doing, and they're delivering a good coordinated service then the patients or the service users will benefit." (Non-acute provider)

For many Pioneers, it was an important feature that the definitions and measures of success were co-designed with patients/service users and staff.

> "… so we haven't sat in a darkened room and made judgements about what success looks like, but that you see them from everybody's perspective, that they are a collaboration of all those lenses really." (Voluntary sector)

> "… the outcomes framework took a long time to develop … because it's co-designed with patients, with clinicians, with commissioners…" (Voluntary sector)

Another interviewee pointed out that it is not just a matter of measuring success, but also how it was achieved.

> "… we also want to measure how it goes towards that success. So if it doesn't succeed, or if aspects of it don't succeed, we can still learn and disseminate the learning ….So I think you're looking at every aspect. The process issues, the social issues, the financial issues, the economic issues, the political issues. Learning lessons on all aspects." (Voluntary sector)

It was also noted that, to begin with, process measures looking at how well coordinated services had become, would be more valuable than looking at outcomes.

> "What you should be looking for [initially is] … how you're building foundations. Do you share information, do you have an open book approach, do you have transparency, do you have a shared vision? All those sorts of things which are critical underpinnings of successful integration – I think that's what you look for first and then you look for outcomes." (CCG)

Some interviewees pointed out that any unintended consequences of Pioneer initiatives are also important and need to be measured. These can be either negative consequences – such as the closure of wards or even whole hospitals with the loss of jobs, increased pressure in unexpected parts of the system, whether the right patients/ service users are being targeted by the initiatives, whether costs are increasing – or positive consequences, such the potential reduction of alcohol abuse, crime, etc for some of the community-based initiatives. This highlights the importance of not being too focussed on a narrow set of metrics, but looking across a range of measures.

Timeframe for measuring success

It was common for interviewees to point out that transforming services will not lead to instant results, and that considerable time will be needed before improvements in outcomes can be measured as opposed to changes to resource use and outputs. Five years was the sort of timeframe often mentioned before results could be expected.

> "We talk about the Pioneer being a five to seven year programme. It's about transformation of change. We will struggle to see some of the results in five to seven years if we are truly transformational." (Local authority)

> "I've come up against people who were saying, well, if we go for integration it's going to deliver X, Y and Z like next week. And I'm saying well, hang on a minute, I don't think there's any evidence anywhere in the country that it will deliver that within such a short timescale. It might deliver some of that in five years' time." (Non-acute provider)

In a few cases, the Pioneers were thinking even longer-term, particularly for initiatives aimed at children.

> "… evaluating this project [needs] a much longer timeframe … [where you] see what happens over 10 or 20 years … it will be a long time to see any difference." (CCG)

Two other factors related to the need to dampen expectations of immediate improvements in outcomes were, firstly, the fact that system change could lead to some indicators deteriorating before they improved, and, secondly, the fact that Pioneers were meant to experiment suggesting that some initiatives were likely to fail.

> "We've done a baseline survey … but we expect it to go down before it goes up, because obviously, it is change and no one likes change." (CCG)

> "And remember … we always said some of this may not work, and if it doesn't work that's fine, because that's what you learn from…." (CCG)

In the absence of short-term measures of success, there were considerable references to relying on anecdotal evidence, and even to using such evidence to adjust Pioneer activities.

> "The evidence may be anecdotal in certain areas and you've got to take that leap of faith in a relatively comfortable environment and space to do that, and know that we learnt something from this but it didn't work and we're going to tweak, we're going to move it, we're going to mould it, we're going to take it forward." (Local authority)

Such monitoring of more short- and medium-term measures could be done quantitatively as well as qualitatively, and the importance of doing this was recognised in order to keep track of how well initiatives were progressing so adjustments could be made before it was too late. One interviewee referred to the 'trap' of only looking at final outcomes, which could be a long way off.

Collecting metrics was also important for CCGs and local authorities for monitoring contracts. And continual monitoring was thought to be particularly important for the more innovative initiatives.

> "… it's almost like an action research where you just keep an eye, and some of it we're making up as we go along, you know, that's the whole idea of being innovative; if you know exactly what you're doing and exactly how you're going to get there it probably isn't innovative. So you have to have that sort of courage really, to do things differently and accept that, as long as you're monitoring it, it might not go the way you want it to, so then you pull it back." (CCG)

> "They're … going to follow the journey and they're going to have gateways so you can stop and review that situation there and then, what's working, what's not, then go back and change it, so it's a constant rolling thing rather than evaluation after a year, it's a constant rolling programme as part of the evaluation." (Local authority)

How success will be monitored and measured

Pioneers are monitoring their activities, progress and the degree to which their outcomes are being met, in a number of ways. Many sites have set up workstreams or steering groups which are tasked with identifying the key metrics to measure and/ or guide local evaluation activities. Developing a 'dashboard' or a local 'outcomes framework' was frequently mentioned, which are generally designed to allow regular (e.g. monthly) monitoring of key performance indicators (KPIs). While these are developed to suit the specific activities being undertaken by each Pioneer, the metrics are usually based on existing indicators collected routinely and which are used for monitoring at national level (e.g. for the NHS Outcomes Framework, the Social Care Outcomes Framework, the Public Health Outcomes Framework, the BCF). While a number of Pioneers were monitoring substantial numbers of KPIs, many interviewees felt that it was important to identify a smaller number (perhaps ten) of key measures to focus on that really measured the impact of the programme.

> "I've seen the list of KPIs … there's probably 70 of them. So, for me, it's actually picking through them, which are the really important ones and how do you quantify some of those ones that are most definitely qualitative to get the sense of 'Is it worth it, is it not?' … what's meaningful, what makes a difference for me [as a commissioner]." (CCG)

The majority of KPIs are measures of activity and outputs, rather than looking at outcomes. They are designed to use existing data, so as not to create an extra burden.

However, a key metric for all sites is measuring patient/service user experience, but how this will be done is likely to vary between Pioneers, as there is no standardised instrument and no routine data looking at patient/service user experience of integrated services for them to draw on. Whereas some sites are opting for existing measures – e.g. the 'Patient Activation Measure' (PAM) (Hibbard et al 2004) or the Friends and Family Test – others are developing their own measures of patient/service user experience.

> "… there aren't any measures around people's satisfaction with integrated care, so in this year, we're looking at developing baseline measurement through the community and through the GP practices, of doing regular surveys of people's satisfaction with integrated care, their experience of the integrated teams …" (CCG)

Also mentioned was monitoring complaints through the usual routes, and collecting real-time patient experience in hospital ('by-the-bed' data collection).

Some Pioneers supplemented patient experience surveys with qualitative work among patients, such as collecting users' stories.

> "… we use patient stories a lot to incentivise improved care, so we'd hope that you'd start to hear more and more positive patient stories coming from our clinicians, from our clinical leads, and from our patient leaders. That would be the evidence that it's working …" (CCG)

Although it was recognised that some of this initial work may not be scientifically robust, these users' stories were valued as they can provide very quick feedback to the Pioneer team, who are then able to make adjustments to their services if needed.

> "… in essence what it [our evaluation] does is, it takes patients' stories and looks at how they are fed back to the teams in terms of the success or not of the new way of working, how integration's making the patient experience more effective, what patients are saying in terms of difference and change. And then, what the neighbourhood team do is create an action plan based on the feedback to try and address some of the not so positive feedback, as well as celebrate some of the positive feedback." (Non-acute provider)

These evaluations were not necessarily exclusively focussed on patient/service user feedback, as some sites carried out qualitative interviews among doctors and other health and care staff to ascertain their experiences and views on how the Pioneer was progressing.

While many of the KPIs would be focussed on specific client groups, some Pioneers carried out a broader data analysis in order to monitor the potential impact of Pioneer activities, e.g. by looking at levels of demand for services and whether it is changing in line with expectations given the changes to the local population and changes in provision associated with the Pioneer.

Pioneers varied with respect both to performance monitoring and local evaluations, with some having systems in place, and others still developing their plans. If new initiatives were underway without any accompanying framework for monitoring progress, interviewees expressed frustration.

"… there's no case studies to prove that anything is changing for the better; we know things are happening now out there but no one's capturing it." (Local authority)

As expected, all Pioneers were planning to carry out at least one evaluation, and in many sites several strands of evaluation were planned. These generally involved a third party (e.g. a local university) to advise on the design and/or to carry it out. The types of evaluation varied, covering both process and outcome studies, and including both quantitative and qualitative methods. However, the ambitions of the evaluations differed, with several sites planning rigorous outcome evaluations using matched samples. Several interviewees explicitly mentioned they were commissioning action research to feedback and further develop Pioneer activities in real time. One interviewee said that the evaluation was specifically to provide 'live learning' rather than simply produce a report after several years.

In the most ambitious sites, this involved co-design of the service, its objectives, the metrics to measure it, and the evaluation.

"You work in participation with key stakeholders in any given site, and they include users and carers as well, and you help them design a service. And as researchers we provide the evidence for what we feel might be the best way forward and they create a set of improvements or they create a design for their integrated care and then we apply the metrics that we've fashioned. As the project is rolled out, the stakeholder group meets every six months or so, and we bring everything that's in as it accumulates on the measurement of the initiative, and the stakeholder group then decides what needs changing, what needs keeping in terms of what's going well and what's not going so well, and we monitor the patients …" (Local external evaluator)

Difficulties with evaluation

Interviewees expressed a number of problems in commissioning or carrying out their own evaluations. In some cases, funding for an external agency to carry out the evaluation is simply not available ("it costs money to do good evaluation" (CCG)) and Pioneers may not have sufficient staff or people with the right expertise to carry out the evaluation in-house.

"… it does require somebody who knows about evaluation, knows what works, etc ... it does need to be someone with [the] right background rather than somebody who is a performance person and counts numbers or somebody who is more of a manager." (Local authority)

Many of the issues raised will be familiar to evaluators in general. One example is obtaining the necessary data for monitoring purposes.

"It's very easy to get hospital metrics because we've been collecting them for 40 years ….We're not used to providing that level of detailed information about community hospital care, about GPs. Primary care is a nightmare to get data out of and adult social care as well. We're working on it but we do need to get that so we understand what's happening, where some of the blocks are and where some of the levers are to make some of the changes." (Acute provider)

Even when the data are collected, access is not necessarily straightforward, and following an individual through the whole health and social care system can be difficult given that a common identifier is not necessarily available across different services.

Some interviewees, on the other hand, felt overloaded with data and had problems deciding which measures to focus on, particularly in the early stages of a Pioneer's activities.

> "What I say to people is 'Let's only have 2 or 3 indicators … and let's measure them from the start. So we set the baseline and then measure them to death to be able to make sure that we've got progress.' There will be other data about interventions that work … but actually it's fundamentally about, 'Does the patient believe that this service is better than it was?'" (Acute provider)

Collecting qualitative information has its own problems. For example, carrying out case studies among patients can be difficult for a number of reasons, as this interviewee pointed out:

> "In terms of the [case study evaluation] … it's a good model … but … there are two major things that we struggled with. First of all, the model [requires] … patients who can be surveyed by the … lay evaluator [who] will go in and spend some time with the patient talking about their experience of care, and then use that as the case study to feed back to the team for them to develop the action plan and look at the learning. And some of the teams have struggled to identify the patients because they're asked to identify a patient who has got evidence of health, social, multi-disciplinary engagement, but are also well enough and compliant enough to contribute to the process … sometimes they struggle with that because of the complexity and the disease profile of the people they're seeing. They're often too complicated, too ill to participate, so that's been a bit of a challenge. And then the second challenge that we've had [is] … about staff then creating the time to, first of all hear the feedback, and then creating the time to develop the action plan, and then creating the time to work with the action plan over a period of time, and effect some change as a result of putting strategies and approaches in place that respond to the feedback that they've received." (Non-acute provider)

There are also difficulties designing a robust outcome evaluation, as determining attribution can be difficult. An example given by one interviewee had to do with keeping people out of hospital.

> "How can you measure conclusively whether or not the people you intervened on didn't go to hospital but they would've gone to hospital if you didn't do something. We've spent lots of time discussing with other sites how they measure it and no-one has a perfect answer so far. In the past, we've looked at our cohort and looked at how they did the year before, then the current year, and was there a shift up or downwards, but there's other things in the system that could have impacted that." (CCG)

One potential way around this mentioned by some sites is to roll out the intervention over time to different localities, so that comparisons can be made between areas with the initiative and those without the initiative.

One interviewee felt that attribution was too difficult and that evaluators should focus instead on...

> "… whether any of those real sticking blocks within the system, have any of them been unlocked as a result of the Pioneer programme". (CCG)

Another difficulty relates to the timescale Pioneers are working towards in terms of delivering results (as discussed previously), as several sites mentioned the fear of being pushed from the centre to show results before they can realistically be delivered, or even just to put in place baseline measures early on even though they might not be the most appropriate metrics.

The opposite of this was also a concern, however, where initiatives may have been started without a clear idea of the outcomes expected, which means nothing has been measured at the start so there is no baseline data to compare with over time.

Some interviewees also felt that certain initiatives would just be very difficult to evaluate in themselves; one example of this is MDTs, since the patients/service users being treated by an MDT are so diverse and potentially subject to very different interventions and outcomes.

One interviewee pointed out that new measures need to be developed to capture outcomes for the more innovative interventions.

> "We are in danger of measuring the system by the old measures, and funnily enough it won't be very successful because it's not what we want to be measuring, so if we try and measure the cure rates of this, we won't get to the right place … it is much more around citizen outcomes, but it's also got to be something that has got some rigour and some way of being assessed in a correct way so that we know whether the integration that we have done has truly made a difference." (Local authority)

Also, given the importance of reducing per person costs, the difficulties of trying to measure whether there are real efficiencies and savings was frequently recognised.

> "People need to get their head round the way the money works. There will be spend in social care, primary care and acute and in the community, and we don't have a single joined up view of how much these patients cost us as they go round that." (CCG)

Moreover, if you take the wider perspective of improved services impacting on a much wider system, including voluntary organisations, housing, crime reduction, etc. then it becomes very clear how difficult it is to develop a clear indicator of costs averted (or benefits accruing) in the round.

Practical issues in evaluation design were also mentioned, such as obtaining a sufficient sample size to ensure the study is robust, or the difficulties of carrying out a RCT due to often-held objections to randomising patients/service users to intervention and control groups.

Some interviewees felt that evaluation is not necessarily what is required, and that relying completely on evidence can inhibit innovative interventions.

> "There is always a struggle and a difficulty to prove prevention. It's almost impossible to do, but you can't then set up a system which says we'll only invest in prevention and early intervention when we've proved that it works. You need to recognise the realities of what we can't prove … it's being used as a barrier to stop innovation." (Voluntary sector)

Some sites were still attempting to identify the appropriate balance between a robust evaluation that stands up to external scrutiny and carrying out more routine monitoring that helps support development of Pioneer activities and show where changes may be needed.

It seems clear from the evidence collected during the interviews that, since Pioneers will be taking quite different approaches to monitoring and evaluation, it would be quite challenging to combine or compare the local evaluations of the 14 first wave Pioneers.

Obtaining help with local evaluation

As mentioned above, most sites are turning to external support for carrying out their evaluations, although a shortage of funding means this is not always possible (at least to the desired extent). Yet few of the sites have in-house evaluation expertise, which results in concerns whether they have the appropriate skills to set up their performance monitoring systems and interpret the resulting data.

Even where external evaluation support was available locally, some Pioneers expressed a 'hope for more tangible support for evaluation from the centre'. While one interviewee said such help would be useful because evaluation is 'really complex' to get right, a few made more specific requests such as developing a national definition of 'integration' so Pioneers would all be working within the same framework (despite the existence of the National Voices 'I Statements' that were meant to be guiding the work of the Pioneers), or for DH or NHSE to help by developing measures of patient/service user experience of integration – 'a national patient experience metric we could implement would be hugely useful.' (CCG). On the other hand, one interviewee thought the centre should be less prescriptive in deciding what should be measured, and mentioned the BCF as an example.

NHS England monitoring

NHS England is planning to monitor Pioneer progress using a consistent set of KPIs/metrics. At the time of writing, seven measures (shown below) based on routinely collected data, and overlapping with the BCF metrics, are proposed for inclusion (although these could be amended over time):

- reducing avoidable emergency hospital admissions
- delayed transfers of care from hospital per month per 100,000 population
- total delayed transfers of care
- delayed transfers of care from hospital which are attributable to adult social care per 100,000 population
- proportion of older people (65 years and over) who were still at home 91 days after discharge from hospital
- permanent admissions of older people (65 years and over) to residential and nursing care homes, per 100,000 population
- overall satisfaction of people who use services with their care and support.

6. Pioneer activities and resources

Table 6.1 (page 60), Table C1 (Appendix C) and the site-specific logic models (Appendix E) compare key features and interventions of all 14 first wave Pioneers. As these tables and logic models show, while there are many similarities across the Pioneers, each one also 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 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 within their geographical area as constituting the Pioneer. In some sites, 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 6.1 shows a list of 14 of the most prevalent Pioneer initiatives within each site, and their status (as of autumn 2014 when the Table was compiled) – i.e. whether they are active, being planned or for future development. Both Table 6.1 and Table C1 were completed by the Pioneers themselves with input from the evaluation team (whereas the logic models were initially developed by the evaluation team and then sent to the Pioneers for comment). However, in this context, it is important to note that the various categories in Table C1 and interventions in Table 6.1 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 obtained from interviewees during both rounds of fieldwork.

Governance

None of the Pioneers was constituted as a distinct legal entity with formal decision-making powers distinct from its constituent organisations. Instead, each was governed by a cross-organisational steering committee or project board that encompasses senior managers and others (e.g. GPs, councillors) 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 governing body included representatives from all of these organisations. In some areas, this group was accountable to the local authority's Health and Wellbeing Board (HWB), while, in others, accountability of the Pioneer steering committee or board was dual to reflect the separate governance structures of the CCG and local authority. The Pioneer steering committee or project board was usually supported by a small programme management team which oversees overall progress day-to-day and by specific working parties or workstreams. Costs of the programme management team were often shared between partners, especially the CCG and local authority, and, in some cases, the budget may have included resources for jointly funded appointments. Only the NW London Pioneer has invested more significantly in support of programme management by top-slicing 2% of the budget from each of its eight CCGs in order to fund a number of transformation programmes, including the Pioneer.

In many Pioneers, there was a lead organisation (either officially or nominally) that was the 'driver' or 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 the direction of the Pioneer 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." (Non-acute provider)

A potential solution adopted in several areas was to have joint appointments by the local authority and an NHS body (usually the CCG), who would facilitate, and often lead, the Pioneer programme and be a member of the management board.

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 even vary between localities within Pioneers.

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 feature in smaller sites with high levels of devolution to community or ward levels.

A number of tensions were identified, usually in the early stages of a Pioneer's programme, and were often to do with trying to include such a wide range of stakeholders. It was not unusual for the governance arrangements to evolve over the first year or so. In some cases, the changes aimed to achieve a better balance between the organisations involved.

In the larger Pioneers, with a wide diversity of stakeholders (i.e. sites with 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." (CCG)

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 competitive logic that informs commissioning and the purchaser-provider split. This happens especially, but not exclusively, in areas where commissioners are relying largely on procurement processes.

"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 it's just been taken now and gone to market." (Non-acute provider)

The relationship between the informal steering/working groups that were set up to drive forward Pioneer work and the formal governing bodies of the partnership organisations could also lead to tension, especially as the latter operated under entirely different decision-making frameworks and potentially to different (often nationally set) agendas. Most obvious is the contrast between CCGs governed by GPs and health care professionals/managers, and local councils governed by elected representatives (with electoral constituencies to represent).

In some sites, it was felt to be difficult for the Pioneer steering groups to obtain decisions and prevent issues being recycled without resolution. This lack of formal power was seen by some as a liability for the programme, and could also lead to tension between middle managers (who tended to sit on the Pioneer steering and/or management/working groups) and more senior leaders on the boards of the formal governing bodies of the constitutent organisations.

> "But because Pioneer has no teeth, it isn't a decision-making body, it isn't anything, it's a programme, it's not anything, it's just that you are all in it together. That's for me what a Pioneer is, that there is no teeth there." (CCG)

In some areas, the involvement of some stakeholders, particularly local providers, appeared 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 played a prominent role. In fact, the convergence, at least in general aims, between the Pioneer programme and the BCF in some cases shifted responsibility for governance to the HWBs, which do not include representatives from provider organisations. In fact, the role of the HWBs raised some concerns, since they were perceived as legitimate governing bodies, but with very limited power:

> "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." (Acute provider)

> "It was a national requirement for the Health and Wellbeing Board to sign off on the Better Care Fund plans, but if they didn't, it didn't matter ….We talked about the remit, raising the profile of the remit of Health and Wellbeing Boards. Give them the responsibility for doing things, don't just make them a tick box exercise." (Local authority).

Integrated care strategy/service models

Most Pioneers were 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 mentioned the importance of integrating mental health services, often in relation to dementia.

Most also said they wished to increase involvement of the voluntary sector. 'Whole system integration/transformation' of all parts of the entire health and social care economy was a common refrain. In a smaller number of sites, references were 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 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/service user experience was universally anticipated as one of the primary outcomes. However, it was also recognised that, in the short-term, cost savings were required from the system, so the Pioneers urgently needed to design innovative and cost-effective interventions, i.e. those that would lead to improved patient/service user outcomes and experience, but at a lower cost than at present. There seemed to be a widespread presumption among the Pioneers that this would be 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 varied between the Pioneers (see Table 6.1), particularly the details of their implementation, they shared a variable combination of many of the following elements: developing community assets and community resilience and increased use of volunteers; increased support for self-care/self-management of conditions; identifying people most at risk (of hospital admission) and providing them with care plans; the use of telehealth or telecare; multi-disciplinary teams (MDTs) (e.g. of health and social care workers, often based around GP practices); use of case managers; improved access to services (e.g. 7-day services, single point of access); rapid response services to reduce unplanned and unnecessary hospital admissions; and, providing more support to carers. At the level of the individual Pioneer, the precise combination of these initiatives led to a highly complex intervention, with all the difficulties for evaluation that such complexity entails.

In some sites, certain initiatives, such as MDTs, were in existence prior to becoming a Pioneer and were simply brought within the Pioneer rubric. In these cases, as part of the Pioneer work, an existing initiative may be enhanced (e.g. adding a care navigator to an existing MDT), or scaled up across a larger geographical footprint, or rolled out to other populations or service areas.

Other initiatives, however, involved service models that were entirely new or still in development. 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 ….You've then got 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." (CCG)

Whilst the ambitions and objectives of Pioneers were initially quite diverse, the second round of fieldwork suggested that many sites were focussing on a more limited set of initiatives, at least under the rubric of the Pioneer programme, most commonly care coordinators, locality-based MDTs, care planning, rapid response and single point of access. This is discussed more fully in chapter 9.

Table 6.1 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 and 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 and 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 the 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. The table was originally prepared for the interim report and thus represents the situation in autumn 2014.

Patient and public involvement (PPI)

Involving patients, service users and the public featured to some degree in all of the Pioneers. However, the extent of this varied among Pioneers and across time; some benefitted from pre-existing PPI initiatives that they could link to, and there was some indication from the second round of interviews that PPI had progressed relative to the earlier period. However, there were instances where Pioneers acknowledged that their PPI work had been slow to get started or where more attention was needed.

> "I think we've started some really good conversations around what does that mean in terms of engagement, though, and we've got a number of thoughts about how we start to develop that going forwards. So we've not got to that point yet, but I think we're on with that conversation." (CCG)

However, this was not the most common account. Interviewees were generally keen to stress that PPI was securely in place and an important element of their Pioneer activity.

> "[PPI is] very important indeed. Very fundamental, absolutely, absolutely fundamental. Yes, and the one thing that everybody does realise is that this whole programme, it's got patients and carers running through it like a stick of rock." (CCG)

The value of PPI was often strongly emphasised during interviews, particularly the involvement of patients/service users (there were fewer references to work with the public more broadly).

> "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." (CCG)

Pioneers discussed the ways in which the patient/service user voice was helpful in 'building a case' for health and social care integration, keeping stakeholders focussed on the ultimate goals of improving patient/service user experience and providing challenge where needed.

> "[A local series of PPI workshops] is really pushing professionals, working with a whole range of members of the public, not just people who are 'professional patients', and being quite challenging in terms of what they expect from us. And some of our colleagues have found it a lot more challenging than they were expecting. I think they thought, 'Yes, yes, we do that.' And, actually, hearing things in a different way has made people rethink their approach." (Local authority)

Stakeholders being willing to confront uncomfortable realities about patient/service user experience could act as an important enabler for Pioneer activity.

> "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." (CCG)

The extent and nature of PPI varied in different localities from extensive and well-developed to in development. Larger Pioneers with more complex geographies and governance arrangements faced a bigger challenge coordinating PPI, but also had greater resources to devote to it. PPI methods included a wide range of activities: the involvement of Healthwatch; action research projects; involvement of citizen's panels; consultation events; and representation on strategic and decision-making bodies. In one example, 'patient champions' had been trained to participate in procurement processes.

"We've got three lay members that we've recruited and we've got patient champion groups that they run. People from that have come and said, 'we want to be involved in the procurement', and we've trained them to do procurement." (CCG)

A further important tool to build momentum and spur activity was the National Voices' 'I Statements'. There was universal support for the value of the 'I Statements' among interviewees and frequent reference to their use. In some cases, this built upon existing similar local statements and there were instances of some local modifications accordingly, but overall there was strong endorsement of the statements as a valuable and powerful tool underpinning Pioneer activity.

"I think what the 'I Statement' does is it makes it real for people. So we can sit there with process maps and Gantt charts and lovely colour tables. But I think if you put a person in it and you put a person as part of the journey, you explain that this is the journey that this person will go through, and these are the services that will be available, and this is the outcome that will be achieved for that person, then it makes it more real. It touches the heart then, and especially for the clinicians, that is what gets them on board." (Local authority)

However, there were a number of challenges that interviewees described in their PPI activity. As noted above, activities to engage the wider public were less frequently mentioned. So too was the involvement of carers, where there were reports of a need for PPI activity to be stepped up.

"It's about our including the carers. Absolutely we have got a lot from the engagement process, as carers [are] saying that they are not involved enough, that you know, when people talk to the patient, they don't talk to them." (CCG)

Pioneers in some areas were also struggling with the involvement of the community and voluntary sector, particularly in areas where this was large and complex. It was also noted that the effect of austerity had been to significantly reduce the number of such agencies or their capacity. One interviewee commented on the problems of adequately representing these diverse organisations.

"No I don't think having someone from the voluntary sector on the steering group meets the needs of the voluntary sector … it's a difficult one because I could see the voluntary sector … be quite insulted that there was only one space, you know, with that level of importance. So I wouldn't want to speak for them as to whether they should have a space on that or whether there should be a whole different mechanism to engage them." (Voluntary sector)

A further difficulty concerned the complexity of communicating in an accessible way to the public what the diverse Pioneer initiatives were and their aims. In some areas, it was perceived that the Pioneer was not a 'public-facing' initiative, but rather was about realigning the activity of health and social care organisations, and that the public would have limited need to engage with this strategic programme. However, more commonly, the view was expressed that there was a strong need for better communication with the public about the Pioneer programme, not least because failure to so do risked the initiative being seen as a purely cost-cutting exercise, especially in the context of unpopular hospital closures. One of the larger Pioneers had established a specific communications working group, led by a Healthwatch representative, to coordinate public information about Pioneer activity.

> "It has to tell a story that isn't about saving money. It might save money, but it may not, but it is about actually doing it in a better way, and they see that…. Because there's this perception that the hospital care is good, anything else is less good, and we need to actually start selling a different story. We're doing it because actually it's better, not because it's cheaper." (CCG)

However, a voluntary sector representative described the challenges of translating the complex bureaucratic processes and discourses involved in the strategic developments in ways that would lead to meaningful dialogue with 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." (Voluntary sector)

The involvement of the public may also add complexity to the decision-making process, especially where different, and sometimes opposite, positions co-exist within public opinion. One Pioneer had reportedly had considerable success with its strategy of transparently laying out the problems to the public, engaging them in the difficult choices to be made and enlisting their help.

> "I called a public meeting at a big hotel in [the locality], got some reps to pay for it and got everyone in, all the staff, politicians and said this is the problem ….I just told them as it was, straight, didn't pull any punches and said we're in a right mess. We think we've got the bones of a solution to get ourselves out of it, but we need a load of work doing on it, can you help? That was quite a revolutionary thing, to go out and ask people to be actively involved with how we redesign the service. So they felt they had ownership of it, and we evolved it along the way and it was a lot of what gave it its success ….I thought it seemed an obvious thing to do but other people have said wasn't that a great way to do commissioning." (Non-acute provider)

However, there were mixed views about the scope of PPI, and one interviewee argued that it should not be seen as a panacea for making difficult choices about service reconfiguration. While service user and public views need to be taken into account, direct involvement in service design may necessarily be limited.

> "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." (Voluntary sector)

One interviewee commented that it was necessary not only to communicate to the public what Pioneers were doing and why, but also to educate them about the need to use services differently in a reconfigured future system.

> "There is something that is almost [at a] national level of starting to re-educate people's expectations of how they access information, what's their first point of call, but also about them being, you know, owners of their own health and social care, of preventing ill health, of having some personal responsibility … being aware of the realistic choices that they have in terms of what's available." (Acute provider)

However, despite the nuances of the debate, for most interviewees, PPI was an essential element of Pioneer activity that reportedly fostered change in how issues were perceived and addressed by important stakeholders.

> "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!" (CCG)

Information technology (IT) and information governance (IG)

Information sharing was recognised by all Pioneers as an essential building block in their integrated care models. There were three key reasons why this was critically important: to allow health and social care professionals to coordinate and manage care for individuals; for the purposes of risk stratification (i.e. identifying those who were most at risk of hospital admission or who would most benefit from coordinated care); and for the potential tracking of costs to enable the development of pooled and capitated budgets. Across all Pioneers, problems with IT and IG formed a significant barrier to progress.

> "The sharing of information across the whole health community is probably the number one thing to solve." (CCG)

It was noted that these problems were not new, but the promise of Pioneer status had been that it would finally provide a vehicle to solve them.

> "It's dealing with the big barriers, so things like shared information systems ….For 10 to 20 years, I'm aware that there's been discussions about having a shared client record, patient records and if Pioneer can push through a solution to that, so that everybody signed up to it, then that's a huge part of the work done." (Voluntary sector)

In some cases, the challenges were due to problems with deficient and out-of-date IT hardware or software, or lack of IT interoperability.

> "I think it would be very helpful though to just have some more control over joining up of systems, so RiO versus Cerner versus EMIS versus Adastra versus System One, you know, that's five systems that we have to join up … in the locality, and each system does a different thing." (CCG)

> "Put a million quid into it [IT system]. 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." (CCG)

However, while intensely challenging, these sorts of technical problems were not considered insurmountable. More problematic appeared to be issues of IG that hindered sharing patient/service user information within and between health and social care services. It appeared that the regulatory framework in this area was a cause of great confusion and contradictory advice.

> "It is technical or is it also because of the legal framework in terms of sharing data? I get such different messages, I don't even think the government knows what the message is. Some people say we can't share, others say they can." (Acute provider)

This lack of clarity either prevented the sharing of information entirely or led to highly impractical and inefficient practices. One interviewee's account gives a flavour of some of the inefficiencies that staff were having to work with as a result of the way in which IG requirements were being implemented.

> "I discovered literally two weeks ago when I went into the intermediate care office, just to see what happens from their perspective. The lady I spoke to, she said, 'Obviously you phone me, then I phone your practice, and one of your practice members prints out all the information I need. They then fax it to me and I have to put it all on here [computer].' They have to do that 4 or 5, 6 times a day for our practice. Six feet behind her is the district nurse sitting there who's got total access to my system and can print off exactly what she needs, but she's not allowed to print off patient information and give it to the lady who sits 6 feet in front of her." (CCG)

There were problems establishing information sharing across a wide range of stakeholder organisations, but it was notable that information sharing agreements involving GP practices was especially problematic. In part, this was thought to be due to a strong tendency towards risk aversion in the light of the perceived ambiguities around lawful practice.

> "So we've got a mismatch here. We've got Norman Lamb saying 'There's no legal standing for you not sharing your data' – in fact, they've produced this duty to share, now, data, information – but on the ground, that's not what it's feeling like to primary care, and they're getting advised by their data controller, 'don't go there'." (CCG)

> "GP practices are small businesses; they don't want to take risks a) with their patients' data, which they also always feel that they are legal guardians of and it's sacrosanct within local communities, and b) they don't want to risk large fines because they can't afford to pay them. They'll go bankrupt." (CCG)

Pioneers found it particularly unhelpful when national health and social care bodies contradicted each other.

> "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." (CCG)

It appeared that Pioneers had to try to solve the 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 interviewees lamented that little support had come from national bodies (including the Health and Social Care Information Centre) in terms of clarifying IG rules or providing technical solutions. Having Pioneers separately trying to solve the issues was seen as the least efficient and effective approach, and it was unclear who was ultimately responsible for funding the associated IT requirements.

"Some of this is about people trying to sort it out in their own way. Part of it is that no one knows quite whose responsibility it is ….We could definitely implement this if everyone agreed, and it would cost, I don't know exactly the figure, but it would cost no more than £10m or £15m to sort this for [our locality]. And if you're spending £4b then £10m is not a lot of money to have an efficient [IT] … system. But no one knows quite who should be paying it." (CCG)

On their own, Pioneers had found it intensely difficult to 'bust' this particular barrier.

"I don't see any evidence of being a Pioneer … actually changing that process. So, it didn't unblock any of the bureaucracy and processes that were required ….It doesn't feel like Pioneer's been able to unblock any of that." (Local authority)

Resolving the issue requires concerted national and strategic coordination. One interviewee cautioned against simply issuing more guidance as this added to the policy 'noise' about IG (i.e. the plethora of contradictory guidance documents).

"There is far too much literature and guidance about, from every, from almost everyone who's got [something in] the game on this. Attempts so far to clarify have had almost entirely the opposite effect. Because the more people say, the more muddy the water gets, the more confused it is." (Local authority)

One interviewee also warned against a perceived obstructive and risk averse information governance 'industry' being allowed to set the agenda.

"There is an information governance industry so people are employed to be cautious and risk averse in relation to information governance and the default setting is 'No, you can't share information unless you have very specific and watertight arrangements'. Whereas in fact, the legislation was changed a couple of years ago to say that [the] default should be to share information unless there is a strong reason not to." (Acute provider)

The above quotation hints at the possibility of local actors surmounting some of the perceived barriers to information sharing. Indeed, it is important to note that there was a (minority) more positive narrative counter to the dominant one. This stressed that IT was an important enabler, that the barriers had been overstated and that there was actually more flexibility in the system than was commonly perceived or expressed. These narratives sought to deconstruct the idea that IG was an insurmountable problem and did not want IT/IG challenges to become an 'excuse' for inaction.

> "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….If you're involved in direct care with somebody, and you're working in a coordinated team, and actually, you've got the patient or the service user involved and you ask their consent, there are no information governance issues for you sharing information." (Local authority)

Interviewees' narratives about the perceptions of the public were also divergent. One perspective was that the public were content for information to be shared between stakeholders providing health and social care, already believed that health and social care organisations shared relevant information, and would be disappointed and frustrated by the sorts of inefficiencies being created by problems with information sharing.

> "The vast majority of people … it comes as news to them that actually we can't and don't and are restricted and prohibited in what we're capable of sharing ….There is an expectation that where an individual is cared for across the system that people find ways of transferring that information around the system." (Non-acute provider)

However, a strong counter-narrative was that the public were resistant to relaxation of policy around information sharing, particularly where they feared information could be shared with agencies involved in the administration of welfare benefits.

> "The specific thing in relation to social care is that, when GP's have been asking for consent to share information about patients, there are a significant number who choose not to share their information with the local authority. They are concerned about impact on financial assessments and benefits." (Acute provider)

One interviewee referred to the local solutions that another Pioneer was attempting and the controversy it had generated, highlighting the difficult balance that Pioneers were attempting to strike.

> "I thought it was atrocious what they did, to take away people's rights! I thought it was absolutely appalling! I'd be furious if some of the work-arounds were disempowering me as an individual about what happened to my data. Sorry, I just felt it was well out of order and I think illegal ….It's not okay to decide just because you hit a certain risk score that your data can go where the hell because somebody feels it should. Not okay, no, not impressed. I'm on the side of the people that broke that." (CCG)

Most Pioneers were developing and implementing specific IT/IG workstreams and 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.

> "Particularly in [our locality], because they put a lot of effort into getting this ASH status, Accredited Safe Haven for data – which was a lot of work to prove that we were secure – that means that they can get hold of certain data that should enable them to start risk stratifying soon." (CCG)

The BCF initiative that introduced the NHS number as the mandated key identifier across health and social care was also noted as a potential enabler. In spite of these complex issues, there were examples of Pioneers reporting progress on IG issues.

> "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 our players in the system but that was quite hard to get in and lots of work." (CCG)

Despite the problems, interviewees tended to see the Pioneer programme as a positive way to expand the scope of IT systems and information sharing, 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/service users. Developing a local consensus among stakeholders was regarded as crucial to underpin this.

> "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." (Non-acute provider)

Undoubtedly, Pioneers wanted effective action at the national level to tackle the problems, particularly those associated with IG, which they perceived they could not solve at the local level in isolation. Nevertheless, there was a determination to persist with confronting the challenges in light of the crucially important contribution effective information sharing was seen to make to the success of the Pioneer project.

> "When we went through all the IG hoops and hurdles and barriers, we kept on saying 'Look, no, we're not accepting that'. Again, 'patient journey', 'patient at the heart of what we are trying to do,' keep thinking about what they want out of this and challenge some of the myths." (CCG)

Workforce development

The likely significant future impact of integrated care models on staff and on existing working practices was widely acknowledged, and most Pioneers had a workstream concerned with 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. The changing role of GPs highlighted particular professional development needs in terms of helping them to adjust to their new role within more integrated contexts and to understand better the new health and social care economy in order to better manage patient care.

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 also needed.

> "They don't work together! You can't put a group of people in the room and say 'Let's integrate', because nurses go and sit in that corner, care navigators sit in that corner, and just because you are in the same room doesn't mean you're integrated, you know? I suppose my own personal experience is when you walk into that room with somebody that is sitting on a ward saying 'I want

to go home today', and its like 'Well that's nothing to do with with me', or 'No that's one of mine'. Actually no they're not, they're a person, they want to go home today and what as a group makes that happen?" (Non-acute provider)

"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." (CCG)

Most sites had developed multidisciplinary teams, case managers and care navigators, although there was variation between sites in what these initiatives actually involved. Other innovative roles that were already operational in localities which had significant workforce implications included:

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

It was noted by a number of interviewees that the development of an entirely new type of workforce, able to work holistically, might 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 more holistic care for a patient/service user.

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." (Non-acute provider)

While the need for workforce development was referred to, so too were the barriers to changing the workforce. 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." (CCG)

Some Pioneers were also concerned that staff might 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).

Some sites reported still more fundamental difficulties recruiting staff in the first place. 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." (CCG)

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 interviewees reported good relationships with the local university that allowed them to align the curriculum for staff training with their objectives for integrated care. Other localities had introduced their own in-house training and development courses for staff. These included, for example, rotating staff between community and acute placements as part of their training, and delivering in-house training on what were considered to be core competencies of working in a more integrated way, including communication skills, person-centred care, motivational interviewing and awareness of the mental health aspects of physical health. It was, however, noted that the curriculum for some staff groups was not open to modification by Pioneers to equip them for the new demands of integrated working, as this was largely set at the national level by professional accrediting bodies.

There was disagreement between individuals 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/service user simply to administer medication. One Pioneer was addressing this issue by exploring the adoption of the Dutch Buurtzog model of nurse-led 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 other staff (Gray et al 2015). It was widely recognised that the pressure to reduce staffing costs worked against the objectives of integrated care. It was also recognised that valuing and motivating frontline staff promoted integration.

> "There are lessons in Holland on domiciliary care, about putting in higher grade levels of domiciliary care that shows better outcomes, particularly fewer admissions to hospital. I think dumbing everything down isn't a good approach. I think having lots and lots of very low level workers to drive out cost often creates the complete opposite, a less supportive system and things fail more rapidly and then escalate more quickly." (Acute provider)

> "… if you pay somebody the minimum wage and you ask them to go above and beyond every day, especially on a Friday night, you don't respect the fact that you want a work-life balance, but you don't expect them to have one, that you expect them to manage on a very low wage with petrol costs and everything else that comes with the role of community staff. They are

demotivated. When they use the word 'I am just a carer', we've instilled that in them because that's what we treat them like. Not every care staff member that is out there has the aspiration or the ability or the aptitude to actually do it, but most of them have, a lot of them have, so you actually treat them as professionals, they work more professionally, they train more professionally, they are more accountable for what they do and you get better outcomes." (Non-acute provider)

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 [the 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!" (Non-acute provider)

Financial resources

Financial resource considerations raised a number of significant concerns among interviewees. One point often 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 in support of the Pioneer had to be based upon existing resources (subsequently £90k was transferred to each site in summer 2014) (Integrated Care and Support Exchange 2014). One site reported that, while they knew that Pioneer status came with little or no additional money for management or service delivery, it would be helpful to have greater flexibility about how they can use the money they already have, for example, in relation to the regulations that govern the use of surpluses.

A related point made by one interviewee was that, in order to achieve potential cost savings, organisations need to invest, but this was difficult if sufficient funding is not available.

"Much of a successful integration system for us is about investment in primary care services and in community care services, but as an economy that has been in a financial deficit position you are wholly dependent on dis-investment before you can invest in an integrated care system and that inherently puts a delay in the process." (CCG)

In a few cases, Pioneer sites received funding from voluntary organisations which was used to support the roll-out of their programmes. However, such funding was time limited and, in one case at least, it was expected that the redesigned services would eventually provide sufficient financial efficiencies to sustain the transformed system.

In some areas, specific initiatives within the Pioneer programme were prioritised so that they would be eligible to receive additional funding from other schemes; however, in some cases, this lead to questioning the role and meaning of the Pioneer itself in the integration process.

"Pioneer hasn't stopped that of course, but again it's that sense of 'Has it helped at all'? It's difficult to see any evidence that it has, so are we confident that we're exploring all those avenues? Yes, we are, and...the [funding scheme] will have an ambition of resetting the social care deal that we do with communities in a way that's, you know, powerful, restorative, sustainable and that would benefit both the health and social care systems, so they're integral partners to that, but, you know, again it's that sense of 'How does that … what's the interplay with that in Pioneer?'" (Local authority)

Despite not bringing new money into the system, the BCF also provided Pioneers with some financial room for manoeuvre, although the extent seemed to vary between sites (see chapter 8 on the BCF).

The Pioneers were also operating under severe financial restraints, including the capping of CCG resources and the significant budget cuts imposed on 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 often been subject to financial cuts. In other words, the budget reductions imposed by central government over the past few years have limited commissioners' capacity to act in a number of areas that were considered to be fundamental to the objectives of some Pioneers.

"We are desperate to become an integrated care organisation and we have a number of projects running, long-term conditions being one. But, actually, we don't have a prevention budget anymore. And what governments have done successively … is cut from the centre budgets that would deliver some of these lower level, community-based interventions to turn around and to focus more on wellness and away from acute and responsiveness, to that more proactive, community intervention." (CCG)

Concerns about some partner organisations having to contribute more funding than others also emerged as a tension and, as already mentioned, could have consequences for the level of cooperation and partnership between them.

A significant concern was the shift of resources from acute health services to social care/community services. Although this was a key objective of integrated care for most Pioneers, 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." (CCG)

While there was a strong presumption that integrated care could help reduce costs, and one Pioneer had undertaken nationally recognised modelling which supported this assertion, it was appreciated 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 … and nobody can work out how to get the bloody evidence base either!" (Local authority)

There was scepticism, in particular, that providing care for people in their own homes (rather than in a hospital bed) would result in cost savings. Another interviewee noted that, with the projected increase in very old people with multiple conditions over the coming years, an increase in hospital admissions, with their associated costs, seemed inevitable.

Finally, some interviewees pointed out that simply having more funding does not necessarily lead to better services, and that it is as important (and perhaps more important) to have better planning of services in places, perhaps joint commissioning, etc. Others highlighted that increased funding is not much help when there are significant staff shortages.

"I think that's also, we've got to be realistic, that one of the challenges we've got is you can have the money, but you can't always now find the resource because we've got such a shortage of nurses, therapists, medics, what-have-you, and that's been one of the challenges that we've found across all of the Better Care Fund initiatives. If it's about a new resource, that new resource is not always there, even if the money is there" (Non-acute provider)

Commissioning and paying for services

Procurement issues

Interviewees discussed some of the potential challenges of commissioning integrated care services. Some concerns had to do with the (supposedly) disadvantaged position of third sector providers, essential to many integration initiatives, in terms of the impact of competition, fragmentation and short contracting cycles on their ability to stay in the market. Also, some providers were said to find it difficult to accommodate new commissioning approaches. Concerns were also expressed about the difficulties of designing contracts that provide the flexibility that is necessary for a system that is undergoing significant transformation.

"I think procurement and contracting arrangements are out of the window, I don't think you can say to somebody, 'We aspire to do things this way, but we contract with you on time and task, take it and we'll change it later', I don't think you can do that. I think if you want to change, then you have to change, you can't tweak it around the edges and then change it later, and I think that's a barrier." (Non-acute provider)

Current procurement policy emphasising competitive tendering of services, particularly outside hospital, was thought to be hindering integrated care activity, in part because it was a disincentive to collaboration among provider organisations. Collaboration between organisations requires 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.'" (Non-acute provider)

One way commissioners were responding to the need for greater collaboration between providers 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.

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." (CCG)

Moreover, procurement models that were designed around a condition specific pathway, such as a prime contractor model, were said to work against the objectives of whole systems integration.

While there was interest among other sites in adopting a similar comprehensive contracting approach (e.g. prime provider), they eventually decided against pursuing this option both because of existing contracting rules and regulations and the significant time and resources that the process would require.

Many sites felt that primary care represented a gap in their commissioning and thus tended to be left out of their plans for integration. This was most likely a direct reflection of the fact that, when the initial interviews were undertaken in spring/summer 2014, CCGs had no control over commissioning services from their local general practices, since this was the responsibility of NHS England. This lack of control over primary care commissioning, 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 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." (Local authority)

"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."(CCG)

This weakness in the commissioning system following the implementation of the Health and Social Care Act 2012 has subsequently been responded to by NHS England with the introduction of so called 'co-commissioning' of primary medical services from May 2014, in which CCGs can opt to play a direct role in local commissioning decisions while NHS England remains responsible for contracting with primary care practices. In 2015/16, over 70% of CCGs became involved in co-commissioning.

Joint commissioning and pooled budgets

Views on the joint commissioning of services appeared to vary between Pioneers. Most said they currently did some joint commissioning (i.e. between the local authority and CCG) or were planning to do so. Much of the current 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. Several sites made no mention of joint commissioning, but instead referred to 'aligning incentives' between the CCG and local authority, and a few did not consider joint commissioning to be the best way forward (or necessary) to build sustainable integration of health and social care.

Even where joint commissioning was reasonably advanced, interviewees recognised that it was just a part of a much wider process. In fact, some mentioned that the lack of joined-up providers was the greater challenge.

> "… we've done a lot of our integrated commissioning, but it was very clear that what we faced was non-integrated providers. So we'll have two trusts, fragmented primary care, an incoherent group of voluntary community sector services, bits of independent sector." (CCG)

Pooled budgets were not often explicitly mentioned by Pioneers, except in relation to the BCF specific budget pooling exercise, or were only mentioned as a long-term objective. Pooled budgets already exist in some areas, typically between community health services and social care. In a few places, these had been tried and had already come to an end. In other sites, 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."(Non-acute provider)

> "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." (CCG)

It was also recognised that pooling resources, as for the BCF, could help break down barriers between organisations and lead to improved partnership working.

"But the interesting around the BCF was that has allowed us to move into a quite detailed discussion around spending both across the acute provider, the community health provider, social care provider and CCGs. About what are your underlying pressures, what are your budgets that you're declaring to monitor, and what are your expectations in terms of savings going forward. So that we are absolutely clear as a system what we've got to do to support each other. Because we've clearly taken the view that as a system we stand or fail, if we solve everything for primary care, social care and community health and the acute just falls into a great big black hole then that's not solved the problem. So the BCF was a good way of getting us into that." (CCG)

Provider payment systems

Concerns were expressed by most Pioneers that the current payment systems, particularly the so-called Payment-by-Results (PbR) activity-based hospital payment system, and the 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 and were obstacles to change. However, few Pioneers were at the stage of implementing major changes to provider payment systems to support integration.

"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." (CCG)

Some interviewees were clearly aware of the challenges involved in setting up new payment systems and contracting models 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." (CCG)

Several Pioneers had 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) hospital 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. Pricing changes, incentives to reduce emergency admissions and block contracts were used both to promote the reduction of unplanned admissions to NHS acute trusts, and to enable community health services 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."(CCG)

"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." (CCG)

More generally, Pioneer status was said to provide an opportunity for devising, developing and experimenting with new, more ambitious payment methods. Commonly, the aim was to move away from activity-driven hospital payment or block payments towards outcomes-based payments (e.g. for patient experience as well as clinical outcomes) and, in a few cases, to allocate needs-weighted capitated budgets to (groups of) providers. Another form of payment being considered or developed was whole care pathway funding (e.g. the Year of Care model). Some Pioneers were examining an approach that involved commissioning a prime provider, who would be responsible for delivering the services supplied by a range of providers, and any cost savings that might arise would then be split between the providers involved.

Several Pioneers were examining more innovative arrangements, such as expanding the use of personal budgets, initially available for social care and health care separately. However, in January 2015, NHS England announced pilots of individual personal commissioning (IPC) involving patients/service users taking control of their own integrated health and social care budget. A number of the IPC pilot sites are also Pioneers (see Appendix D).

"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." (CCG)

Personal budgets 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.

"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." (Local authority)

"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 jargony in local government and I don't like the word, but a citizenship model is about seeing them in a different way." (Local authority)

Interviewees 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 cost services accurately in order to be able to set a reasonable budget for an individual user.

> "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." (CCG)

Some interviewees were concerned that discussions on payment systems were more backward- than forward-looking, and challenged the assumption that moving away from volume-based payments and the purchaser-provider split would automatically deliver integrated care.

> "Block contracts were horrendous because there was no volume. Now I'm hearing everybody saying, what we need is to get away from this volume. I'm saying let's not forget the history of where we've been, which is you give me an amount of money but if demand grows, how do I handle it. I'm a little bit nervous at times when I'm sat in rooms with people saying… 'Capitation … will sort the problem'. No it won't, it will only sort the problem, if we actually fundamentally change the way we do business on the ground." (Acute provider)

It was often remarked that designing the new, more integrated service model should take priority, and that financial arrangements should follow, in order to avoid the risk that funding, rather than professional commitment, would come 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 Chapter 8).

> "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." (Non-acute provider)

On the other hand, the commissioners' lack of direct management role leads some to feel that the financial lever was still the most powerful, and maybe the only, instrument that commissioners could use to promote change.

> "What we've got to do as commissioners is to use our commissioning leverage and ultimately procurement to steer, we don't directly manage them [the providers]. But what we can do is help steer them in the right direction, use the incentives of commissioning … to help them develop the right models of care, as opposed to the wrong models of care." (CCG)

7. Barriers, facilitators and central support

Barriers

As set out in chapter 1, previous studies of integration initiatives within health and other public services have identified a wide-ranging and fairly consistent set of barriers to the development of integrated care (e.g. Cameron et al 2012, Goodwin et al 2013, RAND Europe 2012, Frontier Economics 2012, Wilkes 2014). The establishment of the Pioneers was intended, with support from the national partners, to encourage and facilitate innovation, learning and 'barrier busting' in an attempt to move beyond these well-established obstacles.

Discussion of barriers was a substantial element of the first round of interviews. The intention was to examine the extent to which these barriers were being overcome by Pioneers. However, preliminary analysis suggested that it was too soon in the lifespan of the Pioneer programme for the Pioneers to have identified solutions to the most entrenched and complex obstacles. In the early days of the Pioneers, interviewees were still developing their understanding and articulating the nature of these barriers. To some extent, this might be expected since, as one interviewee observed, Pioneers were selected in-part because they already had experience of integration and might reasonably have been expected to have solved the simpler problems.

> "A real challenge for a lot of Pioneers is that you wouldn't be a Pioneer if you hadn't already done a lot of the easy stuff. The things we are really grappling with are those complicated IG [information governance] issues, those complicated new commissioning frameworks, those complicated financial formulas. The stuff no one else has done." (CCG)

To a large extent, the accounts of obstacles conveyed in interviews re-iterated much that has already been identified in previous studies. In order to expand upon (rather than simply repeat) this earlier work, we have summarised the barriers in a series of tables, while at the same time identifying in a more practical way where attention or leadership is most likely to be required for solutions to be found. We identify those issues where, with time and appropriate support, Pioneers might reasonably engage with and work through these challenges at a local level. Other barriers, however, appear to be beyond the ability of Pioneers, either individually or collectively, to resolve, and will require intervention by Government or arm's-length bodies at national level. In some cases, collaborative effort will be needed between the local and national levels.

While most of the barriers in the tables have ongoing relevance, we also identify a few that refer to particular external events, such as the potential impact of the (then forthcoming) general election in May 2015. The themes also vary in their significance and whether they apply to a particular Pioneer or are generalisable to more than one site. It is important to reiterate that the tables present perceived and reported barriers as recounted by interviewees. (A full account of barriers is found in chapter 7 of the Interim Report, with a list of reported barriers provided in Appendix D.)

We use the following schema adapted from Cameron et al (2012) to organise our analysis of the barriers:

- External events
- Contextual issues
- Organisational issues:
  – Strategic support
  – Governance

  - Partnership working
  - Finance and commissioning
  - Information technology and governance
- Cultural and professional issues:
  - Workforce development

The groupings are not mutually exclusive, and some barriers could be included in more than one category.

External events

Certain events were perceived as barriers by the Pioneers, such as the uncertainty in the period before the 2015 General Election, or the initiation of the BCF (Table 7.1). The Health and Social Care Act 2012 was the most significant event of this type and its disruptive impact cannot be overstated.

> "When we initially put in the spec thing to say that we wanted to go forward as a Pioneer, I think it was really the wrong time to do it. The people round the table were in complete chaos, people were in new roles, there was a lot of flexing muscles going on. We were in a very, very different place then than we are now as a system because the system had just changed and gone into CCG's. New people were in CCG's, so people were transitioning themselves and the roles were transitioning." (CCG)

The impact of these reforms was still being felt during the period of data collection throughout 2014.

> "I think we still have got different organisations not being able to completely see how they get from where they are … into the new world, and the new vision. I don't think that's necessarily unexpected, because it's chaos, isn't it? It's the chaos, it's change chaos theories, and I don't think we know how to do that yet. So, we're asking people to step off the edge of the platform and not know how they're going to hit the ground, but that's where we are." (CCG)

Table 7.1 Perceived barriers reported by interviewees: External events

a.	Systemic reorganisation of national and local health care economies following the Health and Social Care Act 2012 led to significant upheaval, instability, and fragmentation. Required time for the new organisations to become established and sometimes led to detrimental 'territorialism'. The local health care economies that CCGs 'inherited' from Primary Care Trusts varied. The extent of attention devoted to Pioneer activity was affected in some instances by 'remedial' activity needed by the new CCGs. Also impact of a diminished sector of public health workers and their transition from NHS to local authorities.
b.	The BCF was sometimes seen as a distraction of time and effort on the part of system-leaders and planners.
c.	Political uncertainty prior to the May 2015 general election.

Contextual issues

The ongoing challenges faced by some sites subject to severe financial pressures and/or regulatory measures were also major barriers, as was the proliferation of similar policy initiatives from central government which could distract effort and attention (see chapter 4). Infeasible expectations about the speed of demonstrable 'results' from the Pioneer programme were also referred to. Key contextual barriers are outlined in Table 7.2.

Table 7.2 Perceived barriers reported by interviewees: Contextual

		Local	National	Combined
a.	Pressure by national and local policy-makers to demonstrate the success of new integration initiatives at a stage too early in the programme's implementation.			!
b.	Multiple and complex similar transformational agendas and overlapping policy initiatives emanating from central policy-makers. Could divert considerable time, energy and focus away from Pioneer work. Also, a risk that the different initiatives could conflict.		!	
c.	In some instances, acute/community trusts or social services departments suffered from significant financial deficit/and or were subject to 'special measures', which diverted senior management attention away from Pioneer activity.		!	
d.	The growing demand for costly A&E services by patients at a time when integration seeks to reduce usage – diverts resources and slows the pace of transformation.			!
e.	Underdeveloped evidence-base on effectiveness of integrated health and social care initiatives.			!

! = Ongoing barrier

Organisational issues

Organisational barriers are shown in in Table 7.3 under the headings of strategic support, governance, partnership working, finance and commissioning, and IT/IG concerns.

Reports about the detrimental impact of austerity and the often chronic financial constraints under which some Pioneer stakeholders were working loomed large and, as noted previously, the Pioneer programme came with little additional funding. Obstructive or opaque policy/legislation on commissioning, contracting and competition were seen as a hindrance to Pioneer goals. How far such perceptions were correct is perhaps less important than the extent to which they led in some instances to the adoption of a cautious approach in experimenting with new forms of contracting, especially where compatible financial systems were not in place to allow costs to be tracked and budgets pooled.

> "From a council perspective, we've had significant cuts over the last three or four years … the council is in a position now, certainly from my perspective, where it can no longer do that [make efficiency savings]. The low hanging fruit has been taken, and this is about fundamentally changing services and stopping certain services which will mean over the course of the next 12, 18 months, that will bite for the people of [the locality]." (Local authority)

There were also competing demands facing different organisations in the Pioneer (e.g. meeting the 4 hour A&E waiting time targets versus care integration), which meant that Pioneer work was not always treated with the same degree of urgency by key stakeholders.

> "On the provider side, they took out so many layers of management that people have these wide spans of responsibility, and I think that really makes it difficult to look outside of your organisation and to really do things differently, because they're so, spend so much of their time fire-fighting ….We know

that we want to do things differently, 'Why aren't community nurses working with social workers?' Actually that's not the top of their priority list. The top of their priority list is, 'God, we've got a recruitment crisis' or 'I've got a CIPs [Cost Improvement Programme] that's not going well' or 'I've got to take more money out'." (CCG)

Concerns were reported about strategic leadership at the national level. On the one hand, there were complaints that Pioneers were not given sufficient freedom to experiment and try innovative approaches, but this co-existed with the contrary view that there was no clear national direction. More consistent was the feeling expressed by a great number of Pioneers that there was insufficient support from the centre in dealing with some of the most difficult challenges, such as engaging the public with the need to reconfigure hospitals.

"Doesn't matter what they say, the needs of survival of the organisation is a great determining step because of the legislative setup and because of the regulatory setup …. You go to the TDA [Trust Development Authority] and they'll say 'Yes, that's really exciting, interesting information about integrated care, but how do I get this hospital to become a Foundation Trust?'" (CCG)

For the larger Pioneers, the size and complexity of their local health and social care economy could create its own problems, including the sometimes different geographical footprints for local authorities, CCGs and acute trusts, together with their varying multi-level governance systems. Some sites were frank about making slow progress in engaging the mental health, community and voluntary sectors. Tensions could also exist over which local partner would lead on different activities and the appropriate governance arrangements, perhaps resulting in a lack of clarity over local leadership.

"I think what we've got is a lot of senior responsible and accountable people sitting round the table, all of whom probably have a very good view of what they would like from integration and driving things in better ways ….What I'm not clear about is that that group understands; what is the plan? I don't think there is a clear plan." (Non-acute provider)

There were a range of barriers mentioned relating to general practice, which were seen as especially problematic given the lack of 'levers' available to local commissioners.

"Essentially, anyone's who's employed by a large statutory organisation you can say 'You might not like it matey but you're going to work like this' ….Obviously, you want to do it from bottom up so they can see the vision and understand and buy in to it. But … we can't say to GPs, 'You have to work like this', because they can say 'Well actually I'm not that interested'." (CCG)

The ability to share service user information was seen as critical to the goal of working together, yet this featured as one of the barriers mentioned consistently by interviewees.

"There is a practical issue around information sharing and interoperability. Until the day I retire it will remain but you are almost obliged to mention it because it is mentioned at almost every meeting I go to; the 42 separate systems that currently hold people's information in [the locality] is a barrier." (Voluntary sector)

Table 7.3 Perceived barriers reported by interviewees: Organisational

		Local	National	Combined
Strategic support				
a.	Strategic direction from national government is fragmented. Differences in approach, with DCLG reportedly favouring more locally devolved responsibility, while DH/NHSE adopt a more 'command and control' approach.		!	
b.	Excessive reporting demands from national bodies – constantly 'feeding the beast'. National targets/performance indicators may not be relevant to local initiatives, but force Pioneers in particular directions.		!	
c.	Health care and social care have different regulatory frameworks and the regulator does not examine systems such as integrated services, instead only looking at individual organisations.		!	
d.	Conflict between TDA objectives that promote growth and increased activity, while local systems seek to shrink the acute sector as part of integration.		!	
e.	Integration was less of a priority where stakeholders had urgent competing demands (e.g. meeting 4 hour waiting time A&E targets).			!
f.	Financial constraints, particularly in local authorities, led to a lack of social care services in the community or extended delays in transfers to out-of-hospital settings, resulting in e.g. 'bed-blocking' and GPs using acute beds for 'step-up' patients.			!
g.	The desire and encouragement to co-design services with local residents could conflict with the need to provide NHSE and others with 5 year plans.		!	
h.	The need for realistic timetables to tackle some barriers, especially where solutions might require legislative change that takes time to achieve (e.g. competition law).		!	
Governance				
i.	Different locus of accountability between local authorities and CCGs (e.g. local elected members vs. NHS England).			!
j.	Governance structures may not have authority to make decisions or control resources and were reliant on the CCG and local authority. These were non-aligned and had different demands, expectations and planning/funding/reporting cycles. The lack of representation of acute trusts on local Health and Wellbeing Boards was also noted.			!
k.	Too many planning meetings to attend, especially for providers because of the pressure to deliver patient care. Also, non-attendance by senior officials (who could make decisions), so that meetings could deal only with scenarios and possibilities.			!
l.	Lack of clarity on appropriate geographical boundaries or areas of activity in some Pioneers: local authority, CCG, wards, GP practices, neighbourhoods, etc., which complicated planning and provision of services.	!		

! = Ongoing barrier

Table 7.3 *continued*		Local	National	Combined
Partnership working				
m.	Some Pioneers were very complex with a large number of stakeholders and/or a large geographic footprint, which made partnership working more complex in terms of size, communication, governance, etc.	!		
n.	The local primary care landscape was not always conducive to integration, e.g. due to lack of capacity, having many single-handed or small GP practices. There was also reportedly resistance to some proposed new integrated working practices (e.g. visiting care homes).	!		
o.	Where there were problems involving GPs, remedial options for local commissioners were lacking since they had no control over commissioning, recruitment, distribution, or performance management of GPs. Also, it may be difficult for a local CCG to deal with an obstructive GP, since the CCG is managed by GPs (a potential conflict of interest).		!	
p.	Inadequate local engagement/'buy-in' of the independent, community and voluntary sectors, in part, because they were often required to compete against each other for contracts, making working together particularly challenging.			!
q.	Inadequate local engagement/'buy-in' of the mental health sector, due in part to the legacy of underfunding and 'Cinderella' status of the sector.			!
r.	In some Pioneers with multiple partners, a sense that transformation could happen only at the pace of the 'slowest', most conservative or risk averse stakeholder. Also, not all key partners could contribute the same amount of staff time/resource.	!		
Finance and commissioning				
s.	Financial austerity had severe negative impacts. Significant time and energy was diverted to redesign services to cope. Short-term measures that move financial shortfalls around the system were considered futile rather than tackling the underlying systemic deficit – 'pushing pressures around the system'.		!	
t.	Lack of additional central government funding for the Pioneer programme to allow the system to 'double-run' during transformation. Associated difficulties reallocating resources between different organisations (e.g. from acute to community care), particularly during austerity, without destabilising providers or creating tensions between organisations.		!	
u.	PbR incentives for acute providers to increase activity work against providing more care outside hospital.		!	
v.	National policies/legislation on choice and competition and the 'purchaser/provider split' in commissioning. Providers were reluctant to share specialist information/expertise if concerned this would be used by commissioners in a later competitive tender. Tensions/lack of trust where providers were threatened with competitive tendering to silence dissent. Where commissioners sought to co-design with providers, there were fears about potential accusations of collusion. There were also fears that new contracting models could lead to provider monopolies. Concerns that regulators might penalise contracting bodies experimenting with new forms of contracting. Lack of clarity on competition rules led to risk-aversion. The NHS was perceived to have a poor history of sub-contracting and there were worries among independent providers that the NHS would contract out only the unprofitable work. There was also reportedly some aversion among providers to the new contracting arrangements being considered.			!

! = Ongoing barrier

Table 7.3 *continued*

		Local	National	Combined
Finance and commissioning				
w.	Commissioning organisations were sometimes reluctant to pool budgets as it meant giving up complete control over their own budget in order to have influence over a larger one. There were also discrepancies in the extent to which different stakeholders could track health and social care costs.	!		
x.	The consultant contract reportedly makes it very difficult to move to seven day working because paying for 'anti-social' hours can be prohibitively expensive.		!	
y.	In some health and social care economies, there was reportedly a lack or fragmented pool of providers, unable to respond to the demands of integrated commissioning.	!		
Information technology and governance				
z.	Information sharing was seen as critical, but the level of integration of information and intelligence needed was technically difficult to achieve across multiple IT platforms and with obstructive information governance regulations. Obstructive practice by national bodies was reported (e.g. The Health and Social Care Information Centre reportedly preventing the linking of GP and acute data).		!	
aa.	Patients/service users may oppose information sharing without appropriate safeguards and information, e.g. fears that information will be shared without knowledge or consent with benefits agencies.			!
bb.	There was concern that the genuine problems with IT/IG were being exploited by some local partners/agencies as an excuse for inertia/lack of progress.	!		

! = Ongoing barrier

Cultural and professional issues

Another range of obstacles related to the cultural and professional contexts within which Pioneer activity was being planned and delivered (Table 7.4). Some of these were longstanding issues about differences between the occupational cultures and working practices of the professions engaged in health and social care.

> "There is clearly a difference in culture across health and social care organisations and within health organisations. I've seen that between acute and community, primary care at the GPs, whether its links to say, pharmacy and things like that. But the cultures have been quite different, so bringing together people with a common purpose has been a challenge, so it's not just about bringing them together, sharing an office and hoping for the best." (CCG)

Other barriers concerned issues of responsibility and accountability. While the rhetoric of the Pioneer initiative might be to promote innovation and 'barrier-busting', interviewees were sceptical about the extent to which they would be insulated from blame if initiatives did not work as planned.

> "Sometimes, within this Pioneer programme we need people to take risks. We need people to say 'Okay, we're going to make that decision, we're going to stick with it and we're going to learn, we're going to learn from it'. Because that's the only way you can learn, but no one's willing to take a risk and I think that's one of the biggest [barriers]. Because someone's going to be held responsible at the end of the day. And I think that's the feeling of Big Brother: who's going to be held responsible if that decision or whoever made that decision goes wrong and who's accountable for that? No one's willing to put their neck on the line." (Local authority)

Workforce issues were also significant concerns. Many of the teams coordinating Pioneer work were small and lacked capacity. There were also said to be multiple challenges with recruiting staff with the right skills mix to deliver more integrated services. The health and social care professional development bodies were reportedly slow to respond to the new contexts of integrated working, failing to provide the right sorts of training programmes and the new, holistically focussed workforce that integrated care demanded. Engaging front-line staff was challenging when they were occupied with maintaining and providing existing services in difficult circumstances ('fire-fighting'), and who were often sceptical, having seen previous similar initiatives 'come and go'.

> "Some [staff] feel threatened by it. Some feel that they are in a position where they feel like they are doing a good job, that they are delivering what they should be doing and why would they need to change, there's a percentage of people there. There is a percentage of people who are frustrated with the current system, recognise that it's not sustainable and want to do something about it. And then there is another group who are waiting to be convinced, so they can be swayed one way or the other. And I think that's probably common around the country as well." (CCG)

In summary, there was a wide range of barriers that Pioneers were working through, and some of these obstacles required action at national level. During the first round of data collection, many interviewees adopted a pragmatic approach, and viewed barriers as not necessarily insuperable impediments to their integrated care initiatives, but rather as challenges in need of resolution.

> "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." (CCG)

By the second round, because the majority of the barriers were still in place or were becoming more significant as Pioneers moved from design to implementation, there seemed to be increasing exasperation among some interviewees at the lack of progress being made in tackling them, alongside the emerging worry of the potential of other initiatives, such as Vanguards, to distract attention away from the Pioneer.

> "… we were hoping that Pioneer would help us to accelerate some aspects of that, of which I've alluded through information sharing ….But at the moment, it doesn't seem to have given us, you know, those extra lengths that would have really, really moved things forward, and it's disappointing, I have to say." (CCG)

Table 7.4 Perceived barriers reported by interviewees: Cultural and professional

		Local	National	Combined
a.	Differences between the health and social care sectors in terms of language and conceptions of health and wellbeing, professional cultures and working practices.			!
b.	Different priorities between professions: e.g. the people of most concern to social workers were not necessarily the same as those of most concern to GPs. Social services could not always provide for patients/service users that GPs identified as a priority if they did not meet social care eligibility criteria.			!
c.	Despite the stated intention of encouraging innovation and 'barrier-busting', the current climate in health and social care was risk-averse, especially in an austerity context. The 'permission to take risks' (and therefore potentially fail) was not seen as genuine.		!	
d.	Lack of agreement on priorities among local system leaders. 'Blame culture' within and across local health and social care sectors located responsibility for failures in integration elsewhere in the system.	!		
e.	Professional territorialism and being held accountable by different employing organisations led to duplication of effort by staff (e.g. by carrying out multiple assessments of the same person).			!
f.	Difficulties communicating the Pioneer vision to the public, who e.g. may be suspicious that a focus on self-care is a measure to reduce access in order to cut costs. Difficulty coordinating patient and public involvement activity in Pioneers with a large geography and complex range of stakeholders. Public opinion (e.g. opposition to hospital closures) occasionally exploited for political gain.	!		
Workforce development				
g.	Generally, few staff available to coordinate Pioneer development and lack of capacity can be exacerbated if key staff members left.	!		
h.	Multiple challenges of engaging frontline staff: e.g. when 'fire-fighting' in often trying conditions, there is little time/resource to focus on longer-term implications of integration; scepticism about NHS initiatives that had previously been seen to 'come and go'; previous initiatives did not live up to expectations leading to demoralisation.			!
i.	Difficulties recruiting staff particularly in certain areas of the country. Also high staff turnover (especially following health care reforms) negatively affected longer-term strategic planning and service provision aiming for integration. Promoting a 'play-it-safe' work culture can be detrimental to 'barrier busting'.			!
j.	National professional bodies reinforced disciplinary boundaries, imposed overly rigid training programmes, and could be inflexible in maintaining regulations (such as nurse prescribing).		!	
k.	Existing approaches to training professionals do not produce trainees equipped for integrated working, and not enough trainees to meet demand.		!	
l.	Physically co-locating teams could be problematic.	!		
m.	If relying on volunteer input, there could be difficulties in recruiting and maintaining sufficient numbers.	!		

! = Ongoing barrier

Facilitators

As well as identifying barriers, the interviews also sought to explore facilitators or enablers that supported integrated health and social care activities. Those discussed were generally the obverse of the barriers and are presented thematically below under the same broad categories. As for barriers, the themes varied in their significance and generalisability to more than one site. However, it was a consistent finding across all interviews that facilitators and enablers received considerably fewer mentions than barriers. It was also the case that interviewees were sometimes identifying as facilitators initiatives that were still in development and, therefore, yet to be tested in practice. Tables 7.5-7.7 present perceived facilitators as reported by interviewees.

Contextual facilitators

Overall, a small number of contextual facilitators was noted (Table 7.5). Legislative and policy initiatives such as the Care Act 2014 and the BCF were mentioned as forming a supportive backdrop to the development of Pioneer activity. However, the key contextual factor that acted as an enabler was a Pioneer's size, scale, complexity and geographical footprint. Large, complex Pioneers were clear in articulating the additional challenges they faced in strategic, governance and operational terms; the relative simplicity of others was noted as a distinct advantage.

> "I get people saying to me all the time, 'If only we had the landscape that you've got.' We have one local authority … one clinical commissioning group, one mental health provider, predominantly one acute trust … and one community health provider … so actually, the conversations are a lot easier here than they are in most other parts. I don't even want to think about how other areas are managing with multiple CCGs, authorities and goodness knows what else." (Voluntary sector)

Pioneers benefited from a context where they could call on local champions to push the integration agenda forward.

> "To give you an example, [local councillor] is a real community champion and is quite passionate about this agenda, so she would recognise the value in terms of when she's presenting the various reports in cabinet around whatever it may be, in terms of whatever, adult social care or area governance arrangements or what we're trying to do." (Local authority)

Table 7.5 Perceived facilitators reported by interviewees: Contextual

		Local	National	Combined
a.	Pioneers with less structurally complex health and social care economies were sometimes able to move more quickly because of the relative simplicity of their organisational landscape.	👍		
b.	Local champions to push and progress the work and 'win hearts and minds'.	👍		
c.	Supportive legislation (e.g. the Care Act 2014).		👍	
d.	The BCF brought commissioners from local authorities and CCGs together.		👍	

Organisational facilitators

Organisational facilitators are shown in Table 7.6 (although it should be noted that not all the facilitators are found in all Pioneers). Good local leadership was identified as critical, from local authority councillors through to senior and operational managers, working within appropriate governance structures. Developing and presenting a clear and coherent message about Pioneer aims and activities, and having mechanisms to gather information about progress and successes, were thought helpful for bringing organisational stakeholders on board and for public engagement.

Perhaps the most significant organisational factor was the advantage gained from being part of the Pioneer programme. Interviewees welcomed being part of a wider group of sites that they could contact and share learning with. Being a Pioneer accelerated the process of bringing key local stakeholders on board and provided an incentive for them to work together, given that they felt under central scrutiny and faced some degree of reputational risk. Significantly, it provided an incentive to build and maintain crucial relationships between key stakeholders, in sometimes difficult circumstances. 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.

> "And you have to keep going back over it and reinforcing those relationships as well because they do get tough and I wouldn't want you to think it's all lovely and we're all skipping through the flowers here in [the locality]! We do have some tough conversations and challenges, but we seem to be able to keep in mind that we're here to do the right thing for people and help them live the lives they want. That keeps us focussed on getting through some of the challenges our organisations face." (Voluntary sector)

Table 7.6 Perceived facilitators reported by interviewees: Organisational

		Local	National	Combined
Strategic support				
a.	Being part of the Pioneer programme: the status of being a 'Pioneer' was galvanising; the 'buy-in' of key local partners that was needed to achieve Pioneer status; Pioneer sites being 'under the microscope' made stakeholders more inclined to work together; the ability to share learning with other sites (and within a single Pioneer for larger sites).		👍	
b.	Reconfiguring the acute sector before attempting to integrate services that provide more out-of-hospital care.	👍		
c.	Pioneer activities being further developments or thinking or initiatives already under way, rather than something completely new.	👍		
d.	Collecting the right information/indicators so that impact/success can be measured and visible to staff, patients/service users and the local population. Evidence of historical success gave confidence upon which to build, and examples to draw on.	👍		
e.	Engaging stakeholders. Good patient and public involvement. Managing communication, ensuring a coherent and consistent message.	👍		
f.	Having a 'network model' of GP practices; this puts pressure on others within the network to improve performance.	👍		

Table 7.6 *continued*		Local	National	Combined
Governance				
g.	Effective local governance in place, representing all key partners. Ensuring system leadership included those at a sufficiently high level to have a strategic overview, able to take difficult decisions. For local authorities, having the councillors on board, providing leadership, liaising with local communities.	👍		
h.	Having patient/service user representatives attend governance meetings to ensure their viewpoint is available at all stages. Involving users in the design of services.	👍		
Partnership working				
i.	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 stakeholders. Getting all key partners, including local commissioners (CCG and local authority), around the same table, talking frankly, increased understanding of others' perspectives and led to a new shared perspective.	👍		
j.	Co-location of operational teams facilitated communication and partnership working between different professionals.	👍		
k.	Willingness to include the voluntary sector as equal stakeholders.	👍		
Finance and commissioning				
l.	In places with a sound financial position, there was more freedom to innovate and the funds needed to 'pump prime innovation' and to 'invest to save'. Providers being in a secure financial situation and with contractual certainty was also important.	👍		
m.	Working flexibly with the commissioner-provider split opened up wider opportunities to share ideas and innovate.	👍		
n.	Pooling budgets gave 'added value' and allowed activities to be funded that otherwise would not have been. With pooled budgets, patient/service user need was more to the fore, as there were fewer concerns over whether the funding was coming from the health or social care budget.	👍		
Information technology and governance				
o.	An integrated IT system/an electronic integrated health and social care record that could be easily shared, and an information sharing agreement between key partners, and acceptable to patients/service users, was crucial.	👍		

Cultural and professional facilitators

Cultural and professional facilitators are given in Table 7.7. As already discussed, maintaining key stakeholder relationships was a crucial enabling factor. So too was creating opportunities for developing practitioner insight into the patient/service user perspective. The 'I Statements' were described as a powerful tool in enabling this to be formulated into a collective understanding.

> "The National Voices ['I Statements'] gave us a discussion point, a fixed point to start from, which really helped us understand the ambition of self-care, self-management, the desire to be in control of one's care, to not be told one story more than once, and all those sort of things. That needed defining at the very beginning so that they formed basically the foundations of every design principle." (CCG)

Adequate staff numbers were considered necessary, but were not sufficient in themselves if staff 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. 'Bottom-up', staff 'ownership' of the changes being sought through the Pioneer programme was thought preferable to imposing changes from the top. Such approaches were based on involving staff in developing the new service models. Breaking down status and hierarchy was seen as important for integrating the workforce into less hierarchical multi-disciplinary teams. What was crucial was building 'buy-in', trust and shared values among team members.

> "It is very much taking the workforce with you, and obviously the public, but the workforce could be the point of failure. If the workforce doesn't support it, they won't support the public and therefore that is very, very key in making it happen. The public needs to tell us what they need, but it is the workforce who needs to make it happen." (Local authority)

Favoured strategies for winning over the public and patient/service users included keeping them fully informed at all stages, and ensuring that representatives were involved in service design.

Table 7.7 Perceived facilitators reported by interviewees: Cultural and professional

		Local	National	Combined
a.	Creating a shared culture across different professional groups, based on shared values; a 'can do' culture.	👍		
b.	The focus given by the 'I Statements' in encouraging practitioners to think more deeply about patient/service users' holistic needs. Looking at things from a user perspective helped break down barriers and tensions between different groups of professionals, and contributed to a common language and shared values. Being collectively patient/service user-centred.			👍
c.	Freedom to try things out, not having a 'culture of blame' if things go wrong, and piloting new initiatives and sharing the learning before roll-out. Reassuring staff so they 'feel safe' in the face of change.			👍
d.	Pioneer status broadened the focus from thinking locally to looking at international initiatives/models.			👍
Workforce development				
e.	Sufficient resources in terms of staffing as well as funding. Continuity of staff, particularly in the aftermath of the recent NHS reorganisation.		👍	
f.	Staff recognising the necessity of integration for long-term sustainability, and each organisation/group of professionals recognising benefits for them as well.	👍		
g.	Staff 'ownership' of clinical/social service models. A bottom up, organic approach with staff driving change and developing the framework rather than it being imposed from the top.	👍		
h.	Integrating the health and social care workforce into a single management structure and building integrated co-professional teams with shared values. Breaking down status and hierarchical boundaries to facilitate working together and sharing tasks.	👍		
i.	Joint approaches to training and career development so that staff could move between health and social care.			👍

Advice and support

A central element in the design of the Pioneer programme was that Pioneers would have access to tailored, expert support from the Department of the Health and other national partners, including the allocation of an 'account manager' to facilitate access to this support. This was one of the key benefits that sites foresaw when they applied for Pioneer status.

All sites valued opportunities to share with other Pioneers and many had set up their own informal networks with other (often neighbouring) sites. However, the general feedback was that the formal support available to Pioneers from national partners had been slow to arrive:

> "The amount of support you get centrally from being a Pioneer is virtually non-existent." (CCG)

One Pioneer mentioned that support in solving problems had so far been limited to an offer to 'put them in touch with other sites', which they had already done for themselves. 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 met the needs identified.

> "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." (Voluntary sector)

Further, the types of assistance on offer were not necessarily what Pioneers were looking for.

> "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." (CCG)

However, a minority of Pioneers indicated that they had been well supported, although much of their support did not come from the centre but from e.g. academics instead. It was also the case that Pioneers were at different levels of awareness of their support needs.

> "We've had loads of support .…From the word go, we had loads of academic support for data analysis, that was really good. We've had some people from [a large charity] nationally come down .…It feels like we've been supported in the right areas, but that's because there's been a lot of interest in it." (Acute provider)

Much of the support which was initially seen to be on offer was in the form of attending meetings organised for all Pioneers at a central location, often in London (e.g. the Pioneer Assemblies). For some sites, the cost of sending staff to attend a London workshop was considerable and it was suggested that these events sometimes be held in other parts of the country. When they had attended, interviewees found this to be very helpful, particularly the opportunity it gave to meet staff from other Pioneers. However, not all individuals and organisations within a Pioneer had access to these opportunities and, in some cases, access to support did not extend, in an effective way, beyond the lead organisation or 'core working group'.

> "So I went to that [Pioneer Assembly], what a great meeting! I learnt so much from that meeting of the national picture, where we were going, what the expectations were and all that. I haven't been since and I haven't heard anything of it and that is an example of how … because I'm not in that little inner team, I'm not getting the benefit of the stuff that's being said at those sort of things." (CCG)

Conversely, a frequent complaint was that the key contact for the Pioneer was inundated with requests for attendance at workshops/conferences and updates. The reporting requirements were felt to be onerous, especially given existing reporting requirements from other national bodies, and were not necessarily seen as adding value to the local system. However, the reporting requirements were felt to have decreased over time.

> "What I have seen is that it's created a bit of feeding the beast; there's been a lot of reporting up, very little reporting down. So, again, I don't know. I don't know what the added value is, at the moment." (CCG)

However, evidence from the second round of interviews (in spring/summer 2015) gave some indication that support from national partners was improving, which reflects the improved offer of support which started to become available in 2015 (and which has been subsequently combined with the support package available to the New Models of Care programme). This included increased advice, including visits, from international experts from the US, New Zealand and the EU; support from national partners to discuss issues such as contracting and information sharing, and aligning such support with that provided to the Vanguards; a series of webinars; and an active Pioneer Support Group. 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] there were a good number of people involved so that you felt like you were having a conversation not listening to a conference." (Acute provider)

The main requests for support related to overcoming barriers focussed on information sharing and commissioning/contracting including payment systems. Another topic where sites requested advice was local evaluation and the evidence base supporting specific interventions. While peer learning was valuable, there appeared to be a need for experts who could mentor and coach. Pioneers had been expecting support from the centre that could operate at a higher level of expertise and skill in solving problems and they needed to receive this from individuals of appropriate seniority and calibre. For example, one interviewee recounted that they were promised international expertise.

> "From my understanding, it's allowing us really to rapidly integrate across all health and social care services and all age groups and break down barriers which previously had been non-breakable and give us access to national expertise to overcome some of these barriers and solve problems." (CCG)

While there were concerns that central support and advice could morph into performance management, Pioneers wanted engagement with experts who were sufficiently knowledgeable, experienced and confident to provide appropriate and constructive challenge.

> "I want people to come and challenge some of our Pioneer stuff. I don't think it's good enough ….I think too much of it is just managing the status quo. It's not truly transformational, therefore we need to be challenged on that. But the set-up of the Pioneer support we had in the first period was non-existent and it still isn't particularly great." (Local authority)

Direct interest from Ministers and senior government/NHS officials was welcomed and valued as it symbolically promoted the integration agenda, and in practical terms, maintained the focus of senior system leaders.

> "And 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. So I think there is something about adding confidence and traction to the system to enable leaders to stay at the table despite some of those really tricky dialogues that they're having around contracts." (Voluntary sector)

As well as access to high-calibre experts to help with the most intractable issues, two other key needs were identified for the centre to deliver: greater clarity on processes and legalities that were currently blurred (e.g. information governance, contracting); and more flexibility.

> "In addition to the knowledge sharing stuff, we were also hoping we would get genuine dialogue with central government about what the barriers and challenges were and some flexibility around how we might deliver. The jury might still be out on that bit but I hope there is some genuine flexibility and freedom given to Pioneer sites that will give us a bit of pace." (Voluntary sector)

This flexibility needed to be underpinned by clarity on the acceptable parameters of the risks that could be taken by Pioneers to 'flex' the system in the drive for greater integration.

> "I think what would help is if there was a degree of 'air cover', if you want to use it like that. For systems to say, look it's okay for you to take a risk on changing your system around contracting, for example. We need that because we need somebody to say to Monitor or TDA or CQC that we are asking providers to do this in a different way." (CCG)

'Air cover' was mentioned by several interviewees, including a need for political coherency and for government departments and national bodies to be 'on message' about the goals and implications of the integration agendas being pursued.

> "There's also giving people 'air cover' politically, ideally, to do some of the things that they need to do. And I don't know how realistic that is and it's probably totally unrealistic, but, for instance, in [our locality] you've got somewhere that's in the eye of the storm. And you've got politicians battling it out over hospitals, and actually there needs to be a really strong coherent narrative from the centre that says 'actually this is the right thing'. There needs to be a level of support and almost advocacy at the centre." (CCG)

8. 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 had been aligned with local Pioneer programmes and was expected to assist 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 relatively scarce personnel. The series of interviews conducted in late 2014 provided an opportunity to examine reactions to the changes in the national conditions for spending the BCF, together with the requirement to submit revised BCF plans; the second round of interviews, conducted in spring/ summer 2015, was able to investigate the interaction between the implementation of both the BCF and the Pioneer programme. This chapter is based on these two rounds of interviews, and on analyses at both national and Pioneer levels of the data included in the BCF plans provided to the evaluation team by the Better Care Support Team at NHS England.

Pioneer BCF plans in the wider BCF planning exercise

Approval process
The submission of final BCF plans for the 2015-16 financial year was required by 19 September 2014 and subjected to a Nationally Consistent Assurance Review (NCAR) process, as a result of which the 151 plans were placed in one of four categories: approved (6 HWB areas); approved with support (91); approved with conditions (49); not approved (5) (Nationally Consistent Assurance Review 2014). The Review team review placed all but three Pioneer area BCF plans in the first two categories. Of the remaining three, Cornwall and Harrow were approved with conditions and Hillingdon was not approved.

Funding
The minimum sums each CCG was required to allocate to the BCF varied significantly both by absolute value and per resident aged 65 and over, the population category that is the main target group of the BCF schemes (Table 8.1). The levels of additional contributions from local authorities and CCGs also varied greatly across Pioneers and several pooled significantly more than the minimum requirement (including Tri-Borough in NW London and WELC) (Table 8.1). Indeed, the average planned spend per capita aged 65+ was some 7% higher in Pioneer than non-Pioneer areas (£613 and £569 per capita, respectively). It is, however, relevant to note that the minimum amount pooled by the CCG was determined by the general formula for allocating resources to CCGs and might not be related to levels of need across NHS and local authority boundaries and the funds available to meet them in both services.

Table 8.1 Sources and amount of funding of BCF plans for 2015-16 in Pioneer and non-Pioneer areas (£000 absolute values and £ per resident aged 65 and over)

Pioneer	HWB	Absolute values (£000)				Per resident aged 65+ (£)			
		Local authority	Min. CCG	Add. CCG	Total	Local authority	Min. CCG	Add. CCG	Total
Barnsley		2,016	18,358	0	**20,374**	45.10	410.69	0	**455.79**
Cheshire	Cheshire East	1,798	22,093	0	**23,891**	21.85	268.44	0	**290.29**
	Cheshire West and Chester	2,202	22,107	0	**24,309**	31.87	319.93	0	**351.79**
Cornwall***		6,677	37,835	0	**44,512**	50.47	285.98	0	**336.45**
Greenwich		1,761	18,010	0	**19,771**	62.45	638.65	0	**701.10**
Islington		1,409	16,981	0	**18,390**	71.89	866.38	0	**938.27**
Kent		10,640	90,764	0	**101,404**	35.35	301.54	0	**336.89**
Leeds		4,802	50,121	0	**54,923**	40.18	419.42	0	**459.61**
North West London	Brent	2,600	19,832	0	**22,432**	72.22	550.89	0	**623.11**
	Ealing	3,073	22,283	3,860	**29,216**	76.44	554.30	96.02	**726.77**
	Hammersmith & Fulham	48,622	13,148	18,385	**80,155**	2,731.57	738.65	1,032.87	**4,503.09**
	Harrow	1,190	13,183	0	**14,373**	31.99	354.38	0	**386.37**
	Hillingdon	2,349	15,642	0	**17,991**	60.39	402.11	0	**462.49**
	Hounslow	1,610	15,288	0	**16,898**	53.67	509.60	0	**563.27**
	Kensington & Chelsea	22,254	13,180	13,656	**49,090**	989.07	585.78	606.93	**2,181.78**
	Westminster	23,686	18,203	21,958	**63,847**	867.62	666.78	804.32	**2,338.72**
South Devon and Torbay*	Devon	9,162	50,248	277	**59,687**	48.15	264.05	1.46	**313.65**
	Torbay	1,481	10,533	0	**12,014**	43.18	307.08	0	**350.26**
South Tyneside		8,852	12,515	0	**21,367**	302.12	427.13	0	**729.25**
Southend		1,153	11,619	0	**12,772**	34.01	342.74	0	**376.76**
Staffs and Stoke (1)**	Staffs	5,777	50,294	48,667	**104,738**	31.90	277.71	268.73	**578.34**
	Stoke-on-Trent	33,494	18,419	24,291	**76,204**	791.82	435.44	574.26	**1,801.51**
Waltham Forest, East London and the City (WELC)	Newham	52,160	21,040	34,157	**107,357**	2,297.80	926.87	1,504.71	**4,729.38**
	Tower Hamlets	1,629	18,738	183	**20,550**	99.33	1,142.56	11.16	**1,253.05**
	Waltham Forest	2,543	16,054	0	**18,597**	92.14	581.67	0	**673.80**
Worcestershire		3,686	33,507	0	**37,193**	29.35	266.78	0	**296.12**
Total Pioneers		**256,626**	**649,995**	**165,434**	**1,072,055**	**146.63**	**371.40**	**94.53**	**612.57**
Total non-Pioneers		**879,429**	**2,809,870**	**579,898**	**4,269,197**	**117.34**	**374.90**	**77.37**	**569.61**
Total HWBs		**1,136,055**	**3,459,865**	**745,332**	**5,341,252**	**122.88**	**374.24**	**80.62**	**577.74**

* The Pioneer catchment area is South Devon and Torbay CCG, which is larger than just Torbay Council, but smaller than Torbay and Devon together (31% of the population in the two areas is involved in the Pioneer).

** The Pioneer catchment area is 4 CCGs that span Staffs and Stoke, but cover a smaller area than Staffs and Stoke together (68% of the population in the two areas is involved in the Pioneer).

*** The population living in the Pioneer area is slightly larger than the one considered in this table, since the Pioneer includes the Isles of Scilly whose BCF data is not available (so data in the table refers to 99% of the population in the Pioneer).

(1) For Staffs and Stoke, the BCF activities may be less aligned to their Pioneer objectives (which are described in Chapter 4).
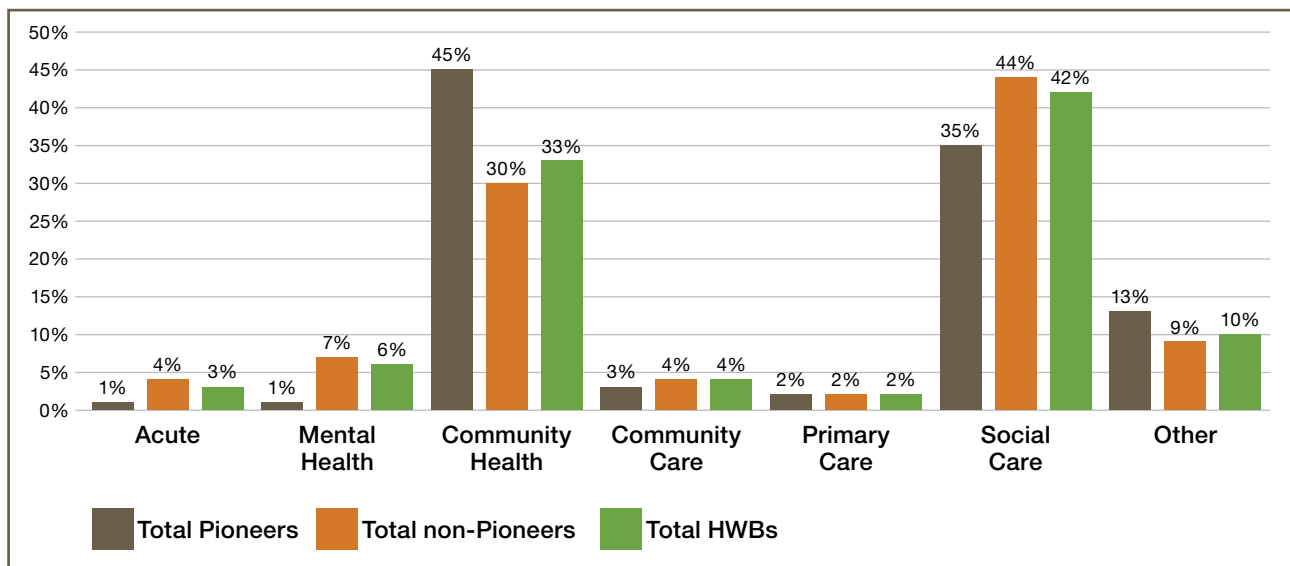
Expenditure plans

The BCF plans show that the largest proportion of spending nationally was allocated to schemes classified as social care, followed by community health services, while other categories of expenditure – such as NHS acute and NHS continuing care – were more modest (Figures 8.1, 8.2a and 8.2b). However, in Pioneer areas, it was community health services schemes that were allocated the most expenditure in their BCF plans while the resources allocated to acute care were much lower than in non-Pioneer areas. This difference appears to be explained by the BCF returns made by three authorities (London Tri-Borough) who categorised over 95% of their programme as allocated to community health schemes. Nonetheless, this allocation is consistent with a more ambitious shift from acute care to community care in Pioneer areas, which planned to invest a lower than average proportion of BCF resources in the acute sector in 2015-16 (Figures 8.1, 8.2a and 8.2b).

The proportion of expenditure listed as 'other' is higher in Pioneer than in non-Pioneer areas, and it is especially high in six Pioneer sites (WELC, Leeds, Islington, Greenwich, Kent and Worcestershire). Beyond potential cases of inaccurate coding, it appeared that this code was used as a label for integrated care activities that transcended health and social care. In addition, some Pioneers explicitly used it for BCF/Pioneer infrastructure support activities. Figures 8.2a and 8.2b show the wide variation between Pioneers and individual HWBs by level and type of spending.
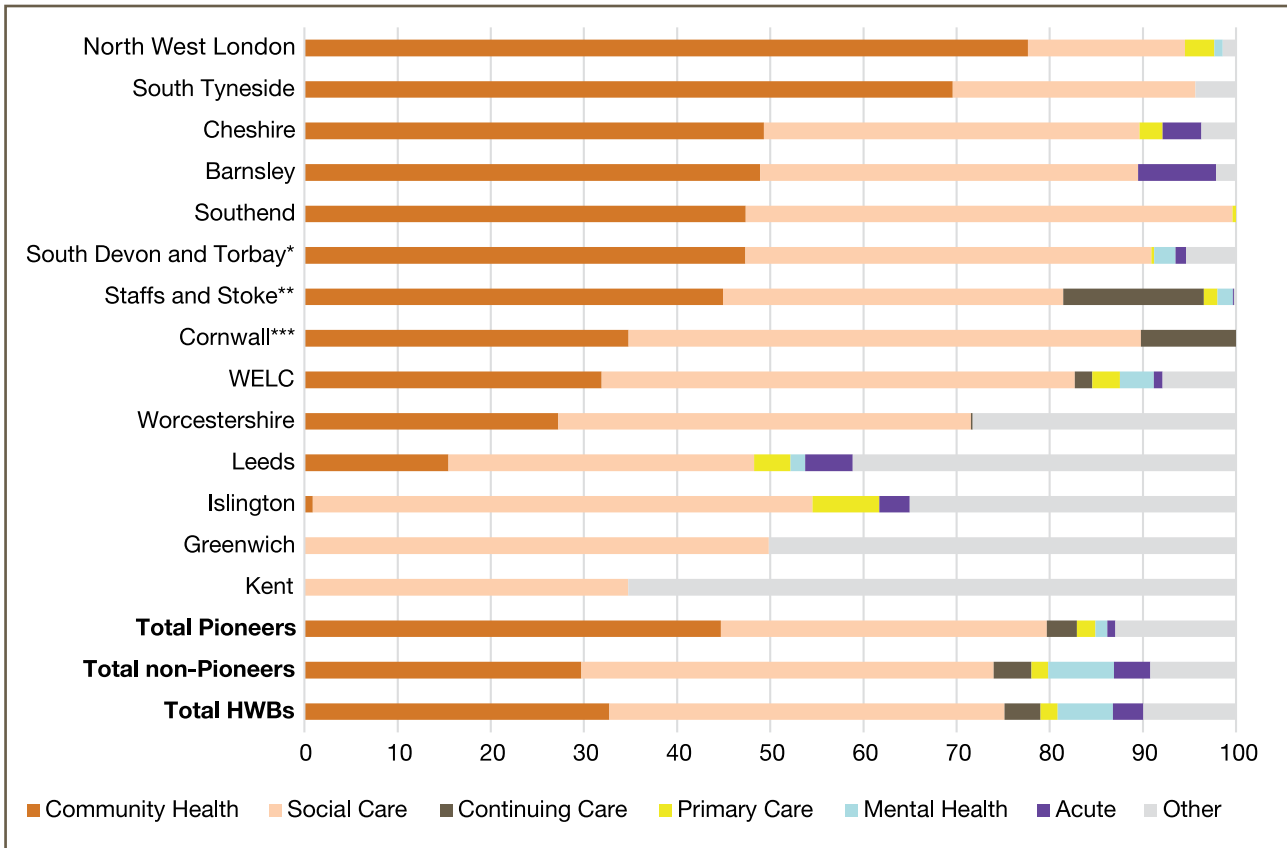
Figure 8.1 Allocation of BCF expenditure in 2015-16 by spend category

Source: NHS England

Figure 8.2a Type of expenditure in BCF plans in 2015-16 in Pioneer and non-Pioneer areas (% value)
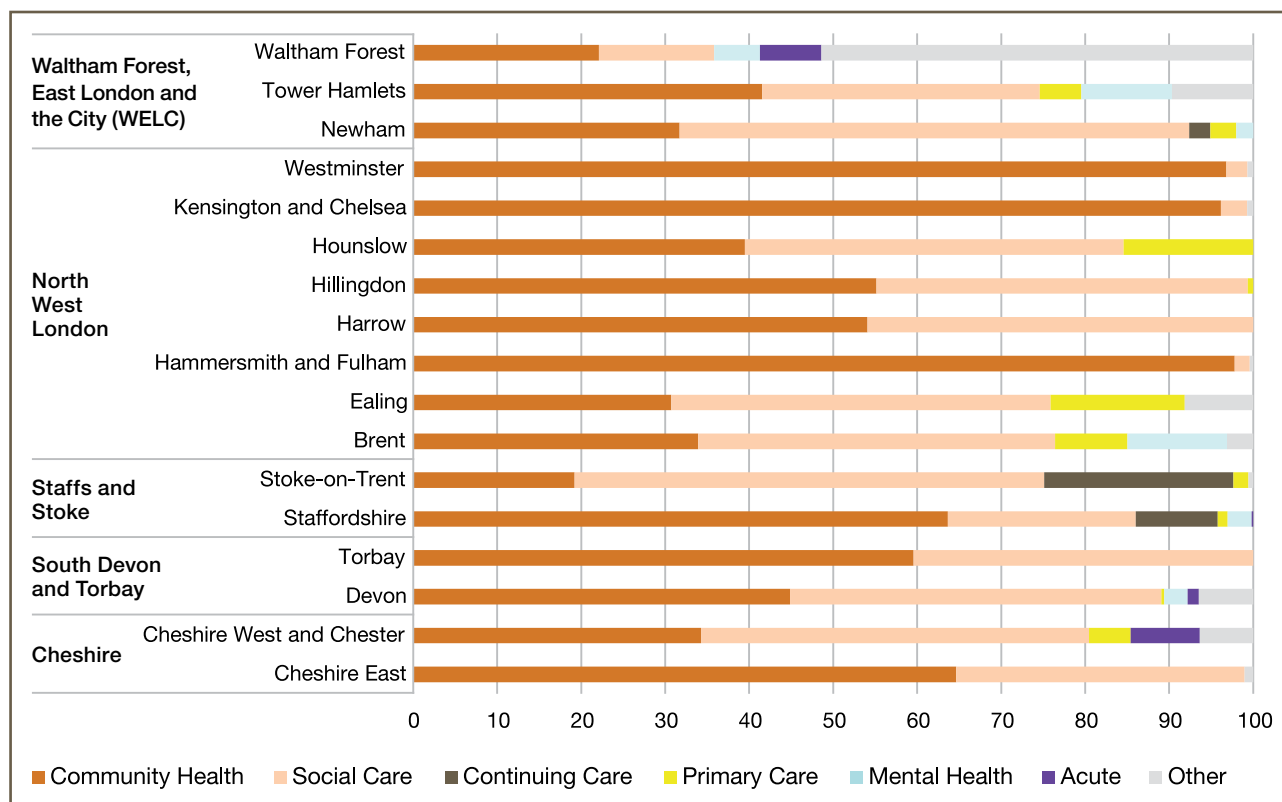

Source: NHS England

* The Pioneer catchment area is South Devon and Torbay CCG, which is larger than just Torbay Council, but smaller than Torbay and Devon together (31% of the population in the two areas is involved in the Pioneer).

** The Pioneer catchment area is 4 CCGs that span Staffs and Stoke, but cover a smaller area than Staffs and Stoke together (68% of the population in the two areas is involved in the Pioneer).

*** The population living in the Pioneer area is slightly larger than the one considered in this figure, since the Pioneer includes the Isles of Scilly whose BCF data is not available (so data in the table refers to 99% of the population in the Pioneer).

Figure 8.2b **Type of expenditure in BCF plans in Pioneers with more than one HWB (% value) 2015-16**


Source: NHS England

The BCF in the context of personal social services cuts

The BCF was launched in a context characterised by a sustained reduction in resources made available by central government to councils with adult social services responsibilities (CASSRs) (NHS England 2014a). This reduction in resources is clearly seen in data relating to the period of 2010/11 through 2013/14 (Figure 8.3). Of note is that 'non-client income', which refers to social care expenditure funded directly by the NHS or through joint arrangements, shows an increase over time following the introduction of the policy to transfer funds from the NHS to adult social care to help protect it from the consequences of cuts to local authority funding more generally. This policy was succeeded by the introduction of the BCF and the associated guidance that '[BCF] funding must be used to support adult social care services in each local authority, which also has a health benefit' (NHS England 2014a).

Figure 8.3 Adult social care expenditure 2010/11 to 2013/2014: Net expenditure and non-client income (£000 at 2015/16 prices)
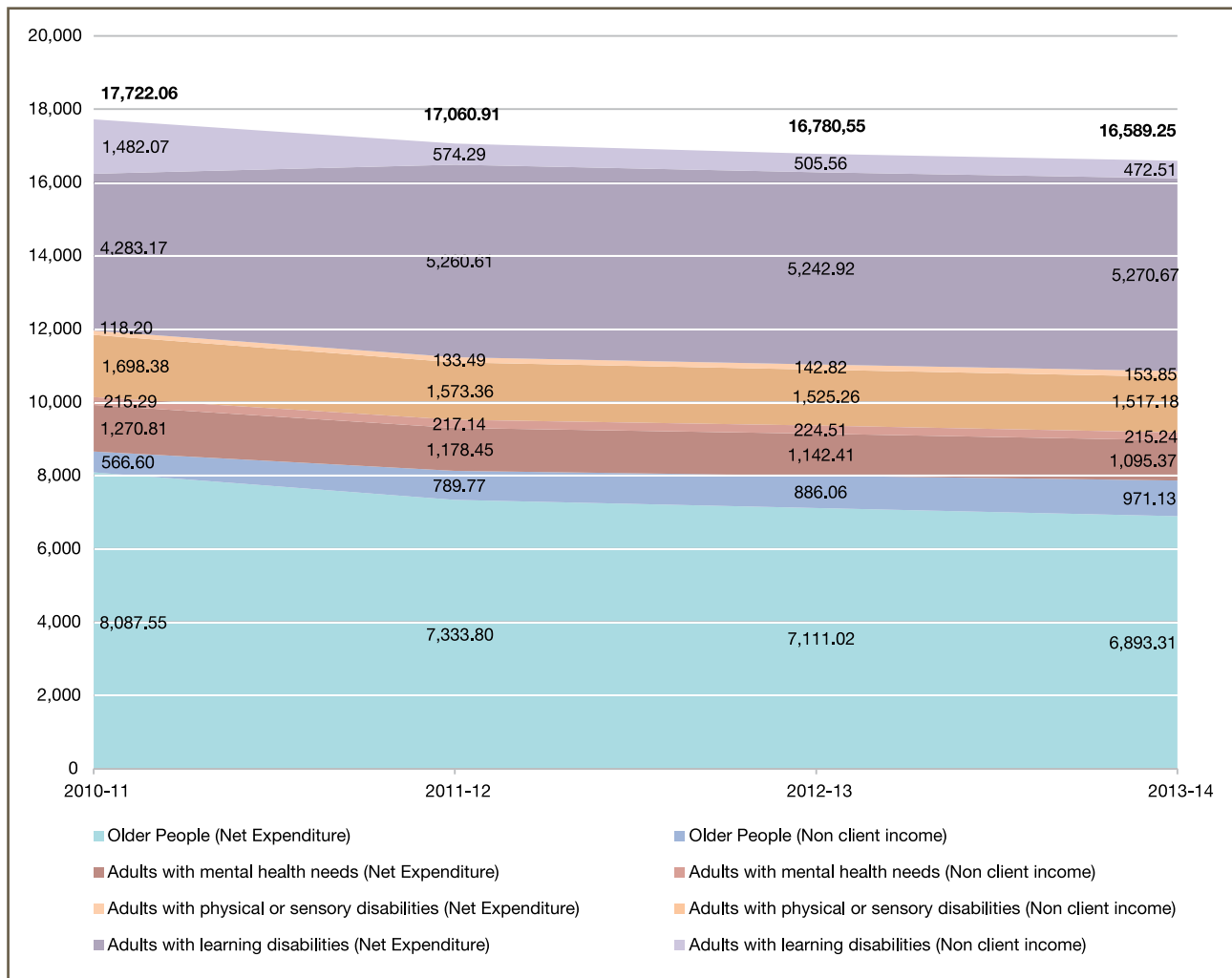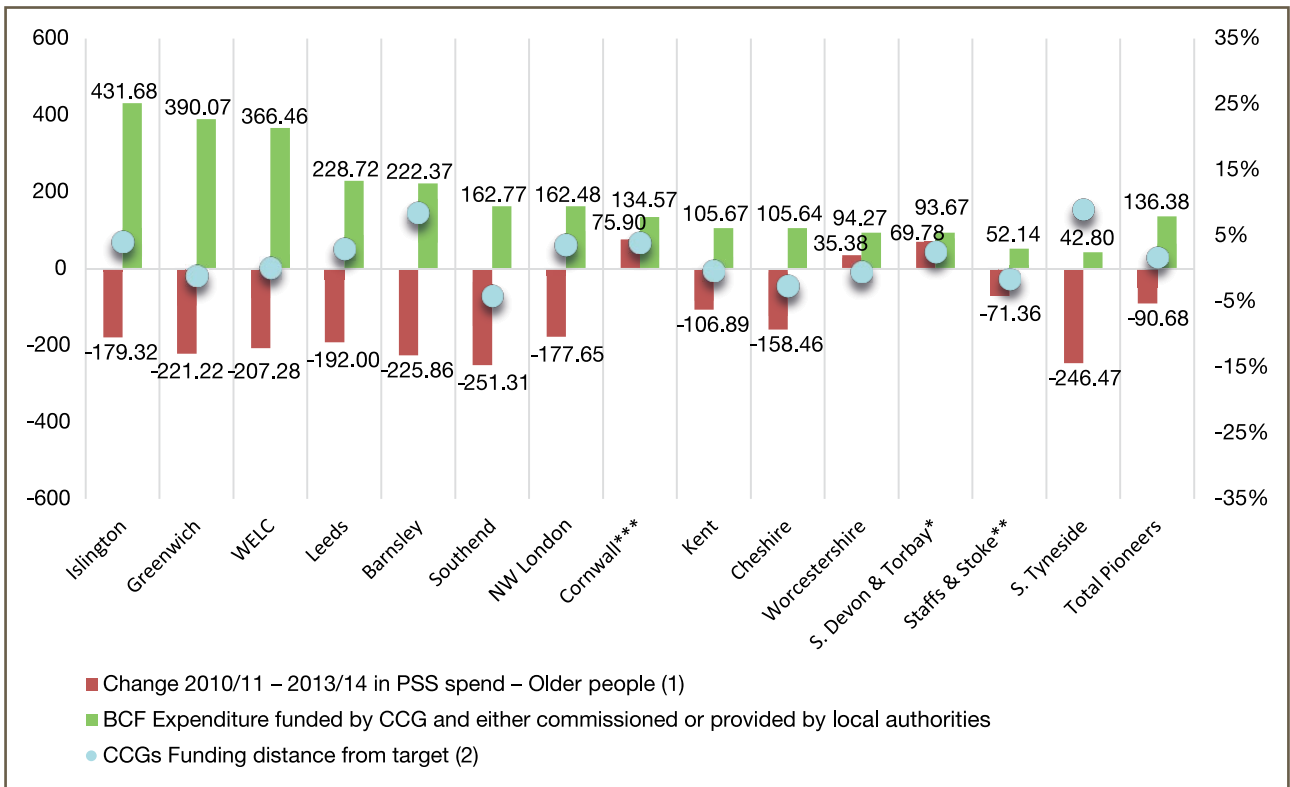

Source: NASCIS PSSEX, ONS

We attempted to assess how far BCF funds have been used to compensate for local authority reductions in personal social services (PSS) funding. We found that the size of resources that flowed from the NHS to the CASSRs broadly matched the size of cuts in PSS expenditure over the last 4 years (from 2010/11 to 2013/14). The amount of BCF expenditure planned for 2014/15 by local authorities (measured by BCF schemes that were funded by the CCG and commissioned and/or provided by the local authority) in Pioneer areas exceeds, on average, the PSS cuts, although the picture varies by area (Figures 8.4a and 8.4b). (This comparison is not relevant in those areas where no reduction in PSS expenditure was observed: Cornwall, Worcestershire and South Devon and Torbay.) While in some Pioneers, the match is very close (Barnsley, Kent, NW London on average), in a few areas the BCF investment flows from CCGs to local authorities go beyond PSS reductions (Newham, Greenwich, Islington).

Figure 8.4a Reduction in Personal Social Services (PSS) spend on older people (2010/11 to 2013/14), BCF expenditure funded by CCGs either commissioned or provided by local authorities, and CCG funding distance from target (£ at 2015/16 prices per resident aged 65 and over and % values)

Source: NASCIS PSSEX,
NHS England, ONS

(1) Total net expenditure + Non-client income.
(2) A positive value indicates the CCGs in the area being overfunded on average; a negative one indicates them being underfunded on average.

Figure 8.4b Reduction in Personal Social Services (PSS) spend on older people (2010/11 to 2013/14), BCF expenditure funded by CCGs either commissioned or provided by local authorities, and CCG funding distance from target (£ at 2015/16 prices per resident aged 65 and over and % values); for areas where Pioneers encompass more than one HWB
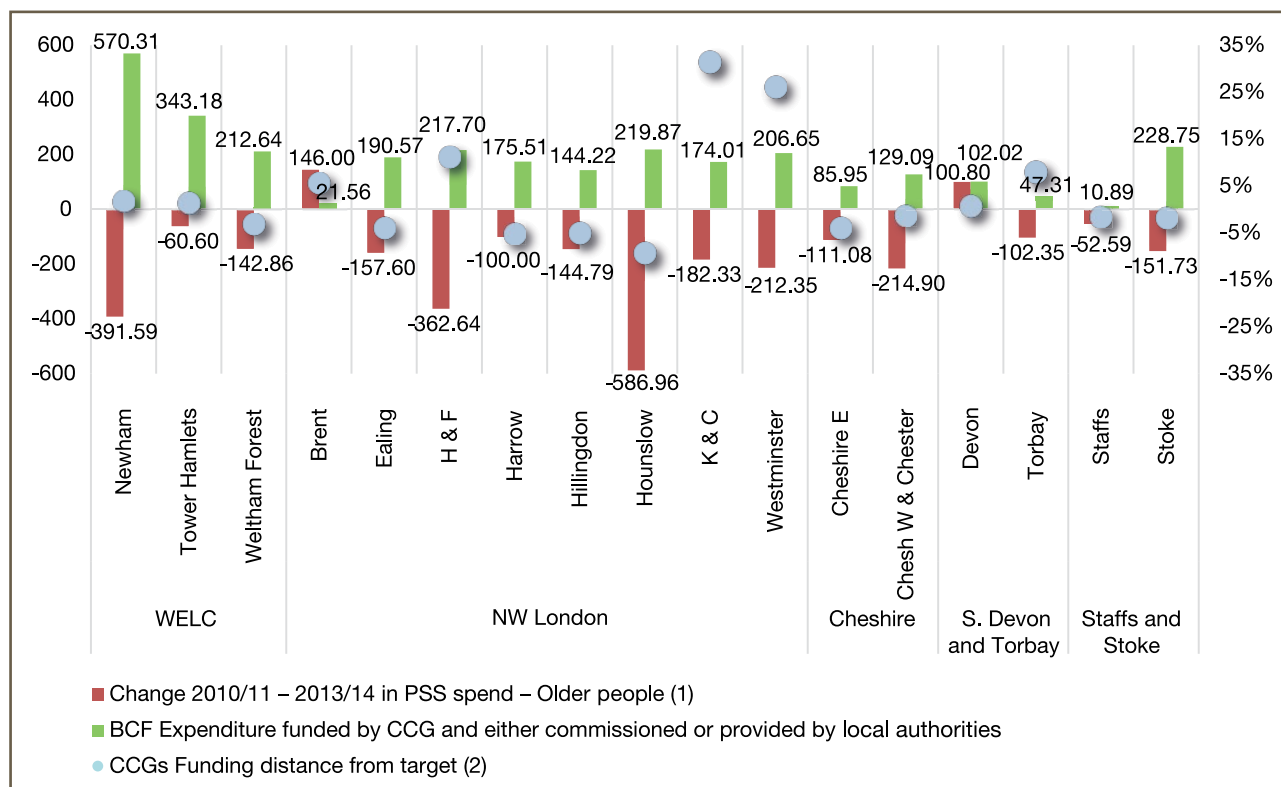

Source: NASCIS PSSEX, NHS England, ONS

(1) Total net expenditure + Non-client income.
(2) A positive value indicates the CCGs in the area being overfunded on average; a negative one indicates them being underfunded on average.

Local context

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

> "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." (CCG)

Overall, local authorities tended to be supportive of the BCF goal of providing an incentive to engage in joint commissioning and/or funding with the NHS, especially given the impact of local authority cuts on their budgets and planning resources. However, most local authority interviewees were critical of what they saw as a disproportionately bureaucratic set of processes associated with the BCF. This view was also associated with the overstretched nature of planning and management resources that were also in demand to manage the impact of spending reductions and the introduction of the Care Act 2014 in councils, and mainstream financial and commissioning plans in CCGs. By contrast, NHS providers tended to be critical of the limited extent to which they had been included in BCF planning processes, and CCGs

expressed diverse views about how far the BCF was supportive of promoting greater integration. Some Pioneer programme leaders in areas with complex geographies, felt that the focus of individual CCGs on planning BCF spend for their own patch undermined the ability of the Pioneer to develop service and financial strategies across the footprint of the Pioneer as a whole. Many stakeholders highlighted the challenges and uncertainties inherent in realising the savings set out in BCF plans.

Alignment between BCF and Pioneer strategic goals

Analysis of the BCF plans submitted by local authorities within 13 of the Pioneers (i.e. excluding Staffordshire and Stoke) showed a high degree of alignment between activities supported by the Pioneer programmes and their BCFs. Similarly, interviewees from these 13 Pioneers generally acknowledged the consistency and interdependence between the BCF and Pioneer programme.

> "I think its 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." (Local authority)

Interviewees were divided in their views about whether the BCF had been a helpful process so far or whether it had in some way distracted from, or slowed down, their ability to implement Pioneer activities.

> "I think the honest answer is, it's been both a help and a hindrance. The reason for that is, it's helped [in part to] provide a bit of pace to an established integration program. What it did was create a huge amount of bureaucracy that has actually largely detracted from what we were already doing." (CCG)

It was reported to have generated fruitful discussion between local authorities and NHS commissioners, and enhanced the scrutiny and, thus, the feasibility of delivering schemes in the BCF plans. It was also said to have focussed attention on integrated care: in areas where the Pioneer programme was largely driven by the NHS, the BCF was seen as a way to get the local authority more involved in, and aligned with, CCG planning activities.

> "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 [it was] around integration and beds, it was much stronger health-led. So BCF has helped the local authority come into the picture." (CCG)

However some sites commented that the underlying approaches of the Pioneer and BCF initiatives tended to differ, with the first being more amenable to organic development ('trial and error'), while the BCF was perceived as a more constrained, bureaucratic and performance-managed exercise.

Concerns

A number of tensions and concerns were also reported during the interviews. In the first group of interviews (in autumn 2014), it seemed that interviewees did not always understand the implications of the BCF, including its financial implications for providers. In one site, it was apparent that different local stakeholders all thought that the BCF was 'their pot of money'. Moreover, 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 site, there appeared to be an expectation by the local authority that Care Act implementation would be more substantially financed by the BCF than the terms of the Fund envisaged. There were also 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." (Voluntary sector)

In the second round of interviews (in spring 2015), it seemed that stakeholders had gained a much better grasp of how the BCF had the potential to support the whole health and social care economy. Several sites, notably the more complex ones, suggested, however, that the BCF had been handled within its own silo, and that the time-consuming, finance-driven negotiations underlying it had been a distraction from the wider re-design of the health and care economy as a whole, as well as, to some extent, from the implementation of the Pioneer programme itself. Many sites questioned the added value of the BCF, either because they considered they were already on a joint journey or saw it as too modest in scope to have a substantial impact on the health and care economy.

> "What you've got to aim for in the end is a fully integrated health and social care budget. To worry about a few million pounds here or there, have the most forensic detailed line by line monitoring of that, is not where it's at for us really. So we do what we need to do on it, but I don't think it's added any value." (CCG)

This view was more likely to be expressed in sites focussed on whole system change, or where the Pioneer spanned a number of local authorities, or 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 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." (CCG)

Concerns were expressed about whether the BCF targets to reduce avoidable admissions would be achievable. While the underlying premise of the BCF – namely, the transfer of funding from hospital to community care – was widely supported, some perceived it to be a significant gamble. In high performing systems, for example, where significant levels of care were already being provided in the community, it was suggested there might be fewer 'inappropriate' acute admissions to target for diversion to community services. In such circumstances, further reductions in admissions might not be possible or, if achieved, might result in negative outcomes for patients for whom hospital admission was the more appropriate course. 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]… 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." (CCG)

The need to achieve targets for reducing acute care activity through increased activity by services in the community resulted in the majority of Pioneers deciding not to increase the amount of resources – beyond the minimum required – that had been committed to the BCF pot.

Providers' concerns

Providers generally expressed more reservations 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." (Acute provider)

More generally, many interviewees from health providers felt 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 together with the difficulties encountered when attempting to re-direct resource allocations because of complex contracting procedures and the disincentive effects of other financial mechanisms like PbR. However, the later round of interviews provided a more positive account from some providers, notably community providers, who saw the BCF offering access to new resources to 'pump prime' services that otherwise would not have been funded.

Process

On a practical level, there were strong criticisms, mainly by local authorities, of the overall BCF submission and monitoring process. They highlighted concerns about the time and energy expended on BCF negotiations, but more particularly on the way the second round of BCF planning had been managed with short deadlines and intensive monitoring, which gave the impression that the assurance process had been more focussed on process than content.

"Yes, that's the most process led piece, like taking a really good idea and then just killing it with process." (Local authority)

In fact, the bureaucratic demands of BCF plan preparation and submission processes were a major point of emphasis in the later interviews compared with the earlier ones. It was felt that the strong focus on bureaucratic processes had undermined the effectiveness of the BCF and had distracted from the need to deliver substantive and systemic changes.

9. Early signs of progress and lessons learned during the first 18 months

In the absence of an agreed set of quantitative measures of the extent to which the Pioneers had been able to implement their plans, but in order to gain some understanding of how far Pioneers were making progress, in the second round of data collection (in spring/summer 2015) interviewees were asked what they would want to draw to the attention of a visiting Government Minister. A range of developments were highlighted, including quite a few that Ministers had already been shown.

However, it is important to note that many interviewees were keen to point out that it was too soon in the lifespan of the Pioneer to identify progress if this was defined specifically as measureable changes to front-line activities and service user outcomes. Interviewees also generally reported that it was too early to expect patients/service users to notice changes.

> "What I would like, and what I would be able, to show him might be a slightly different thing. Though I would love to be able to show him integrated health and social care working on the ground for people, at the moment … I wouldn't be able to show him that." (Local authority)

Infrastructure and inputs

Some interviewees chose to highlight the activities within Pioneers that were fundamental building-blocks of integrated care. Chief among these were the positive and constructive relationships and alliances that Pioneers were building, despite (at times) trying circumstances or the challenges posed by local health and social care economies, particularly in the larger and more complex Pioneers with multiple stakeholders.

> "I'd like him to see that we have managed to keep all of the conversations going in a very positive, collaborative way regardless of the individual agendas of each of the different organisations, and that we haven't been disrupted by those individual organisational agendas. That we have been part of this movement, of a culture that tries to look more at the needs of the individual than the needs of the organisation or the health or social care professional." (Local authority)

In some sites, this had progressed to co-location of teams, the complexity of which could be easily overlooked.

> "I would want us to show the Minister our model of bringing people together and the real significance – and I know the literature views this in different ways – but I think the real significance of the whole physical co-location of people in one building, one site, and the benefits that brings in terms of trust, understanding, working relationships, impact on patient outcomes and really, it's the essence for me of a joined-up model of provision." (Non-acute provider)

Important also were reported changes in perspective among stakeholders, who were said to have come to a more developed understanding about their roles and responsibilities in the transformation of local health and social care services.

> "So if someone were to visit in 15/16 … I would expect them to have a conversation with the partners about how they understand their role, what they've had to do to create their role or to carve out their role. How that relates back to their substantive organisation … because that would be the progression, [it's] that level of maturity, thinking." (CCG)

Supporting these changes of perspective was a sense of a developing cultural shift among and within local stakeholders, including increasing 'ownership' of the process of integrating services.

> "I'd want them to learn that, actually we think integration is a great idea too and we're passionately committed to it and we want to get on with it and make it a huge success, but you need to trust us to deliver it locally." (Local authority)

Part of this cultural shift was a 'can-do' attitude that sought to identify the challenges of integration and the continuing efforts to tackle them. This often had to do with issues around IT/IG.

> "There's a number of pieces of work going on to support [IT] interoperability, which I think we're doing. I think there's stuff that's quite progressive in terms of information governance. I'm looking at the NHS number use within social care at the moment because we've flagged it in our initial bid as something we were doing and progressed with." (CCG)

A further element of the cultural change taking place was the increasing prominence being given to the patient/service user voice and the efforts being made to increase consultation and engagement activity.

> "When you're significantly changing services, you have to engage and people have to be part of it. So I think from that perspective we were … we had those roots already established ….Whether it was to the extent it should have been, and I think co-production and engagement can never be enough, can it? So I think it was a case of some of the same people to begin with, but we've actually enlarged our pool of people as we've progressed and they get involved in increasingly more things with us." (Local authority)

Most Pioneers were able to highlight specific activities or services as providing tangible evidence of progress within their area.

> "I'd like to show evidence of how we've tried to manage the 'front door' and created a single joined-up point of entry for health and social care within the city, so that as a result of that, hopefully people get into the right service and into the right service much quicker than they were doing." (Non-acute provider)

> "I think we would show them what we've done in the community/voluntary sector with the Lottery funding. I know that's early days but the plans around some of the community builders that have been recruited now from the local community and what they'd be doing." (CCG)

> "Well we've had Ministers in, so basically, we have showcased the overall care coordination and rapid response services, which are our most developed, but we've done some incredibly good work with psychiatric liaison and we can show really good results for that. I think that as we expand some of our work out through different services, like the falls procurement that we're doing, we would want them to see that, but I think most of all I would want to help them to see how we join the service up across boundaries." (CCG)

Outputs, outcomes and impact

As noted, many Pioneers stated that it was too early to be able to identify outputs or outcomes for patients/service users, let alone long-term impacts. However, many Pioneers had set targets for their initiatives, and some monitoring had begun (see chapter 5). Some interviewees also felt able to highlight some short-term outcomes, typically an improved patient/service user experience or, in some cases, improved staff experience.

> "I'd like to showcase some patients who could tell the Minister about the difference that they've seen and the impact that they've seen in terms of either their own care or the care of their spouse. So that would be the first thing." (Non-acute provider)

> "So we did that for [a Minister], we also took him into [name removed], which is one of our integrated teams. Showed him around the building, but got him to sit down with some of our frontline practitioners and get him to ask them, 'What's it like for you?' They explained to him what it's like for them working on the frontline. So if a Minister was to turn up and wanted to go and find out more about it we take them out on a visit. If there was a patient willing to see them we'd take them to see a patient. So we put it in context of, this is what we've done, that's the kind of rhetoric but there's the reality." (CCG)

And one Pioneer at least was able to claim to be able to demonstrate financial savings, even at this early stage.

> "I think I would want the Minister to now start to look at our results and actually see the financial result that we're delivering." (Voluntary sector)

Local evaluations

Although it was generally too early to present findings from local evaluations (which are also discussed in chapter 5), some interviewees referred to evaluation evidence as supporting their perceptions that progress was being made.

> "We've got the feedback from the users and patients about their experience of the programme – which is very positive – and we've got the evaluation and the case study work of the pathway that the users have taken as a result of their engagement with the programme. And I think we've got an emergence of evidence that we're getting better outcomes as a result of all of that." (Local authority)

The local evaluations being developed by some sites was highlighted as a sign of progress.

> "I would want to share with the Minister how we're beginning to evidence some of the impact of this. So I'd want to talk about our evaluation work, but then I'd also want to just make reference to some of the work that we've done through our community bed-based initiatives that we've developed, where we're starting to track people over a longitudinal period of time to see what care and services they are accessing 3, 6, 12 months post-engagement with the initiative so we can start to look at that longer-term impact, the impact it's had on people." (Non-acute provider)

Work in progress

While there were numerous elements interviewees identified as pointing to progress, there were also pragmatic reminders that the Pioneer work was still in process and that more progress was hoped for as the various programmes advanced.

> "I'd want them to see the energy of frontline practitioners. I'd want them to, perhaps, contrast that with what the official system really seems to care about and seems to manage. I would want them to understand that the acute sector is pivotal to making all of this work and we've still got a long way to go." (Local authority)

The fact that there was a 'long way to go' meant that it was not always easy to keep-up motivation among all stakeholders'.

> "Holding this together is really challenging because of course people get tired. So I had to do a little bit of a speech the other day about resolve, people need to keep their resolve, and we need to keep focussed on why we're doing this, and the focus on why we're doing it is for the patients and carers, to improve outcomes and experience." (CCG)

In a few Pioneers, this seemed to be most pronounced with acute providers. While they were fully involved in some sites, in others they seemed to adopt more of a 'wait and see' attitude than to be active participants, and they did not necessarily share the same priorities with other local partners.

> "In terms of people being able to think about the future, our colleagues in the acute trust are not thinking about the future: they're thinking about today....What we're trying to do is go like 'Yes, we know, but actually, we're concentrating on some different things at the moment.'" (Local authority)

Concerns were also raised about potentially moving too far in the direction of caring for people in their own homes, to the extent that this could result in inhumane care in extreme circumstances.

> "I saw a case recently … 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." (CCG)

However, although it was recognised that there was still work to be done and progress to be made, some of the visions outlined by interviewees as to what success might 'look like' were powerful and compelling.

"The solutions for the NHS don't just lie in the NHS, they lie in the community as well. So there is that thing about this is a partnership between community, between health and between social care ….It's about the difference it makes in quality of life, in people's value at their work and in cost and driving out inefficiencies in the system and just that whole thing around culture and behaviour." (Voluntary sector)

Changes in aims or objectives?

When asked in spring/summer 2015 whether there had been any changes in their Pioneer's aims or objectives compared with their original proposals, none of the interviewees said there had been any significant changes. However, it was not uncommon for interviewees to report that there had been changes to various aspects of their programmes, most commonly by narrowing their focus on fewer initiatives and/or, in the larger and more complex Pioneers, for the focus to shift to local areas.

"What I think has changed [over the last 18 months] is we have been more ruthless in the way that we try to narrow down the scope of what we think we're going to do." (CCG)

"… what is quite significant in our programme is that we work with [multiple] CCGs who are developing themselves so the focus … had to change into local Pioneers and local organisations as Pioneers …." (Local authority)

These changes and their implications are described more fully in the next section.

Progress at scale and pace?

Nationally, a key objective of the Pioneer programme was for the sites to drive change 'at scale and pace from which the rest of the country can benefit' (Department of Health May 2013). As already noted a number of times in this report, with the Pioneers embarking on what is envisaged as at least a five-year programme, it was pointed out by many interviewees that the Pioneer was still very much a 'work in progress' at an early stage (i.e. about 15-18 months since inception at the time of interview). In addition, individual Pioneer programmes were continually evolving and transforming within a dynamic context, which increased the complexity of judging progress against proposals originally set out in mid-2013.

In the second round of interviews (in spring/summer 2015), most interviewees reported that their Pioneer's activities were broadly progressing as planned, albeit at a somewhat slower pace than originally intended. Interviewees tended to be fairly sanguine about this, seeing it as a consequence of trying to implement complex transformation in a challenging context.

"I think it is natural that you see a little bit of a shift in these things, but fundamentally I think there hasn't been any changes fundamentally to what we've set out to do." (Voluntary sector)

"Naive ambition, I suppose, which you kind of have to have when you're doing a job like this. You have to believe that you can change the world quite quickly, even if we don't always." (Local authority)

However, there were also examples where progress was potentially being impeded by a retreat into 'siloed' ways of working, as system leaders struggled to cope with the demands of maintaining services in a context of increasing financial pressure coupled with increasing demand.

> "… the fact that I think something's a great idea doesn't mean that everybody else thinks it's a great idea. And, even if they do think it's a great idea, it doesn't mean that their behaviours will translate into them implementing it ….And, when the going gets tough, are people prepared to cede authority and space and services and all the things because that's what's right?" (Local authority)

This reaction is part of a response to what we have termed the 'integration paradox', which is arising in a context where the combination of growing demand and financial austerity is challenging the sustainability of health and social care services. The paradox arises because better integration is seen as a potential solution to growing financial pressures, but those pressures, in turn, are making it more difficult to invest in more extensive and effective patterns of integrated care and can lead to organisations focussing on what they perceive to be their 'core' activities. Interviewees described what this meant in terms of day-to-day operations.

> "Within our own teams, to be released from the day-to-day stuff in order to look at the future, is really limited. So our finance colleagues are busy trying to keep the ship afloat in organisations that are very, very stretched financially and very, very challenged and getting them to say, 'Yes, we know you need to do that, but I'd like you to put on an imagination about how things can be different.' They go, 'I haven't got time to be thinking about the future.' So that's quite hard … to get the headspace for people and the time to do the change when they're busy spinning [plates]." (Local authority)

From the second round of interviews, we identified two emerging trends, partly as a result of this paradox. The first trend, noted in the section on integrated care strategy/service models (chapter 6), was for sites to focus on a more limited (and converging) set of initiatives (e.g. MDTs, care coordinators), which in part may be explained by the practicalities of implementing complex large-scale change incrementally; but in part, it may also be explained by Pioneers only having sufficient resources to focus on meeting immediate financial pressures. Thus, the second trend noted by some interviewees was retrenchment, or a 'scaling back' of Pioneer ambition and activity.

> "… like many other places nationally at the moment, [we] have got a serious budget problem. And so what that does mean is that there's a little bit of pulling people back to work on cost-saving during this difficult time." (CCG)

In some of the larger and more complex Pioneers, there was an apparent shift away from activity planned and managed at a system-wide level to activities being implemented at a more local level within Pioneers.

> "People have also changed a bit from the 'we have to do this as a county' to say, 'some things we have to do as a county, other things, we could and should do as localities.' So the 'one size fits all' doesn't have to apply to everything." (Local authority)

> "I think we've been on a journey and I think that journey started with us trying to put together a common [locality] vision, but recognising that there were

quite a lot of differences in terms of how the different areas wanted to take the agenda forward." (Local authority)

In some cases, this changed the nature of the Pioneer so that it became less about direct planning and delivery of initiatives 'on the ground' to becoming more of an enabler by, for example, focussing on structural issues and infrastructural barriers while leaving service implementation to local units.

"Through the development of our five year health and care strategy, we've had a major rethink about what [programme name removed] means, and instead of being responsible for individual projects, it's now the modus operandi, the brand for the delivery of the five year strategy. So [project name removed] is a concept and a guiding principle that delivers the five year strategy. The work to do all of the stuff happens out there in the world. The [project name removed] bit is the glue that brings it together in governance terms and leading on the enablers." (Local authority)

Learning from the first 18 months of being a Pioneer

Interviewees were asked (during the second round of fieldwork) what lessons they had learned during the first 18 months of Pioneer activities and what they would like to share with the second wave of Pioneers. The most common piece of advice that Pioneers had for the new sites was the need to invest in relationships locally and to build on these relationships in order to engage partners over the long haul.

"It's just as important to have those informal chats and coffees and breakfast meetings and whatever as it is to have the formal ones." (Local authority)

This meant involving all partners, in particular providers.

"… so that it is not a commissioning programme, it's a commissioning and provisioning programme, otherwise you won't get your workforce and your systems to change so that's really of key importance." (Local authority)

Similarly, engaging social care was deemed essential to avoid the risk that the initiative would become too NHS-focussed. Some sites further admitted paying insufficient attention to involving primary care and GPs early on, and urged wave two sites to avoid that situation. Several interviewees also noted that the local community needed to be proactively engaged, especially when a major transformational change was planned alongside integrated care activities. The need to maintain a system's leadership that is open, resilient and effective at addressing tensions was also mentioned extensively.

Another important lesson was that culture emerged as a key ingredient in delivering change, and that building a common culture was best achieved by focussing on patients/service users and their needs.

"… it is about a culture of integration, a culture of working together regardless of often the perverse incentives that are in the system at the moment to do that." (Local authority)

"[Integration is] a heart issue rather than mind issue, and it is around openness, transparency, trust, will, the ability to let go as organisations, all of that really". (CCG)

In terms of implementation, there was wide recognition that delivery of integrated care was challenging and would take time. Advice to new Pioneers focussed on fostering a 'bottom up' approach, and many interviewees suggested that a 'top down' strategy had little chance of success. Local experimentation was praised, even in the larger Pioneer sites, and some were sceptical of the value brought by external consultancies in delivering actual change. Several interviewees also commented that it was important to do things differently and to use the Pioneer programme to innovate.

There was a clear recommendation by interviewees to focus on the 'doing', and not to be overly distracted by process hurdles, despite the challenges that needed to be overcome.

> "Don't get too hung up on processes, contracting arrangements … just do it." (Local authority)

An important lesson learned by many sites was to ensure that frontline staff were sufficiently involved in the development of strategies and workstreams. Winning staff's 'hearts and minds' was deemed critical.

> "I would have looked … for some operational frontline people to have been part of the conversation from the very beginning ….[Finding key frontline staff champions] would have made it easier to translate into the implementation phase." (CCG)

Finally, most sites also noted the importance of having adequate resources allocated to supporting the Pioneer programme, especially in terms of programme management, as well as setting realistic timescales.

> "… be committed to putting in some resource and backfill to allow people to fully engage … for the long haul … for years." (Acute provider)

10. Conclusions

This early evaluation of the 14 first wave sites covered roughly the first 18 months of the Pioneer programme and is the first stage in a longitudinal evaluation that will eventually enable the Pioneer journey to be tracked over a total period of some 6½ years. With 11 second wave Pioneers joining the study in summer 2015, it provides a unique opportunity to make good weaknesses identified in previous integration research: the failure to commission studies in a wide range of settings and over a sufficiently long period to establish their longer-term results and sustainability. In practice, much previous research has concluded before it has been possible to establish whether initiatives have made a difference to the delivery of integrated care in terms of service users' experiences and outcomes. Where such benefits have been found in small-scale pilot situations, follow up studies of how they were – or were not – scaled up and embedded in day-to-day policy and practice have generally not been conducted. Such gaps reflect a wider shortcoming in both public policy and public policy research: a tendency to adopt a short-term focus on the process of designing and introducing policy initiatives to the neglect of the longer-term scrutiny of policy impacts (Challis et al 1988, King and Crewe 2013). However, it must be appreciated that attempting to evaluate the impact on outcomes of initiatives at the level of entire local health and care systems is analytically extremely taxing.

This report, therefore, covers what was essentially the start-up phase in a longer-term programme of evaluation. It was not expected to seek or find evidence of widespread changes in experiences or outcomes. Rather the intention was to lay the foundations for the longer-term evaluation by capturing early experiences of how sites were using their Pioneer status to design and put in place initiatives which would, over a five year period to 2020 or thereabouts, make the provision and experience of integrated care the norm for people using services and frontline staff alike (National Collaboration 2013). At the same time, however, Pioneers were expected to proceed at 'scale and pace' in order to generate and share learning quickly with other parts of the country so that the speed of development could be accelerated more universally. Applicants for Pioneer status were expected, therefore, to demonstrate that their past experiences and future plans would enable them to contribute to the spread of integrated care at a pace that had not previously been evident.

In short, the Pioneer concept implied that those areas selected would be able to bring about whole systems change within their areas with relatively little delay. This early evaluation was not commissioned to conduct comparisons with non-Pioneer sites and, thus, we are not in a position to establish the relative degree of progress of the Pioneers compared with other sites. However, in this chapter, we draw together our findings to provide an overview of implementation readiness and progress within the group of first wave Pioneers by the time our data collection ceased in June 2015. This was some 15 months from the start date of April 2014 that the Pioneers generally adopted and a little under 18 months from the December 2013 ministerial launch event.

At this still relatively early stage in the journey towards more universal personalised and coordinated care, we think it prudent to be cautious in drawing conclusions about this major challenge in cultural and organisational change. The past record of implementing integrated care was recognised to be weak when the Pioneer programme was designed. The policy and practice inheritance was limited, and the NHS was still implementing a major internal reorganisation of the kind that had previously been found to be disruptive of external partnerships. It is against that background, therefore, that we advance the observations that follow, based on themes that have emerged from our fieldwork to date.

Heterogeneity and similarities of wave one Pioneers

In our interim report, we highlighted the degree of heterogeneity among the 14 wave one Pioneers. As a group, they vary widely in, for example, features such as population size, geography, socio-economic background and organisational complexity (in terms of the numbers of organisations involved in principle in the Pioneer). At the same time, they have strong similarities in terms of their underlying logic models, the patient/service user groups to be prioritised, and the sorts of service models and initiatives they have adopted or wish to put in place. At present, organisational complexity appears to be the most significant dimension along which sites vary. We have also identified some early signs of convergence in ambition and the scope of activities between sites (see below), which we will continue to monitor. In the next stage of the evaluation, we will re-visit the possibility of developing a Pioneer typology within the larger combined total of 25 first and second wave Pioneers and in the light of whether continuing convergence is apparent.

The degree of heterogeneity within a small group of sites was further compounded by variations between sites in how they interpreted and, more importantly, used the term 'Pioneer'. Although all sites had been through a common selection process against published criteria, we did not find a common definition or understanding of what it meant to be 'a Pioneer' between sites or between individuals within sites. In most sites, more than one understanding was evident. As a result, evaluation of the progamme is complicated by the multiple views of the nature, purpose and potential benefits of being a Pioneer. At various times and places, 'Pioneer' was used in one or more of the following ways as:

- a 'badge' for a locality, signifying national recognition of innovation and progress in integrating care
- an enabler of the existing local plan for transformation
- a particular governance arrangement, for example, a board that brought all system leaders and their organisations around the table
- a collection of discrete workstreams, characteristically covering a combination of different groups of users and infrastructure projects (for example, information sharing, workforce development, etc.)
- a specific new integrated service, such as a frailty service
- an ethos or way of thinking about and providing care, rather than a specific plan or set of initiatives.

This diversity meant that, initially at least, it was neither always straightforward to identify what was 'in' and what was 'out' of scope for the Pioneer in terms of plans and activities (and, therefore, the evaluation) nor which sorts of actions were likely to be associated with Pioneer status. In some sites, local stakeholders experienced this difficulty as much as the evaluation team. As a result, our interviews sometimes produced different accounts of the local Pioneer and its activities over time and between interviewees. In such cases, it proved difficult for the team to secure a definitive view of the focus and 'boundaries' of individual Pioneers. In addition, these different accounts were indicative that the focus of the Pioneer had been contested in some sites and had not always been fully resolved by the end of our fieldwork.

The anticipated benefits of having secured Pioneer status varied with the meanings associated with the term 'Pioneer'. As a result, there was diversity in local expectations of what might be delivered locally. For example, a key benefit of being a Pioneer was seen in some instances to be the way it provided a concrete reason to 'bring people

around the table', especially where NHS re-structuring had introduced discontinuities in relationships within the NHS as well as between it and local authorities. Pioneer status was also perceived as beneficial in terms of providing 'a national spotlight' that would help to sustain momentum locally if the going got difficult. Some interviewees valued the freedom they associated with Pioneer status, and saw it as offering safe ground in which they could innovate and try out different initiatives. Local actors also appreciated the perceived access to Ministers, both as a form of recognition of local innovation and progress, and as an opportunity to contribute their local knowledge and expertise to national debates. In addition, local actors also recognised that the programme potentially offered opportunities to talk, face-to-face, with individuals facing similar challenges in other localities, and to share promising practice.

The main concern expressed by sites was that they would be subject to pressure to demonstrate progress too quickly. We were frequently told that plans for longer-term system transformation, especially those involving primary prevention, community resilience and culture change, would take at least five years to demonstrate outcomes.

Towards convergence of activities?

Since our interim report in spring 2015, we have developed individual logic maps for each of the Pioneers, conducted additional interviews and collected further data during site visits. The logic maps have been useful in clarifying similarities and differences in both context and activity. Our evaluation has provided additional insights into both the nature of those activities and also the changes that have taken place at some sites. Our current judgement is that, while heterogeneity remains in terms of the scale, complexity and context of the Pioneers, there are indications that implementation is converging around a narrower range of activities than had been indicated by earlier plans and interviews. We are not yet, of course, in a position to assess how far, or whether, such variations in local context are shaping activities and their outputs, but this question will be explored at subsequent stages of the longer-term evaluation.

We have, however, identified an apparently growing convergence in the activities of the majority of Pioneers towards a similar set of specific interventions for older people with substantial needs, such as care navigators, care planning, risk stratification, single point of access and, in particular, multidisciplinary teams organised around primary care (see chapter 6 and the logic models in Appendix E). This approach may represent the beginnings of something approaching a common understanding of the Pioneer role in a growing number of sites as well as a 'toolkit' of interventions for developing integrated care more widely. The core activities identified above are, of course, consistent with the emphasis of much national policy over the past two years at a time of both growing demand and budgetary pressures on health and local government. The logic models demonstrate that, at the outset, the Pioneers generally intended such activities to be part of their local implementation plans, but they appear to be gaining a more predominant role in this initial implementation phase.

Another factor apparently driving convergence and reduced scope of Pioneer activities was pressure on local budgets. It was apparent that some sites had retrenched from longer-term strategies to re-balance the system in order to 'fire-fight' more immediate pressures, especially within the hospital sector, though there were notable exceptions where sites had retained their initial ambitions and focus.

In one case, strong local democratic leadership together with the space created by their ability to meet the metrics of the BCF, facilitated the retention of local priorities. In general, however, it appeared that more immediate pressures in the national policy context were tending to dilute the commitment to longer-term local objectives connected with a shift in the balance of investment between institutional, community and preventive activities.

This apparent convergence in the developing focus of Pioneer activities also represents a narrowing down of some of the broader ambitions to tackle prevention, early intervention and the social determinants of health that the National Collaboration had called for and were reflected in successful bids to differing degrees. This narrowing of the agenda appears to reflect a number of factors other than the deteriorating financial climate, including:

- the national conditions and metrics associated with the BCF
- the influence of visiting international teams, such as the Aurora team from the US which promotes, as a key component of care integration, the deployment of so-called 'care navigators' working in primary care
- the increasing influence of NHS England staff within the sites as part of a change in the nature of support provided to Pioneers after April 2015
- the focus of NHS England's new Vanguard service delivery models, including the less central role of local authorities in these compared with the Pioneer programme.

If the Pioneers continue to focus on a narrower range of initiatives and metrics in future, this raises important questions about their ability to scale up integration and accelerate the pace of change. For example, if there is a process of convergence towards a basic 'toolbox' of integration interventions, what scope is there for innovative ways to bring about integration that may be more effective or efficient in particular settings? Similarly, if there is a process of retrenchment and lowering of the priority given to Pioneer activity, what will be the continued driver that maintains momentum and ensures that scarce resources are devoted to this activity? Also, if, as may be suggested in some of the larger, more complex Pioneers, there is a trend for Pioneer activity to be devolved to sub-Pioneer units (i.e. individual CCGs and local authorities), how will the ambition of coherent integration at the scale of the entire local health and care system be realised, and what will happen if these bodies are unwilling or unable to assume this responsibility? These are all questions that cannot be fully answered at this stage of the evaluation. However, it is clear that, in the current context of austerity, the 'integration paradox' (see chapter 9), which would appear to be a driver for these developments of convergence and retrenchment, is likely to remain.

The role of support from the centre in these processes is potentially important, as is the shift during 2014/15 in this role from NHS IQ acting on behalf of DH to NHS England. Central support was highly valued where it provided project management and other support to local staff (as in the preparation of BCF plans). Over time, however, some interviewees began to question how far the balance between national and local influence was tending to shift towards the former, especially through the combined effects of the BCF national planning criteria, the Vanguard care models (NHS England and Partners 2014) and the associated change of responsibility for the Pioneer programme from DH to NHS England where they sit alongside the models of care (Vanguard) programme. Their re-designation as 'NHSE Pioneers' appeared to symbolise a change in their primary focus of accountability together with their status as joint initiatives with local government.

A related issue is the extent to which the role of the Pioneer programme has gradually changed from enabling and providing legitimate space for bottom-up innovation and distinctive localised ways of working to responding to national system-wide imperatives. One consequence of stronger national influence could be to reduce such space and the opportunity to try out a variety of approaches locally. Equally, top down pressures in local systems resulting both from national influences and greater reluctance to invest increasingly scarce resources in potentially riskier projects would have the same effect. Without, at this point, being in a position to evaluate the relative advantages of different balances between top-down and bottom-up influences, we expect this issue to be a continuing focus in the longer-term evaluation.

Making the transition from design to delivery

In the interim report, we commented on the optimim with which Pioneers were approaching the implementation of the plans contained in their successful bids to become Pioneers. In particular, we noted that the numerous and wide-ranging barriers to change previously identified in the literature on integration were tending to be viewed more as challenges to be overcome rather than enduring blockages to progress. At the same time, we noted that the national definition of integrated care as person-centred, coordinated care had significantly contributed to the development of a shared vision for the Pioneer bids, but appeared to have been less helpful in supporting implementation plans. This is hardly surprising since the national definition of integrated care included nothing about what would produce person-centred, coordinated care and nothing about how to bring it into existence. Our most recent data collection (in spring/summer 2015) has tended to reinforce this perception and suggests that the early optimism is becoming somewhat more muted and less widespread. We also think these findings are related to the inherent difference between, on the one hand, securing collective agreement to a desirable future state to bring about change and, on the other hand, securing commitment to implementation programmes that set out the real changes in investment, working practices and organisational responsibilities which the vision implies.

Moreover, it is at the point of implementation that local capabilities to effect change may become more attenuated. As we noted previously, and our analysis in chapter 7 has tended to confirm, many of the barriers to integration continue to be factors outside the immediate control of local actors, whereas the facilitators are more frequently open to local influence. At the same time, many of the more entrenched barriers only become salient at the point of implementation, whereas their influence may not be given sufficient weight when strategic plans and bids are in preparation. The tendency to underestimate the impact of such barriers can be expected to be reinforced when, as was the case with the Pioneer programme (National Collaboration 2013, Department of Health May 2013), the invitation to become a Pioneer referred to ongoing national work to address barriers and offers to provide support locally where they persisted or were uncovered, Thus, for example, information sharing, payment systems, financial constraint, regulatory frameworks, professional demarcations and workforce planning were all being experienced as factors slowing down or impeding progress. However, in general, we have seen that the Pioneers were critical of the persistence of such barriers and the length of time it was taking the national partners to address and remove them.

Narrower ambitions or pragmatic implementation?

The above considerations may go some way to providing explanations for the limited evidence of change in service delivery to date except in a few Pioneers (e.g. some sites have reported major impacts associated with service changes, albeit limited in scope), despite the expectation that Pioneers would be able to get into delivery mode quickly and enable other areas to build on their experience. This explanation may also help to account for the narrowing of objectives, compared with the ambitions of the bids. We have already suggested that national policy was potentially important in steering Pioneers to focus on a more limited set of interventions to meet immediate pressures. In addition, this narrowing vision may also be seen as a pragmatic response to the enduring impact of barriers that have yet to be addressed nationally, as well as to discovering that some local partners were less committed to the Pioneer vision in practice than was apparent during the process of writing the Pioneer bid. The latter interpretation is supported in some respects by several recent studies on commissioning that found progress was more readily achieved in relational aspects, such as service design and planning, than in the transactional ones involved in delivering significant change to the allocation of resources through contracting (Bardsley et al 2013, Porter et al 2013, Smith et al 2013a, Smith et al 2013b).

There is a further possibility to consider, which is that Pioneers have not so much scaled down their ambitions for the five years as a whole but only in the short-term while they put measures in place to address the immediate demand pressures from those most at risk of hospitalisation. Such an approach can be seen as another pragmatic response to the circumstances in which they found themselves. On the other hand, it is equally important not to lose sight of the long-term objectives, not least if the return on investments and activities require long lead times. In this respect, it is not clear, in the Pioneers that appear to be scaling down ambitions and objectives, whether there continues to be a commitment to their initial wider vision. This is another issue to be pursued in the subsequent evaluation.

Finally, it becomes important to consider the implications for integrated care of this combination of pragmatism and reduced ambition. The combination of focussing on interventions associated with strengthening multidisciplinary teamwork in primary care settings, together with the persistence of barriers to integrated commissioning and service delivery, may tend to encourage greater vertical integration in the NHS (more in line with the intention of the Vanguards) but do little to promote place-based integration across all the agencies that impact on the determinants of health, especially the involvement of local government. If this were to occur, it would focus integration on the medical, rather than social, model of care and limit the programme's impact on the objective of improving health and wellbeing to which many Pioneer bids referred. We will monitor this potential development over the longer-term evaluation.

A related issue is whether this approach is effectively reinforcing two linked but separate systems of assessment and case management for older people with multiple needs for health and care, one located in primary health care and a second in adult social care. Alternatively, are there signs of unified systems being planned? At a time when radical resource sharing appears necessary, it is important to clarify how far developments in the name of integrated care might tend to strengthen separate delivery systems.

While in no way planned or anticipated, it does seem possible that this will emerge from the configuration of influences operating in some sites. In the interim report, we suggested that the 'radical new care delivery options' outlined in the 'Five Year Forward View' (NHS England and Partners 2014) might reinforce such a direction of travel in the Pioneers. Although parts of only three of the first wave Pioneers are also Vanguards, more of the second wave of Pioneers overlap with the Vanguards. Already there are signs that the Vanguards' care models have influenced thinking within the Pioneers. For example, the 'multispecialty community provider' model of care is beginning to shape strategic thinking in some Pioneers.

Getting easier?

It is not uncommon for the Pioneers to be described, or to describe themselves, as being on a journey towards integrated care. The initial timescale for that journey was five years, not just for themselves but across the system as a whole, so that integrated care would become the norm throughout England. The Conservative Party's manifesto for the 2015 general election suggests that the target will now be 2020, two years later (Conservative Party 2015). Both the history of integrated care and the experience of the Pioneers suggest that timetable is likely to be less unrealistic. Embedding large-scale cultural change is not a short-term process. So far, as we have seen, the extent to which the Pioneers have delivered actual changes to service patterns and service delivery is modest. We do not have the data to quantify this precisely, and would face the usual difficulties of attributing causation even if we did. Monitoring changed activities and outcomes is, however, a priority for both central government and the longer-term evaluation and we will be seeking to understand better the link between Pioneer activities/interventions, outcomes and experiences in the next stage of the evaluation.

For the present, however, our evidence allows some scope to reflect on the nature of the journey rather than the destination. In our second wave of interviews (in spring/summer 2015), it appeared that the hard task of turning ambitions into delivery was still at an early stage. We have sought to understand why this might be the case and have presented our evidence in previous chapters on barriers and progress. We repeat here that the Pioneer programme was still at an early stage at that time, only 15 months since it began in April 2014, though we also recognise that some Pioneers presented their bids as building on extensive experience and some also indicated implementation would begin immediately following the programme's launch in late 2013, suggesting that, for them, the programme was at least 18 months old. It is also relevant that the national selection process sought to identify Pioneers that could advance rapidly and share learning quickly so that all parts of the country could make a reality of integrated care within five years.

Nonetheless, perhaps the single most important consideration about the Pioneers at present is whether our data suggest that the journey is getting easier or more difficult. On one scenario, the Pioneers could be seen to have spent this initial period laying foundations from which they can make more rapid progress from design to delivery, roll-out service change and begin to share learning more widely. On another, the barriers and difficulties they have experienced could prevent exactly such a development. At present, we have little evidence to support the first scenario, though it is one which we will explore over the next 12 months. However, the evidence from our most recent interviews suggests that the journey is not getting easier. In addition to the inherent difficulties of large-scale transformative change, the environment

in which the Pioneers are operating is getting harsher and, in many respects, increasingly unsupportive of whole systems transformation.

Our interim report drew attention to the existence of an 'integration paradox', an environment in which integration is increasingly necessary to improve outcomes and secure sustainable services, but also increasingly difficult to bring about because the same environment increases the incentives to defend existing roles and resources for fear of something worse. The extent to which, in this environment, the ambitions and goodwill of organisations and frontline staff can be nurtured to support personalised and coordinated care, together with the systems that this requires, will be an important determinant of outcomes from the Pioneer programme.

Implications for the longer-term evaluation

In the course of this chapter, we have identified a number of issues which this early evaluation has suggested might be core questions for continuing study.

1. How far are Pioneers tending to converge towards a common pattern of interventions based on multi-disciplinary teams organised around primary care?
2. How far are initial ambitions being scaled back, especially in respect of the focus on promoting wellbeing and tackling the social determinants of health as well as promoting whole system change locally in health and care?
3. To what extent are Pioneer activities being defined by immediate pressures to contain demand at the boundaries of hospital services?
4. As well as national policy and resource influences, to what extent are variations in local context impacting on activities and outputs?
5. To what extent does the Pioneer programme provide space for local innovation and initiative?
6. What is the influence of the Five Year Forward View's new models of care on forms of integration as they are emerging in Pioneer sites?
7. To what extent do place-based models of horizontal integration between the NHS and social care versus more vertically integrated service-based models within the NHS begin to emerge? How far are they compatible and mutually reinforcing?
8. Can the national partners offer to mitigate the impact of national barriers on local integration be fulfilled more speedily?
9. To the extent that convergence in Pioneer activities takes place, does this assist in the development of a robust typology of Pioneers across the larger number of sites?
10. How important a factor in driving the development of integrated care is the 'national definition' of it as 'personalised and coordinated care'? What other definitions of and objectives for integrated care are influencing change alongside this person-centred perspective?

All these issues are shaped by our early qualitative evaluation and represent some key points emerging from our analyses of implementation up to spring/summer 2015. It is possible that some of the trends we have identified will not materialise and we emphasise again that it is generally too early to tell how significant they might become. Equally, for the longer-term evaluation, we think it will be important to maintain a focus on the original and continuing aims of each of the Pioneers and the programme overall.

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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 2013 (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 and Isles of Scilly

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.

A more connected and joined up approach has reduced unnecessary hospital addmissions for patients.

Appendix B
Topic guides for interviews with Pioneer staff

Topic guide for first round of interviews (spring – autumn 2014)

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/service 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?

Topic guide for second round of interviews (spring – summer 2015)

1. Have there been any significant changes to the main aims/objectives of your integrated health and social care Pioneer programme as compared to the initial proposal?

2. Which initiatives in your programme involve new services/new models of integrated care, and which were existing models of care (perhaps scaled up)?

3. Is implementation on track, compared with the programme and expectations set out in the original bid/when you were first awarded Pioneer status?

4. To what extent has the national definition of integrated care as 'person centred, coordinated care' (including the 'I Statements') been an important influence on the design and implementation of Pioneer activities to date?

5. Have patients/service users and informal carers begun to experience any changes in service delivery specifically as a result of the Pioneer's work?

   – If "yes", which services, which groups of patients/service users and about how many?
   – If "no", when will the Pioneer begin to produce changes in services at the individual level – which services, which groups of patients/service users and about how many?

6. What factors have limited the extent and pace of implementation to date? What do you think will limit its continuing development in the future?

7. If a minister were visiting your Pioneer, what would you want her/him to see and learn about your work and progress? Why?

8. Does national government need to do anything more or differently to support the development of integration 'at scale and pace'?

9. Are providers' (health, social care, others) sufficiently engaged in the development of integrated models of care and the delivery of the Pioneer? Are they involved in governance arrangements? How far do they see local integrated care initiatives as threats or opportunities to their business models?

10. What are the main learning points from your experience that you would wish to share with the second wave Pioneers?

11. Finally, a few questions on local evaluation and monitoring:

    – Is a local evaluation of your Pioneer underway or planned? Who is/will be undertaking the evaluation?
    – Which indicators is your Pioneer using to monitor its progress and for which patient/service user groups? Which of these do you regard as your most important measures of success? How would you judge success on these indicators?
    – In terms of your indicators, have you started tracking the progress you have made?

12. Is there anything you would like to add about your experience of being part of the Pioneer programme?

Appendix C Table C1: Key features of the Pioneers (autumn 2014)

Barnsley	
1. ABOUT THE PIONEER	
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.

Barnsley

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.

Cheshire

1. ABOUT THE PIONEER		
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.

Cheshire

3. INFRASTRUCTURE AND ENABLERS

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.

Cornwall

1. ABOUT THE PIONEER

1.1	Lead and other organisations involved	Age UK Cornwall & Isles of Scilly, Age UK national, Cornwall Council, Cornwall Partnership Foundation Trust, NHS Kernow CCG, Peninsula 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.

Cornwall

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.

Greenwich

1. ABOUT THE PIONEER

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.
1.3	Pioneer catchment area	Local Community Based Care Transformation Steering Groups for LTC, mental health, unscheduled care, primary care, planned care and children.
1.4	Target population	Greenwich local authority area.
1.4.1	Inclusion criteria	Older adults with complex or chronic conditions and individuals with mental health issues. Currently considering widening the approach to other populations.

Greenwich	
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.

Islington

1. ABOUT THE PIONEER

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 co-terminus).
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 1 patient/service user representative on the Integrated Care Board. Involvement from Healthwatch.
2.5	Timelines (priorities/targets)	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.
		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.

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.

Islington

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/service 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'.

Kent

1. ABOUT THE PIONEER		
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.

Kent

3. INFRASTRUCTURE AND ENABLERS		
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.

Leeds

1. ABOUT THE PIONEER		
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

Leeds

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.

North West London

1. ABOUT THE PIONEER

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.

North West London

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).

South Devon and Torbay

1. ABOUT THE PIONEER		
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.

South Tyneside

1. ABOUT THE PIONEER

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.

Southend

1. ABOUT THE PIONEER

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.

Southend

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).

Staffordshire and Stoke

1. ABOUT THE PIONEER		
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.

Staffordshire and Stoke

3. INFRASTRUCTURE AND ENABLERS		
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.

Waltham Forest, East London and City (WELC)

1. ABOUT THE PIONEER		
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.

Waltham Forest, East London and City (WELC)

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.

Worcestershire

1. ABOUT THE PIONEER

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.

Worcestershire		
2. INTEGRATION PROCESS		
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.

Appendix D Participation of Pioneers in other national health and care initiatives

	Vanguard	Integrated Personal Commissioning	Social Impact Bonds (SIBs)*	National Technology Fund: First Round	£	National Technology Fund: Second Round	£	Prime Minister's Challenge Fund
First wave Pioneers								
Barnsley		Barnsley						37 practices, £2.2m
Cheshire	West Cheshire(2)	West Cheshire		CWPFT-Mobile working East Cheshire Trust: integrated care with mobile working	393,000 734,970			West Cheshire, 37 practices, £3.8m, South Cheshire + VR, 23 practices, £1.9m
Cornwall		Cornwall in South West Consortium	Personalised interventions	CP-FT Cornwall Pioneer+ Mobile equipping	303,200 696,800			
Greenwich				Digipens for clinical recording and upload (Oxleas)	165,000			
Islington						Camden and Islington FT. mobile access (i-nurses)	713,000	37 practices, £2.4m
Kent	Whistable Canterbury CCG(2)			Care planning in the community	70,000			Integrated South Kent Coast Dover and Folkestone 3 GP practices, Royal Victoria Hospital Hub, Folkestone walk in centre, Dover Hub £1.89m
Leeds				Adult community services, electronic patient record	774,000			38 practices, £1.5m
North West London				Ealing HT, Mobile community district	450,000			396 GP practices, £5m
South Devon and Torbay		South Devon and Torbay in South West Consortium		Learning disability nurses+ mobile nursing in MH	103,215 295,000	DP FT- Remote F2F, video consultations nurses	204,000	Shaping community services, £3.575m
South Tyneside								
Southend						Southend FT, Digital record in hospital	975,000	
Staffordshire and Stoke								

	Vanguard	Integrated Personal Commissioning	Social Impact Bonds (SIBs)*	National Technology Fund: First Round	£	National Technology Fund: Second Round	£	Prime Minister's Challenge Fund
First wave Pioneers								
Waltham Forest, East London and the City (WELC)	Tower Hamlets(2)	Tower Hamlets		East London NHS FT, community nursing mobile	198,000			36 practices (Tower Hamlet), £3.1m
Worcestershire			Social isolation			WHCom NHS Trust, mobile devices for integrated community nursing	904,000	32 practices, £2.2m
Second wave Pioneers								
Airedale, Wharfedale and Craven	Airedale NHS Foundation(3)							
Blackpool and the Fylde Coast	Fylde Coast Local Health Economy(2)			Com. Nurse mobile working (BTH-FT)	54,000			
Camden								
Greater Manchester	Salford(1) Stockport(2)		Foster care	University hosp. South Manchester FT, mobile working in the community	252,000	Central Manchester NHS FT, mobile access community	289,000	30 practices, Bury, £2.7m
Nottingham City	Nottingham City CCG(3)							
Nottingham County	Mansfield and Ashfield and Newark and Sherwood CCGs(1) Principia(3)							152 Practices, £5.2m
Sheffield								87 practices, £9.3m
South Somerset	Yeovil District Hospital NHS FT(1)							
Vale of York								
Wakefield	West Wakefield Health and Wellbeing Ltd(2) Wakefield CCG(3)							
West Norfolk								

* Not all SIBs agreed (1) Integrated primary and acute care systems (2) Multispecialty community providers (3) Enhanced health in care homes

Appendix E Logic models for individual Pioneers (spring 2015)

Barnsley

Context	Input	Output	Outcomes	Impact
Issue and its setting	Resources and activities	Products of activities including service types and targets	Changes in participants' behaviour, skills, level of functioning	Changes in organisations, communities or systems (intended and unintended)
National issues: • Services not experienced as 'joined up', tailored to individual needs • Care models reactive, institution focussed, costly and disempowering • Organisational response shaped by silo structures of services, systems and professions • Growth of demand and limits on resources mean current care models and service infrastructures are unsustainable • Initiatives to integrate care delivery and planning have had very limited success **National policy:** • 'I Statements' to structure more personalised and holistic assessments • Proactive care programme targeting 2% most at risk of admission • Information sharing via NHS number • BCF plans to focus on avoidable admissions and realistic savings • Telehealth/telecare enable people to be supported at home • National support programme for Pioneers and commitment to remove barriers **Local context:** • Significant change needed to respond to need: – to impact of inequalities on health and wellbeing – to regenerate local economy – to deal with demographic pressures – to meet cuts to public funding and pressure to change health and social care services – to adopt new technologies	• Pioneer integral element of JHWS implementation and a resource for making it happen • Pioneer activities intended to help invert triangle of care and fundamentally shift the focus from statutory interventions, to more holistic engagement and a citizenship approach at individual, family and community level. • The provision of information, advice and signposting, is key alongside access to flexible and integrated service pathways which support people to maintain control and enable self-management wherever possible, including improved access to telecare and other equipment and adaptations which allow people to remain independent and safe. • Pioneer accountable to HWB and largely delivered through three programme boards: Ageing Well, Promoting Independence and Think Family • Specific programmes include: – 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; – Intermediate Care review; a target operating model for assessment and care management systems; – Integrated personal budgets.	• Easier access to information and advice to help people make the right choices for them about their care and support across the whole system for both service users and staff to navigate services. • Reduced reliance on traditional, statutory services, signposting people to alternative services • Fewer admissions to care homes and for shorter duration towards the end of life • Improved 'welfare' support, particularly those who are isolated, lonely and/or have poor mental wellbeing • Care and support needs met locally wherever possible with an enhanced choice of support options • An increased level of self-care and people managing their own care and support needs • Fewer admissions to hospital and less time spent in hospital for patients who need to be admitted • More cost-effective use of resources • More appropriate use of clinicians' /professionals' time so that they can concentrate on issues for which they are trained and skilled • An increase in the range of services offered by providers, leading to a more holistic package of care	• Additional years of life for people with treatable mental and physical health conditions. • Improved health-related quality of life for people with one or more LTC • People supported to achieve safe, healthy and independent living • People exercising greater choice and control, thereby delaying and reducing the need for care and support. • People improving health through lifestyle choices • Carers supported to be able to undertake their responsibilities and have opportunities to develop their health and wellbeing outside of their caring role. • An asset, not a deficit model to health and wellbeing brings about the change required across Barnsley communities based on engagement and behaviour change, both in professionals and those in receipt of services.	• Barnsley residents, throughout the Borough, lead healthy, safe and fulfilling lives and are able to identify, access, direct and manage their individual health and wellbeing needs, support their families and communities and live healthy and independent lifestyles • Move to localism and active engagement of local people in design and delivery of local services • Increased community resilience and reduced reliance on the state • Transformed and sustainable health and wellbeing system oriented towards prevention, self – management, community development and, where necessary, integrated delivery systems ensuring holistic care and support

Barnsley

Context	Input	Output	Outcomes	Impact
Issue and its setting	Resources and activities	Products of activities including service types and targets	Changes in participants' behaviour, skills, level of functioning	Changes in organisations, communities or systems (intended and unintended)
• As a result, whole system transformation is only sustainable way forward • JHWS with system wide vision for health and care, shared values and priorities for 2014 to 2019, delivery plan and framework for impact measurement • JHWS based on pathway integration and redesign rather than structural integration • Emphasises provision of better information, advice and signposting to alternative services to promote self-help, self-management of long-term conditions as a critical enabler of future sustainability and developing more effective prevention, re-ablement and targeted time limited interventions • All will combine to reduce dependence on institutional/bed based provision and ensure more effective management of long-term conditions.	• Other relevant interventions include: tele-healthcare; stronger and troubled families' initiatives; an innovative model of involving communities in the design and delivery of neighbourhood services (the Dearne approach); and workforce cultural change in dementia services through the "Home Truths" national development programme. • BCF programme developed and delivered within the framework of JHWS, Pioneer and national priorities and outcomes			

Cheshire

Context	Input	Output	Outcomes	Impact
Issue and its setting	**Resources and activities**	**Products of activities including service types and targets**	**Changes in participants' behaviour, skills, level of functioning**	**Changes in organisations, communities or systems (intended and unintended)**
National issues: • Services not experienced as 'joined up', tailored to individual needs • Care models reactive, institution focussed, costly and disempowering • Organisational response shaped by silo structures of services, systems and professions • Growth of demand and limits on resources mean current care models and service infrastructures are unsustainable • Initiatives to integrate care delivery and planning have had very limited success **National policy:** • 'I Statements' to structure more personalised and holistic assessments • Proactive care programme targeting 2% most at risk of admission • Information sharing via NHS number • BCF plans to focus on avoidable admissions and realistic savings • Telehealth/telecare enable people to be supported at home • National support programme for Pioneers and commitment to remove barriers **Local context:** • The area includes approximately 700,000 residents, with a diversity of urban centres, alongside market towns and rural communities, and a rapidly ageing population and cost pressure. • Pan-Cheshire approach to integration focussing on supporting enablers (information sharing, contracting models, and workforce development) as well as existing locality plans that are being expanded. • Involvement in previous integration schemes (whole place community budget in West Cheshire)	• A joint governance board established through the Connecting Care in Cheshire Pioneer Panel • Partnership with ambulance services, fire and rescue services **Pan Cheshire (Connecting Care across Cheshire):** • Use of the 'I Statements' • Joint investment plan for the voluntary sector community • Support to carers • BCF pooled funds to support integration • Care coordinators to manage cases • Investment in integrated enablers (integrated care records, information sharing, community equipment, contracting models, empowerment of residents) • Cheshire Learning & Improvement Academy to enable culture/OD change **West Cheshire Way:** • Workforce development plans • Telehealth • Extra care housing and social care provision • Personal Social Care Capital Grant • Ageing well CQUIN **Mid-Cheshire (Connecting Care):** • Workforce development plans • Provider Board and Commissioner Alliance to manage service change • System integration 'measures' how do we know when it is working **Eastern Cheshire (Caring Together):** • Workforce development plans • Self-care and management introduced • Engagement strategy and co-design of services • Cultural transformation • Integrated care framework including ambitions, standards and outcomes	**Pan Cheshire (Connecting Care across Cheshire):** • Integrated case management: single point of access into services; risk stratification; case management for 30,000-50,000 people; joint assessment tools based on shared IT • Integrated communities: Personal Health Budgets for people with learning disabilities initially; enhanced volunteering capacity; support to carers, paramedic pathway programme • Integrated commissioning: redesigned transition care including intermediate care; redesigned intervention pathways (children in care, alcohol and drug, wellness service, housing support, families interventions, palliative care) • Full package of care for older adults (including assistive technology) **West Cheshire Way:** • Integrated care management teams wrapped up around GP practices. • Care coordinator service to support integrated teams • Early support case management team for complex families • Multi-agency falls service • Hospital at home • Provider hub for mental health commissioning • Integrated crisis and reablement team • Early support discharge • Frailty pathway • Children with disability pathway • Joint specification for care home • Tackling isolation scheme	• Increased percentage of patients with integrated care plans that meet their needs • Improved user access to services • Overall improved service users and carers satisfaction levels • Improved staff satisfaction • Cost savings • Reduced unplanned avoidable admissions, length of stay in hospital, readmissions and delayed transfers of care • Reduction in emergency admissions from baseline by 15% by 2019 (WC) • Increase in people who feel supported to manage their LTC • Reduced numbers of injuries due to falls in 65+ • Shift in resources from hospital bed-based to community/home-based • Reduction in long-term placements	• Improved health and social care related quality of life for people with long-term conditions • % of patients recovering their previous level of mobility at 30 and 120 days • Cost reduction in health and social care

Cheshire

Context	Input	Output	Outcomes	Impact
Issue and its setting	Resources and activities	Products of activities including service types and targets	Changes in participants' behaviour, skills, level of functioning	Changes in organisations, communities or systems (intended and unintended)
		Mid-Cheshire (Connecting Care): • Multi-agency neighbourhood teams • Support to complex families through multi-agency intervention teams (health, social care, police) • First steps pathways for children with complex health conditions • Redesign of urgent care services to integrate services and increase 'localised' care **Eastern Cheshire (Caring Together):** • Community teams structured around GP practices clusters, with dedicated coordinator • Integrated mental health teams • Short Term Assessment Intervention Recovery & Rehabilitation Service (STAIRRS)		

Cornwall

Context	Input	Output	Outcomes	Impact
Issue and its setting	**Resources and activities**	**Products of activities including service types and targets**	**Changes in participants' behaviour, skills, level of functioning**	**Changes in organisations, communities or systems (intended and unintended)**
National issues: • Services not experienced as 'joined up', tailored to individual needs • Care models reactive, institution focussed, costly and disempowering • Organisational response shaped by silo structures of services, systems and professions • Growth of demand and limits on resources mean current care models and service infrastructures are unsustainable • Initiatives to integrate care delivery and planning have had very limited success **National policy:** • 'I Statements' to structure more personalised and holistic assessments • Proactive care programme targeting 2% most at risk of admission • Information sharing via NHS number • BCF plans to focus on avoidable admissions and realistic savings • Telehealth/telecare enable people to be supported at home • National support programme for Pioneers and commitment to remove barriers **Local context:** • Current focus of health care relies too heavily on reducing risks and makes people too dependent on services • Currently, there is a gap of £31m between health & care services available and what is needed • Many living on low incomes (e.g. in absence of mains gas in over half of homes, it can be too costly to stay warm and eat healthily) • Higher than average 65+ and 85+ population, with 34,000+ older people living alone (many in isolated rural areas)	• Collective leadership of the LW programme with new governance arrangements • All partners (CCG, LA, hospitals, community & ambulance services, voluntary organisations, patient groups) agree common vision, values and shared framework • Staff training to develop and maintain skilled workforce which is flexible and integrated • Engage frontline staff and local population (including local Healthwatch) in re-design of services • Implement information governance solutions that support information sharing • CCG & LA to jointly commission services and pool budgets • New contract to facilitate collaboration between providers • Co-located MDTs to include health, social care and voluntary sector workers, based around GP practices • Provision of time to build MDT and nurture team ethos • Training of voluntary sector coordinators and volunteers to help people identify goals and build local support network • Creation of a 'community map' of local resources/voluntary groups • Role/responsibilities and shared toolkits (e.g. MDT guidance) developed within local teams, with accountable lead professionals	• Increased number of people providing community/peer support • Improved quality of life for enrolled patients (20% improvement as measured by Short Warwick-Edinburgh Wellbeing scale) • Reduced duplication (e.g. shared patient information collection and reduction in referral forms) • Reduced emergency admissions (11%) and A&E attendances • Reduced number/cost of social care packages • Reduced length of stay and readmissions • Cost savings in acute, community, mental health services	• Improved patient/service user health and wellbeing (physical, mental, social) • Improved lifestyle choices • Improved experience of care and support (patients and carers) • Greater involvement of voluntary/community sector in supporting frail/vulnerable people • Increased independence for people with LTCs • Improved staff morale/experience • Resources moved from spending on treatment to prevention	• Care is experienced as personal, joined up and enabling independent living • Improved individual health and wellbeing • More cost-effective service models, improved value for money • Local communities more 'self-sufficient'/resilient • Lower per person health and social care costs • More sustainable fit between need and resources

Cornwall

Context	Input	Output	Outcomes	Impact
Issue and its setting	**Resources and activities**	**Products of activities including service types and targets**	**Changes in participants' behaviour, skills, level of functioning**	**Changes in organisations, communities or systems (intended and unintended)**
• Newquay Pathfinder successfully tested Living Well (LW) approach • Extensive community and voluntary networks can be used to provide more support • Early intervention service implemented • Participated in Whole Systems Demonstrator project	• Identification of people who have 2 or more long-term conditions or a social care package, and enrol them in Living Well programme (e.g. using risk stratification or those in receipt of social care) • Identification of conditions most receptive to Living Well approach of supporting behaviour changes and integrated care pathways • Enrolled patients have 'guided conversation' with matched volunteer, case management plans drawn up and shared among local MDT, and key worker allocated • Local MDT provides support to patients and carers • Patients provided with rapid assessment in acute care to reduce time in hospital • Patients with specific short-term conditions provided with telehealth • Patients provided with discharge support • Virtual ward model provides support to prevent admissions • Shared outcomes and measures for performance monitoring			

Greenwich

Context	Input	Output	Outcomes	Impact
Issue and its setting	**Resources and activities**	**Products of activities including service types and targets**	**Changes in participants' behaviour, skills, level of functioning**	**Changes in organisations, communities or systems (intended and unintended)**
National issues: • Services not experienced as 'joined up', tailored to individual needs • Care models reactive, institution focussed, costly and disempowering • Organisational response shaped by silo structures of services, systems and professions • Growth of demand and limits on resources mean current care models and service infrastructures are unsustainable • Initiatives to integrate care delivery and planning have had very limited success **National policy:** • 'I Statements' to structure more personalised and holistic assessments • Proactive care programme targeting 2% most at risk of admission • Information sharing via NHS number • BCF plans to focus on avoidable admissions and realistic savings • Telehealth/telecare enable people to be supported at home • National support programme for Pioneers and commitment to remove barriers **Local context:** • High levels of inequality with areas of high deprivation and illness and poor health outcomes • High burden of mental health disorders, especially depression • From 2011, a new model of integrated rapid response & intermediate care/reablement introduced • Pioneer aligned with the wider South East London Strategy to group primary and community services together in 'local care networks'. • 'Test and learn' approach	• All partner organisations working together to achieve integrated care based on 'I Statements' (this includes voluntary sector and housing) • A joint governance board established for the implementation and monitoring of the integrated care interventions • Joint performance management and collective KPIs • Link with Healthwatch and local patient/public workshops to co-produce services specifications • BCF pooled funds to support integration • Functionally integrated health and social care teams based on localities • Further involvement of mental health services • Appointment of new staff (navigators) to be a single point of contact for patients and carers through the system • Provision of additional support to carers • Staff training to support new roles • Development of virtual patient record • Risk stratification to identify 11.5% at highest risk of hospital admission within one year (1500 pers.) • Investment in telehealth and web-based information services	• Shared care plans produced by multi-disciplinary teams collaboratively (Greenwich Co-ordinated Care Meetings (GCCMs)) • Joint health and social care assessment, planning and case management • Improved health and social care navigation/one stop shop • Initiatives to support self-care and patient education (including telehealth) • Greenwich Joint Emergency Team (JET), providing assistance in response to acute episodes (2 hour target response time) • Improved care from Community Assessment & Rehabilitation Team (CARs) • Acute discharge support service (for mental health patients) • Personal Health Budgets • Care pathways further developed for diabetes, COPD, dementia, etc) with named links to specialist services • Expansion of services provided by voluntary sector, notably to combat isolation • Homecare services on a geographical basis to align with the span of the Local Care Networks and core teams • Access to the medical diagnostic centre and ambulatory care at the acute trust and outreach specialist opinion • Delivery of frail elderly care pathway (through alliance contracting)	• Integrated working based on the 'I Statements' • Increased percentage of patients with integrated care plans • Improved user access to services • Improved staff satisfaction and lower staff turnover compared with other boroughs • Cost savings (BCF £3.8 million out of £19.8 million pooled funds) • Reduced unplanned avoidable admissions, length of stay in hospital, readmissions and delayed transfers of care • Reduced admissions to residential care and nursing homes • People feeling supported to manage their LTCs • Reduced spending in secondary care • Social care budget reduced (>50% fewer people entering full social care) • Increased provider participation in integrated care	• Improved health outcomes (reduced potential years of life lost, improved health-related quality of life of people with LTCs, % of over 65s still at home after 91 days from hospital discharge) • Total costs of health and social care lower • Care is co-produced and empowering independent living

Islington

Context	Input	Output	Outcomes	Impact
Issue and its setting	**Resources and activities**	**Products of activities including service types and targets**	**Changes in participants' behaviour, skills, level of functioning**	**Changes in organisations, communities or systems (intended and unintended)**

National issues:
• Services not experienced as 'joined up', tailored to individual needs
• Care models reactive, institution focussed, costly and disempowering
• Organisational response shaped by silo structures of services, systems and professions
• Growth of demand and limits on resources mean current care models and service infrastructures are unsustainable
• Initiatives to integrate care delivery and planning have had very limited success
 	
National policy:
• 'I Statements' to structure more personalised and holistic assessments
• Proactive care programme targeting 2% most at risk of admission
• Information sharing via NHS number
• BCF plans to focus on avoidable admissions and realistic savings
• Telehealth/telecare enable people to be supported at home
• National support programme for Pioneers and commitment to remove barriers
 	
Local context:
• Islington has 28, 000 residents who have one or more long-term conditions
	• A shared vision of Integrated care 'to deliver a step change in health and social care outcomes for our populations, by taking a whole system approach to service planning and delivery and supporting the population to better manage their health through mobilising their own abilities and the assets in the community'
	• Patient involvement in commissioning
	• Personal budgets
	• Innovative workforce roles
	• Improved career paths for staff
	• Work programme in IG, data sharing and IT interoperability
	• An integrated care organisation providing acute, community and primary care services
		• Neighbourhood based multi-disciplinary teams:
		  – Risk stratification
		  – Personalised care plans
		  – Primary care navigators
		• Self-care programme
		• Integrated discharge
		• Rapid response
		• Re-designed care pathways
			• Better patient experience
			• Better patient outcomes
			• Coordinated care for intensive users of services
			• Delivering high quality, efficient services within the resources available
				• Improved health and wellbeing at population level
				• Deliver more sustainable models of care that reduce cost in the system

Kent

Context	Input	Output	Outcomes	Impact
Issue and its setting	**Resources and activities**	**Products of activities including service types and targets**	**Changes in participants' behaviour, skills, level of functioning**	**Changes in organisations, communities or systems (intended and unintended)**
National issues: • Services not experienced as 'joined up', tailored to individual needs • Care models reactive, institution focussed, costly and disempowering • Organisational response shaped by silo structures of services, systems and professions • Growth of demand and limits on resources mean current care models and service infrastructures are unsustainable • Initiatives to integrate care delivery and planning have had very limited success **National policy:** • 'I Statements' to structure more personalised and holistic assessments • Proactive care programme targeting 2% most at risk of admission • Information sharing via NHS number • BCF plans to focus on avoidable admissions and realistic savings • Telehealth/telecare enable people to be supported at home • National support programme for Pioneers and commitment to remove barriers **Local context:** • 1.5 million population, complex H&SC economy. • Generally better than average life expectancy, lower than average heart disease, cancer & stroke. More marked health inequalities in locations (Swale and Thanet).	• Mapping of data sources and better use of intelligence for evidence-based, integrated commissioning. • Whole population risk stratification analysis led by KCC Public Health. • New information governance arrangements put in place to facilitate integration. • Programme Team in KCC to coordinate Pioneer development. • Multi-agency steering group (includes Healthwatch) – governance retained by contributing stakeholders (SG is a working group of HWB). • Kent Innovation Hub/Labs & Consortium for Assistive Solutions Adoption Programme. • TLAP – Kent to work with leads from Think Local Act Personal and National Voices and work on the development of 'I Statement' action plans across the localities of Kent. • Common assessment framework across the Pioneer using FACE (Functional Analysis of Care Environments) when carrying out assessments with service users • Leadership development support to local leaders. • Workforce development to enable 'leadership of place' • Communication and Engagement Group to promote a consistent approach to communications.	• Map of all relevant data sources/intelligence within Pioneer to inform integrated commissioning. • Whole population risk stratification data available. • Functional Information governance arrangements in place facilitating integration. • Kent Innovation Hub/Labs & Consortium for Assistive Solutions Adoption Programme involving a range of local organisations. • Communication and Engagement Group managing communications across the Pioneer. • Development support provided for local leaders. • Workforce 'leadership of place'. • Year of Care (for LTCs) whole system intelligence dashboard and shadow tariff and annual risk adjusted capitation budget. • 'I Statement' action plans are shared and owned across the locality/Kent by the public, staff, multi-organisationally. • Working towards integrated commissioning of all relevant services across the Pioneer. • Personal Health Budgets and Integrated Personal Budgets systems. **Interventions – system-wide:** • All eligible service users identified by risk stratification have a FACE assessment. • All eligible service users identified by risk stratification have an integrated care plan and access to that plan. • All eligible service users identified by risk stratification have access to their patient record. • Universal access to integrated H&SC teams working 24/7 organised around GP practices. • Dementia Action Alliances in place across the Pioneer (intergenerational work with schools and care homes to establish dementia friendly communities). • Non-elective admissions to hospital (general & acute) reduced by 3.5%. • Delayed transfers of care reduced.	• The citizen experience of H&SC in Kent matches the aspiration of the 'I-Statements'. • Eligible patients/service users have been FACE assessed and have access to their own integrated care plans. • Increased independence as people are able to live and die safely at home – supported by joined up services and by anticipatory care plans. • More control and empowerment for citizens to self-manage. • Patients/service users hold their own Personal Health Budgets and Integrated Personal Budgets. • The patients/service users are in control of electronic information sharing and have access to patient held record. • 'I Statements' produced from the identified themes and action plans • Citizens of Kent see services, care and support delivered in line with the 'I Statements', chosen 'You said – We did' approach.	• Whole system integration achieved: transformed local services working across primary, community, hospital and social care services and with voluntary and private sectors. • Improved individual and population health and wellbeing. • Demand pressures contained and managed and a sustainable fit between need and resources. • More cost-effective service models, improved value for money and lower per person health and social care costs.

Kent

Context	Input	Output	Outcomes	Impact
Issue and its setting	Resources and activities	Products of activities including service types and targets	Changes in participants' behaviour, skills, level of functioning	Changes in organisations, communities or systems (intended and unintended)
• Expected population growth (8.4%, n=123,000) over next seven years, especially in older age groups. Demand pressures on H&SC. • Previous history of integration initiatives and related programmes (HASCIP, Whole Systems Demonstrator (telehealth/care), 3 Million Lives, Going Further Faster). • Previous record of joint commissioning for learning disabilities, mental health and older people's services. • Care still experienced as duplicated, disjointed, frustrating, confusing and time-consuming.	• BCF funds: Across Kent, £27m 2014/15, £101m 2015/16. Ambition of 'Kent £' by 2018, supporting and investing in Kent businesses and the local economy, generating employment opportunities. • Local evaluation (University of Kent).	**Interventions – local:** • South Kent Coast & NHS Thanet CCG multi-speciality community providers. • NHS Thanet CCG & Social Enterprise Kent Ageless Thanet project to improve quality of life, physical and mental wellbeing and reduce loneliness and social isolation. • Ashford and Canterbury Neighbourhood Care Teams. • North Kent (DGS &S) Integrated Primary Care Teams, focussing on people at risk of falls. • North Kent (DGS &S) Community Network development for self-management. • Canterbury and West Kent CCG H&SC Coordinators. • North Kent integrated discharge team. • South Kent Coast CCG proactive reablement care – holistic care package, MDT, self-care support. • West Kent enhanced integrated rapid response service – MDT working with ambulance staff to reduce hospital admissions.		

Leeds

Context	Input	Output	Outcomes	Impact
Issue and its setting	**Resources and activities**	**Products of activities including service types and targets**	**Changes in participants' behaviour, skills, level of functioning**	**Changes in organisations, communities or systems (intended and unintended)**
National issues: • Services not experienced as 'joined up', tailored to individual needs • Care models reactive, institution focussed, costly and disempowering • Organisational response shaped by silo structures of services, systems and professions • Growth of demand and limits on resources mean current care models and service infrastructures are unsustainable • Initiatives to integrate care delivery and planning have had very limited success **National policy:** • 'I Statements' to structure more personalised and holistic assessments • Proactive care programme targeting 2% most at risk of admission • Information sharing via NHS number • BCF plans to focus on avoidable admissions and realistic savings • Telehealth/telecare enable people to be supported at home • National support programme for Pioneers and commitment to remove barriers **Local context:** • Leeds is facing significant financial challenges at the same time as seeking to improve outcomes and quality and make Leeds the best city for health and wellbeing. • Transformation is being pursued to reduce costs and provide responsive services (to meet the needs of people not organisations). Ch Execs have committed to work together as if they were a single organisation.	• Shared city-wide vision (to be the best city to live in) • Shared city-wide vision for children (what is it like being a child in Leeds? How can we make it better?) • 5 shared Joint Health & Wellbeing Strategy outcomes (see Impact column) led by HWB • Integrated Commissioning Executive and city wide Directors of Finance group collaborate to make the best use of the Leeds £ • A Transformation Board that brings together all health and social care partners across Leeds • A workstream to develop IT infrastructure to share information. • Workforce development so that staff can work collaboratively and support individuals to self-care.	**Adults:** • Integrated neighbourhood health and social care teams focussed on GP practice populations, aligned with mental health services. **Children:** • Early start service comprising joint teams (children's centre staff and health visitors). • Leeds Care Record: Single electronic care record used across the H&SC system in the city so that all practitioners can see a comprehensive view of patients care	• Services meet the needs of people not of organisations • Care is provided in the most appropriate setting • The overall cost of health and social care in Leeds is reduced	**People in Leeds:** • Live longer and healthier lives • Live full active and independent lives • Have a quality of life improved by access to quality services • Are involved in decisions made about them • Live in healthy and sustainable communities

North West London

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Issue and its setting	**Resources and activities**	**Products of activities including service types and targets**	**Changes in participants' behaviour, skills, level of functioning**	**Changes in organisations, communities or systems (intended and unintended)**
National issues: • Services not experienced as 'joined up', tailored to individual needs • Care models reactive, institution focussed, costly and disempowering • Organisational response shaped by silo structures of services, systems and professions • Growth of demand and limits on resources mean current care models and service infrastructures are unsustainable • Initiatives to integrate care delivery and planning have had very limited success **National policy:** • 'I Statements' to structure more personalised and holistic assessments • Proactive care programme targeting 2% most at risk of admission • Information sharing via NHS number • BCF plans to focus on avoidable admissions and realistic savings • Telehealth/telecare enable people to be supported at home • National support programme for Pioneers and commitment to remove barriers **Local context:** • Acute services reconfiguration to provide safe, sustainable services pre-dating the Pioneer and facilitated by developing 'out of hospital' strategy including primary, community and local authority sectors • Need to improve vertical and horizontal integration within whole system • Collaboration of 8 CCGs pooling top slice of commissioning budgets to support systems transformation across CCGs.	• Governance structure at NWL, borough and local project or early adopter (EA) levels • Development of vision for integrated care • Programme Management Office to implement vision with budget pooled by 8 CCGs, managed by Strategy & Transformation team responsible for: acute reconfiguration; primary care development; whole systems integration (WSIC); mental health transformation programmes • Significant consultancy input • Responsibility for ensuring co-design and timely implementation of overarching transformation framework • Programme Executive with membership from CCGs, local authorities, providers and lay partners. • Road map for delivering outcomes based on: ten steps to integration; time tabled programme for integrated care to become 'business as usual' (Oct 2013 –April 2015 onwards); five time-limited task groups of over 200 people addressing 'tough questions' (population and outcomes; GP networks; provider networks; commissioning and finance; informatics). • Underpinning philosophy of doing once rather than 8 times, wherever possible. • Programme co-designed between NWL and CCG/LA levels to avoid excessive hierarchy and to promote lay partner engagement in all activities. • Early adopter (EA) projects to go 'further and faster' especially by piloting capitated budgets and accountable care partnerships for specific local populations within the NWL wide framework.	• EAs produce accelerated learning which enables integrated care to begin being rolled out from April 2015 as 'business as usual' • One set of records shared across organisations • Care provided in most appropriate setting following multidisciplinary assessment and care planning • Fewer people are treated in hospital, and those that are leave sooner (specific targets in each BCF plan to meet national targets for reduction in avoidable admissions) • More specialist support for management of people in the community e.g. multidisciplinary home care and rapid response teams • More investment in primary and community care services • More investment in proactive models of care including in third sector services to help and keep people well • Less spending on acute hospital based care • Funding flows where it is needed based on capitated budgets • Payments to providers based on outcomes not activity.	• Approach to care delivery is patient-centred and coordinated around needs of individuals • People empowered to direct their care and support and to receive the care they need in their homes or local community • Providers deliver services in ways that positively enable and support independent living • GPs at the centre of organising and coordinating people's care • Social care and mental health needs considered holistically with physical health and care needs • Commissioners pool health and social care funding and attach to population level outcomes • Providers jointly accountable for delivering outcomes within five domains and securing demonstrable efficiencies	• Improved quality of care for individuals, carers and families, able to maintain independence and lead full lives as active participants in the community • An integrated jointly accountable whole system of care and support • Integrated care is the default delivery model (where appropriate to service user needs and circumstances) • Organisational systems enable, not hinder, the provision of integrated care • More cost-effective and, therefore, sustainable whole system

North West London

Context	Input	Output	Outcomes	Impact
Issue and its setting	Resources and activities	Products of activities including service types and targets	Changes in participants' behaviour, skills, level of functioning	Changes in organisations, communities or systems (intended and unintended)
	• MDTs, care coordination and single shared care plans to enable whole systems provision of care around needs of individuals and carers • International and national expert support as needed • Outcomes framework based on 'I Statements' and lay partner engagement • Living toolkit and toolbox comprising practical help in understanding and addressing 'tough questions' • Bids for EA projects and their implementation			

South Devon and Torbay

Context	Input	Output	Outcomes	Impact
Issue and its setting	**Resources and activities**	**Products of activities including service types and targets**	**Changes in participants' behaviour, skills, level of functioning**	**Changes in organisations, communities or systems (intended and unintended)**
National issues: • Services not experienced as 'joined up', tailored to individual needs • Care models reactive, institution focussed, costly and disempowering • Organisational response shaped by silo structures of services, systems and professions • Growth of demand and limits on resources mean current care models and service infrastructures are unsustainable • Initiatives to integrate care delivery and planning have had very limited success **National policy:** • 'I Statements' to structure more personalised and holistic assessments • Proactive care programme targeting 2% most at risk of admission • Information sharing via NHS number • BCF plans to focus on avoidable admissions and realistic savings • Telehealth/telecare enable people to be supported at home • National support programme for Pioneers and commitment to remove barriers **Local context:** • 25% of population is over 65 and 4% over 85 • Predicted 20% increase in demand for health and care services over next 10 years largely driven by an increase in people with multiple long-term conditions associated with old age and by end of life care needs • Pockets of severe deprivation where people tend to experience a poorer quality of life and lower life expectancy; 24% of Torbay children in poverty. • Alcohol related hospital admissions higher than average for England • Torbay has history of successful integrated care initiatives and a shared vision of making things better for 'Mrs Smith' although rolling out will require sensitive negotiation across the new footprint.	• A shared vision of personalised and coordinated care from the perspective of the patient • 5 shared objectives: 1. Improved patient experience 2. More patient involvement 3. Reduced health inequalities 4. Motivated flexible workforce 5. Financially stable system • Governance arrangements that bring together all the leaders in the health and social care system • Multidisciplinary teams working together to define and redesign services • Staff encouraged to be more innovative in how they work and to exchange ideas and good practice • New workforce roles in development • Interoperability IT in development • Involvement of voluntary sector • Joint commissioning • Mapping local assets • BCF plan aligned with Pioneer vision • An integrated care organisation providing acute, community and social care services • GP federations	**End to end frailty service:** • Risk stratification • Single point of access • Care plan and case management • Support at home from community teams providing 7 day a week services • Crisis management • Co-ordinated discharge **Young people's service model:** • Single point of access • Making information available on existing statutory and community services • Linking people with community assets such as peers, community leaders and existing community projects.	• Seamless services • More personalised services tailored to people's needs • People can stay in their own homes where appropriate • People supported in managing their own health • A motivated and flexible workforce • A transfer of resources from inpatient beds to care provided in people's homes	• Improve people's experience of health and care • People's wellbeing is improved by staying healthy • People have a say in the priorities and the care provided by the health and care system • Reduce inequalities in health in South Devon and Torbay area • Increased community resilience and enhanced social fabric • Financially stable health and care system • Reduction in waste and duplication across the system

South Tyneside

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Issue and its setting	**Resources and activities**	**Products of activities including service types and targets**	**Changes in participants' behaviour, skills, level of functioning**	**Changes in organisations, communities or systems (intended and unintended)**
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Southend

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Issue and its setting	**Resources and activities**	**Products of activities including service types and targets**	**Changes in participants' behaviour, skills, level of functioning**	**Changes in organisations, communities or systems (intended and unintended)**
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Staffordshire & Stoke

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Waltham Forest, East London & City (WELC)

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	• Risk stratification to identify patient groups at high risk of hospital admission in next 12 months, and high risk patients enrolled on care planning programme • Care planners create care plans for enrolled patients, request services for them and review care • MDTs, which include specialists (e.g. community geriatrician) and are co-located with GPs, provide support to enrolled patients • Investment in telehealth/telecare • Patients provided with rapid response service and reablement to support them at home • MH patients assessed and referred to appropriate settings (Rapid Assessment, Interface and Discharge, RAID) • On discharge, patients flagged to community teams for supported discharge for resettlement • MH patients given discharge support from secondary to primary care • Dashboard for performance monitoring			

Worcestershire

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Worcestershire

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• Innovative service model already in place, in particular for: – Personal budget and direct payments for social care clients (met target of 25% of eligible people); – Commissioners and providers using mechanisms for public and service user engagement; – Personalised care plans from existing work on: End of life care, Care home project, Risk stratification and Virtual ward schemes • Agreed Five Year Strategy to commission holistic care for those with multiple needs.	• Working with the local LETB, LETC and local providers of education and training to establish an integrated workforce plan for the future • Well Connected IT Group with representation from all partner organisations to provide technical and governance solutions for linkage of patient/service user level electronic records	**Future Lives:** • Reviewing and reforming all aspects of adult social care. It will result in new models of care that promote health and independence, increase choice and control and reduce the need for long-term services by maximising the impact of investment in prevention and recovery. • Personalised care plans 'owned' by the individual and supported where needed by a member of their family or someone acting as a care coordinator under the auspices of their GP team. The person and everyone involved in providing care and support will be able to access and contribute to the individual's care plan electronically which will be accessible, with appropriate controls in multiple locations.		

PIRU

POLICY INNOVATION RESEARCH UNIT

The Policy Innovation Research Unit (PIRU) brings together leading health and social care expertise to improve evidence-based policy-making and its implementation across the National Health Service, social care and public health.

We strengthen early policy development by exploiting the best routine data and by subjecting initiatives to speedy, thorough evaluation. We also help to optimise policy implementation across the Department of Health's responsibilities.

Our partners

PIRU is a collaboration between the London School of Hygiene & Tropical Medicine (LSHTM), the Personal Social Services Research Unit (PSSRU) at the London School of Economics and Political Science (LSE), and Imperial College London Business School plus RAND Europe, the Nuffield Trust and the Public Health Research Consortium.

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