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Early findings from the evaluation of the integrated care and support pioneers in England

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Early findings from the evaluation of the Integrated Care and Support Pioneers in England

Bob Erens, Gerald Wistow, Sandra Mounier-Jack, Nick Douglas, Tommaso Manacorda, Mary Alison Durand, Nicholas Mays

Abstract

Purpose

Integrating health and social care is a priority in England, although there is little evidence that previous initiatives have reduced hospital admissions or costs. Twenty-five Integrated Care Pioneers have been established to drive change ‘at scale and pace’. The early phases of our evaluation (April 2014-June 2016) aimed to identify their objectives, plans and activities, and to assess the extent to which they have overcome barriers to integration. In the longer-term, we will assess whether integrated care leads to improved outcomes and quality of care and at what cost.

Design/methodology/approach

Mixed methods involving documentary analysis, qualitative interviews and an online key informant survey.

Findings

Over time, there was a narrowing of the integration agenda in most Pioneers. The predominant approach was to establish community-based multi-disciplinary teams focused on (older) people with multiple long-term conditions with extensive needs. Moving from design to delivery proved difficult, as many barriers are outside the control of local actors. There was limited evidence of service change.

Research limitations/implications

Because the findings relate to the early stage of the 5+ years of the Pioneer programme (2014-19), it is not yet possible to detect changes in services or in user experiences and outcomes.

Practical implications

The persistence of many barriers to integration highlights the need for greater national support to remove them.

Originality/value

The evaluation demonstrates that implementing integrated health and social care is not a short-term process and cannot be achieved without national support in tackling persistent barriers.

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Introduction

“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)

The lack of connectedness within and between the various elements of the health and social care services throughout England is a common complaint among many patients/service users, and leads to services that are judged to be inefficient and provide poor value for money, as well as leading to poorer patient experiences and outcomes (Goodwin et al., 2012; Audit Commission, 2011; Audit Commission, 2009; Alltimes and Varnam, 2012). There have been many attempts over the past several decades to integrate health and social care services, and the twin pressures of an ageing population and financial austerity are widely seen to have increased its priority still further (NHS England and Partners, 2014; National Collaboration for Integrated Care and Support, 2013). Integrated care is integral to the goal of meeting the ‘Triple Aim’ identified by the Institute for Healthcare Improvement (2014) of improved patient experiences and outcomes while delivering more cost-effective services.

There are many perceived benefits of coordinating health and social care services including (Goodwin et al., 2012):

- 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 admissions
- Improved patient experiences
- Improved patient outcomes
- More efficient use of resources, reduced cost and greater value for money.

A number of previous initiatives to promote integrated care have been independently evaluated – e.g. the Integrated Care Pilots (RAND Europe, 2012; Roland et al., 2012), the Partnership for Older People Pilots (Windle et al., 2009; Steventon et al., 2011), the Inner North West London Integrated Care Pilot (Nuffield Trust, 2013) – and there is little evidence that these have led to reductions in emergency hospital admissions or cost. (Nolte and McKee, 2008; Goodwin et al., 2013; Mason et al., 2015)

Systematic reviews carried out by Cameron et al. (2012) have identified factors that help or hinder joint working. They identified three broad categories of barriers, which are shown in Figure 1, along with the individual barriers associated with each.

(Figure 1 here)

This was the context within which the government in England called for expressions of interest from the ‘most ambitious and visionary’ local areas to become Integrated Care Pioneers which would be capable of driving change ‘at scale and pace, from which the rest of the country can benefit’ (Department of Health, May 2013). Each Pioneer was expected to: deliver improved patient experiences and outcomes; realise financial efficiencies; encompass whole system integration involving health, social care, public health and potentially other public services and the voluntary sector; and, importantly, make central to their plans the Narrative on person-centred care developed by National Voices and Think Local Act Personal’s Making It Real which is typified by the quotation at the start of this article (Department of Health, May 2013). The Narrative describes person-centred coordinated care from an individual’s perspective using a series of generic ‘I Statements’, which are included in Figure 2.

Following recommendations from an expert panel, 14 Wave 1 Pioneer sites were announced in November 2013 (Department of Health, November 2013). A second wave of 11 more Pioneers was announced in January 2015 (the Wave 2 Pioneers) (Department of Health, 2015). The Pioneers were to be given access to expertise, support and constructive challenge from a range of national and international experts, but only very limited additional funding (£20,000 initially, later supplemented with a further £90,000).

(Figure 2 here)

Evaluation methods

The Policy Innovation Research Unit (PIRU) was commissioned by DH to conduct an 'early' evaluation from January 2014 to June 2015 of the Wave 1 Pioneers to:

- Identify, describe and understand their vision, scope, objectives, priorities, plans and leadership
- Identify and describe the 'intervention logics' adopted by the Pioneers in order to deliver their plans and priorities
- Make a preliminary assessment of the extent to which Pioneers were able to address barriers to integration, and
- Make a qualitative analysis of progress of their first 15-18 months.

This initial evaluation included analysis of documentation for each Wave 1 Pioneer, attending local meetings and holding semi-structured interviews with key stakeholders in each site. Subsequently, PIRU was commissioned to conduct a longer-term evaluation (see below) and this article draws on evidence from both phases of the research. The first data source is provided by two rounds of interviews carried out from April to November 2014 and March to June 2015. The number of interviews per site varied, and 197 individuals were interviewed across both rounds (Table 1). The majority of interviews were carried out with senior and middle managers involved in the strategic direction of the individual Pioneers or in the design of the integrated services. Most interviews were carried out face-to-face and the rest by phone. Occasionally more than one person was included in the interview, which lasted typically about an hour. Before each interview, signed informed consent was obtained (or recorded in the case of phone interviews).

The majority of the interviews were carried out with managers from Clinical Commissioning Groups (CCGs) (64 of the 197) or from Local Authorities (68), with the rest coming from acute hospitals (25), community or mental health services (19), voluntary sector (12), primary care (5) and other organisations (4). With the agreement of the participant, interviews were recorded verbatim, transcribed, and entered into NVivo software (version 10) to facilitate the analysis and interrogate the data. A thorough and systematic approach to the thematic analysis of the interviews was employed. A coding frame was inductively developed and refined based upon early rounds of interviews. The interviews from each Pioneer were independently coded by the lead researcher for that site and summaries of significant findings from each site were generated and considered collectively by the research team in order to identify recurrent themes, compare and contrast findings and detect divergent accounts. Periodic review in team meetings enabled differences in interpretation to be discussed. This process allowed the identification of key themes for the study as a whole to be developed.

(Table 1 here)

The second data source is from the initial stages of the longer-term evaluation which runs from July 2015 for up to five years and covers all Pioneers including the 11 Wave 2 sites. The longer-term evaluation aims to assess the extent to which the Pioneers are successful in providing 'person-centred coordinated care', including improved outcomes and quality of care, in a cost-effective way.

It consists of three interdependent work packages (WPs). WP1 is a process evaluation at Pioneer level and aims to understand the service changes and experiences of those in Pioneers, with a particular focus on identifying facilitators and barriers to integrating services and whether or not barriers are overcome over time. The key elements of WP1 consist of identifying aggregate indicators of integrated care and its consequences using administrative data, and a regular survey of a panel of key informants from all 25 Pioneers. WP2 aims to assess the impact and cost-effectiveness of important integration initiatives undertaken by Pioneers. WP3 involves working with Pioneers, national policy-makers and others to derive and spread learning from WPs 1 and 2.

At the time of writing (November 2016), the only results available from the longer-term evaluation are from the first key informant survey. We aimed to include on the panel a spread of key staff within each Pioneer, including at least one person from participating CCGs and one from participating Local Authorities, as well as one person from other important local partners (e.g. local acute hospital, community health service provider, voluntary sector). We also sought to include every member of the Pioneer 'board'/committee or other group responsible for steering integration activities within the Pioneer area. This last category partly accounts for the wide disparity in the number of panel members per Pioneer, which ranged from 3 to 36.

The survey itself involved an online questionnaire (which took about 20 minutes to complete) with email invitations sent out to all 360 individuals on the sample frame. Three reminders were sent out over the 2-month fieldwork period (mid-April to mid-June 2016), which resulted in 98 useable completed questionnaires. After removing 23 individuals who opted out of the panel (e.g. due to changing job) or who had their questionnaire completed on their behalf by another panel member, the response rate was 29.1% of the 'eligible' base of 337. The 98 survey participants provide a good range of individuals across both Wave 1 and Wave 2 Pioneers (61 and 37 respectively) and the types of organisation involved (Table 2).

(Table 2 here)

Since the sample does not provide 'complete' coverage of all key individuals involved in the 25 Pioneers (and no such sample list could ever be definitive given the difficulties in delineating the boundaries of individual Pioneers and their integrated care initiatives), and given the varying sizes of the Pioneers themselves and the differing number of survey participants from each site, it is difficult to provide interpretations of results based on all the responses. For this reason, the data presented compare sub-groups within that total (e.g. Wave 1 versus Wave 2, or CCG versus Local Authority), as such comparisons provide more meaningful insight into the survey results than do distributions for the full sample.

The evaluation was approved by the LSHTM Observational Research Ethics Committee (reference 7215) in March 2014.

Results

The results presented here are based on the qualitative analysis of the interviews carried out with the 14 Wave 1 Pioneers in the early evaluation, along with results from the first key informant panel survey of all 25 Wave 1 and Wave 2 Pioneers.

Pioneer vision, aspirations and target groups

In the interviews, Wave 1 Pioneers articulated a strong sense of vision for their sites, and they nearly always included a reference to ‘whole system’ integrated care or similar, e.g. to ‘transforming’ the whole health and care system, or to adopting a ‘whole person’ approach. The vision often included a strong commitment to full partnership among key organisations, as well as across a range of professions and disciplines to achieve the aim of multi-disciplinary working, which was seen as a vital activity.

Given the focus of the initial call for Pioneers on person-centred care, it is not surprising that all sites expressed their vision of integrated care from the individual’s perspective:

“...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)

In addition, participants generally viewed integrated care as a means of improving care quality and patient/service user experience, despite the financial constraints in which they were operating. The pathway to these goals was usually perceived to be via reducing acute hospital admissions for patients with multiple long-term conditions. In turn, this depended on providing support in non-acute settings focused on maintaining independence and well-being. Strengthening capacity for self-care and an emphasis on prevention were common aspirations, therefore.

Commonly the key target group for Pioneer interventions was described as ‘frail older people’ or ‘people with multiple long-term conditions’ (who tend to be older). Since alternative expressions, such as ‘high service users’ or ‘groups at high risk of hospital admission’, also tend to mainly consist of older people, this group was the target in the majority of the Pioneers (although how the target group was precisely defined and identified could vary between sites). While less common, other target groups were also mentioned including: people with mental health conditions or learning disabilities; cancer patients (in one site); children; carers; and the ‘whole community’, especially for preventive interventions.

Involvement in design of Pioneer

There was considerable variation between Pioneer sites in the structural complexity of the organisational relationships involved (partly due to variations in the geographical scale and population size of the sites), ranging from the relatively simple (e.g. sites where there is one CCG, one Local Authority and one acute trust with largely overlapping boundaries) to the relatively complex (e.g. one Pioneer included eight CCGs, seven Local Authorities and multiple NHS acute trusts).

The recent online survey asked key informants how involved different types of individuals and organisations were in the design of their local Pioneer programme. Views on levels of involvement varied according to the organisation the survey participant worked for, as Table 3 shows.

(Table 3 here)

Table 3 shows that participants who worked for CCGs ranked CCGs as the most involved, while Local Authority participants gave the highest ranking to Local Authority involvement. Both groups reported a relatively low level of involvement in the design of the Pioneer programme of GPs/primary care and NHS Trusts. CCG participants were much more likely than those from Local Authorities to say that individual service users and carers, the local population and user

representative organisations were ‘very’ involved in the design of Pioneer activities. Unfortunately, the survey does not provide any data to help us interpret this finding, but we hope to follow this up in subsequent stages of the evaluation.

Barriers to integrated care

One intention of setting up the Pioneers, with support from national agencies, was to move beyond the many barriers to horizontally integrating services across health and social care that had been identified in previous studies (e.g. Cameron et al., 2012; Goodwin et al., 2013; RAND Europe, 2012; Frontier Economics, 2012; Wilkes, 2014). The accounts of obstacles obtained in our interviews in the early evaluation re-iterated much of what had been identified in these earlier studies. Many of the entrenched barriers to integration may not be apparent at the time that strategic plans are being prepared, but once implementation is under way, we found that barriers to integration tend to be reported as outside the immediate control of local actors, whereas facilitators of integrated care are more often reported as open to local influence.

The key informant survey included a list of 27 barriers derived from the analysis of earlier interviews and asked participants to rate whether they were a very or fairly significant barrier or not currently a barrier. Table 4 shows the results for the top ten most significant barriers by Pioneer wave.

(Table 4 here)

The apparent differences between Wave 1 and Wave 2 participants may indicate that the relative importance of different types of barriers changes during the course of Pioneer development: e.g. financial issues perhaps take on greater importance as Pioneers move more into the detail of implementing new services in a deteriorating financial context for the NHS and social care, while IT/IG issues become less important, perhaps reflecting that Wave 1 Pioneers have found ‘work-arounds’ for the latter. Again, these are potentially issues for continuing investigation as the evaluation continues.

Progress of Pioneer programme

At the end of the early evaluation in summer 2015, about 18 months after Wave 1 Pioneers had begun, most interviewees emphasised that it was too early in the lifespan of the Pioneer to identify progress, if this was defined specifically as changes to frontline services with measurable consequences for costs and personal experiences of services or other outcomes. They also reported that it was too early for patients/service users, and also most frontline staff, to notice any changes.

The difficulties in demonstrating progress were, themselves, a potential source of further problems in terms of maintaining the motivations of 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 focused 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)

But the general impression among Wave 1 interviewees in spring/summer 2015 was that Pioneer activities were broadly progressing as planned, albeit at a slower pace than originally hoped for. This was often thought to be an inevitable consequence of attempting to implement complex transformation in a challenging context, particularly the need to maintain services under 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)

One year later, the key informant survey asked Wave 1 and Wave 2 Pioneers to identify whether there had been progress with respect to 15 objectives/‘outcomes’. For nearly all these statements, there was a substantial group of participants who did not know the degree of progress (ranging from 9% to 54%). Given the high level of ‘don’t knows’, Table 5 limits the responses to the 22 key informants who identified themselves as Pioneer ‘leads’ (since their role might be expected to require them to form a more comprehensive view of progress and, in fact, they reported much lower levels of ‘don’t know’ than did the full sample).

Overall, ‘substantial’/‘some’ progress was reported by at least half of ‘leads’ for all outcomes except for cost reduction (only 27%), and by three-quarters of ‘leads’ for 11 of the 15 outcomes. ‘Leads’ reported that Pioneers were making progress in two of the three broad areas on which they were focusing, i.e. improved user experience and improved quality of care, but not in the third area of reduced costs. However, for 13 of the 15 outcomes, ‘leads’ were most likely to report that ‘some’ rather than ‘substantial’ progress had been made, and there was very little reporting of ‘substantial’ progress.

‘Leads’ were less likely to report progress for outcomes where routine data are available (e.g. for readmissions or unplanned admissions). The outcomes reported as showing the most progress would appear to lack such ‘hard’ evidence/data, e.g. more accessible services or improved patient experience (although we do not know the extent to which the views expressed are based on evidence from local evaluations which might include data on user experience). The highest reports of ‘no’ progress were: reduction in costs (27%); reduction in unplanned admissions (27%); and reduction in readmissions (27%), which are all outcomes for which routine data are readily available.

(Table 5 here)

Discussion

PIRU’s early evaluation was the first stage of a longer-term evaluation, and covered the first 18 months of a 6½ year study of integrated care. Over the next few years, our evaluation will not only be able to track the progress of a range of integration activities across all 25 Pioneers, but also look in detail at the cost-effectiveness of comparable initiatives being implemented in a small number of different sites. The longer-term evaluation will fill a gap identified in previous integration research, which was their inability to track results over the longer-term. The early results provided in this paper essentially cover the start-up phase of a long-term programme of implementation that was expected to result in integrated care becoming widely established over a longer timescale. Given the relatively early stage in the process of Pioneers coordinating care and integrating services, caution is required in drawing conclusions. With this caveat in mind, we provide a number of observations based on some of the themes emerging so far from our evaluation.

One such observation relates to the survey reports of no progress in reducing hospital admissions and costs but some progress in improving patient/user experience, which are consistent with previous evaluations of integration initiatives which tend to show little or no reduction in costs and unplanned hospital use but some benefits in terms of better user experience. (Nolte and Mckee, 2008; Mason et al., 2015).

Another observation has to do with the considerable heterogeneity we found, in our initial interviews with Wave 1 sites, in their overall vision and aims, the types of activities and interventions planned, and their target client groups. However, 12 months later, we detected a growing convergence in the activities of the majority of the Wave 1 Pioneers towards a similar set of specific interventions for (often older) people with multiple long-term conditions who had extensive needs, and which had a particular focus on setting up multi-disciplinary teams based around primary care. This apparent convergence also means there was less emphasis on some of the original broader and more varied ambitions to tackle prevention, early intervention and the social determinants of health.

This narrowing of the integration agenda could be due to a number of factors, including the pressure on local budgets and the need to 'fire-fight' more immediate pressures, especially in the hospital sector, as well as the increasing influence of NHS England as the Pioneers were incorporated into its new models of care programme. One consequence of the stronger national influence on Pioneer activities could be to reduce bottom-up initiatives and distinctive localised ways of working.

An important consideration of this narrowing of ambition is whether this might lead to greater integration in the NHS, focused around primary care, but do little to promote place-based integration across all relevant local agencies, especially 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 prevention and improving health and wellbeing to which many Pioneers originally aspired.

Another observation has to do with the difficulties of moving from design to delivery of service changes. As we found in both our qualitative interviews and our key informant survey, many of the barriers to integration are factors which are outside the control of local actors, whereas facilitators are more frequently amenable to local influence. Despite assurances from the government that they would work with Pioneers to address and overcome entrenched barriers, such as those relating to information sharing between health and local government, Pioneers were critical of the persistence of such barriers and lack of support from the centre in tackling them.

Despite the expectation that Pioneers would be able to drive change 'at scale and pace', there was little hard evidence of change in service delivery for the Wave 1 Pioneers, not only at the end of the early evaluation (18 months after Wave 1 began) but also at the time of the key informant survey, about 2½ years after their start. The barriers and difficulties they have experienced since their launch do not seem to be getting any easier. As well as the inherent difficulties of trying to introduce large-scale transformative change, the environment in which the Pioneers are operating is becoming more demanding and, in many respects, increasingly unsupportive of whole systems transformation involving the integration of both health and social care. We call this the 'integration paradox'; that is, as more effective integration becomes increasingly pressing to improve outcomes and secure sustainable services within an increasingly adverse financial setting, so it becomes increasingly difficult to bring about because the same environment increases the imperative to keep core services afloat, and can lead to a retreat into more 'siloed' ways of working. The question we will try to answer in future is whether the Pioneers have laid the foundations on which more rapid advances can be built, or whether the difficulties they face will prevent the Pioneers' wider ambitions being realised.

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Figure 1: Barriers to 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

Adapted from Cameron and Lart (2003) and Cameron et al (2012).

Figure 2: What integrated care looks like for an individual ('I statements')

My goals/outcomes

- All my needs as a person are assessed and taken into account.
- My carer/family have their needs recognised and are given support to care for me.
- I am supported to understand my choices and to set and achieve my goals.
- Taken together, my care and support help me live the life I want to the best of my ability.

Communication

- I tell my story once.
- I am listened to about what works for me, in my life.
- I am always kept informed about what the next steps will be.
- The professionals involved with my care talk to each other. We all work as a team.
- I always know who is coordinating my care.
- I have one first point of contact. They understand both me and my condition(s). I can go to them with questions at any time.

Information

- I have the information, and support to use it, that I need to make decisions and choices about my care and support.

- I have information and support to use it, that helps me manage my condition(s).
- I can see my health and care records at any time. I can decide who to share them with. I can correct any mistakes in the information.
- Information is given to me at the right times. It is appropriate to my condition and circumstances. It is provided in a way that I can understand.
- I am told about the other services that are available to someone in my circumstances, including support organisations.
- I am not left alone to make sense of information. I can meet/phone/email a professional when I need to ask more questions or discuss the options.

Decision-making including budgets

- I am as involved in discussions and decisions about my care, support and treatment as I want to be.
- My family or care is also involved in these decisions as much as I want them to be.
- I have help to make informed choices if I need and want it.
- I know the amount of money available to me for care and support needs, and I can determine how this is used (whether it's my own money, direct payment or a 'personal budget' from the council or NHS).
- I am able to get skilled advice to understand costs and make the best use of my budget.
- I can get access to the money quickly without over-complicated procedures.

Care planning

- I work with my team to agree a care and support plan.
- I know what is in my care and support plan. I know what to do if things change or go wrong.
- I have as much control of planning my care and support as I want.
- I can decide the kind of support I need and how to receive it.
- My care plan is clearly entered on my record.
- I have regular reviews of my care and treatment, and of my care and support plan.
- I have regular, comprehensive reviews of my medicines.
- When something is planned, it happens.
- I can plan ahead and stay in control in emergencies.
- I have systems in place to get help at an early stage to avoid a crisis.

Transitions

- When I use a new service, my care plan is known in advance and respected.
- When I move between services or settings, there is a plan in place for what happens next.
- I know in advance where I am going, what I will be provided with, and who will be my main point of professional contact.
- I am given information about any medicines I take with me – their purpose, how to take them, potential side effects.
- If I still need contact with previous services/professionals, this is made possible.
- If I move across geographical boundaries I do not lose my entitlements to care and support.

Reproduced from National Collaboration for Integrated Care and Support (2013)

Table 1: Individuals interviewed per Wave 1 Pioneer

<i>Wave 1 Pioneers</i>	Individuals interviewed:	
	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
<i>Total</i>	<i>140</i>	<i>57</i>

Table 2: Number of respondents by type of organisation

Organisation	N
CCG	26
Local Authority	24
Other NHS (e.g. acute trust, community trust)	23
Other (e.g. Healthwatch representative, voluntary organisation)	25
<i>Total</i>	<i>98</i>

Table 3: 'Very' involved in Pioneer programme design by organisation

<i>Wave 1 and Wave 2 Pioneers</i>	CCG (% 'very' involved)	Local Authority (% 'very' involved)
CCG	83	73
Local authority social care providers	63	78
Local authority social services (commissioners)	58	74
Individual service users	50	17
Local authority public health	50	35
Acute trusts	46	39
Community health trusts	46	57
GPs/primary care	42	48
User representative organisations	42	26
Mental health trusts	33	30
Individual carers	33	13
Local population direct involvement	33	9
Local councillors	29	30
Voluntary sector providers	25	17
Frontline staff	21	22
Other local professional bodies	8	0

Local Medical Committee	4	4
Private sector providers	0	4

Table 4: Barriers to integration by Pioneer wave

<i>Wave 1 and Wave 2 Pioneers</i>	Wave 1 (% 'very' significant)	Wave 2 (% 'very' significant)
Significant financial constraints within the local health and social care economy.	63	49
Incompatible IT systems make it difficult to share patient/ service user information.	38	64
Conflicting central government policy or priorities.	39	42
Lack of additional funding makes it difficult to try out innovative services.	39	39
Information governance regulations making it difficult to share patient/ service user information.	30	46
Too many competing demands for time or resources reducing the focus on working together.	33	36
Shortages of frontline staff with the right skills.	27	46
Increased demand for existing services.	33	30
Working out realistic financial savings that could be achieved.	31	21
The different cultures of the partner organisations.	20	36

Table 5: Progress of the Pioneer programme reported by Pioneer leads

<i>Wave 1 and Wave 2 Pioneer leads</i>	% of leads reporting 'substantial'/ 'some' progress
Patients/service users are now able to experience services that are more jointed up.	91
The quality of care for patients/service users has improved.	91
Services are now more accessible to patients/service users.	91
The quality of life for patients/service users has improved.	86
Patients/service users are now able to continue living independently for longer.	82
The experience of carers has improved.	82
Patients/service users now have a greater say in the care they receive.	82
Patients/service users are now better able to manage their own care and health.	77
Patients/services users now have a greater awareness of the services available.	77
GPs are now at the centre of organising and co-ordinated patients'/service users' care.	77
Service providers are now able to respond more quickly to patients'/ service users' (changing) needs.	73
The number of readmissions to hospital have reduced.	68
Unplanned admissions have reduced.	64
Job satisfaction among frontline staff involved in the Pioneer programme has increased.	59
On average, per patient/service user health and social care costs have decreased.	27

