

Evaluation of the Integrated Care and Support Pioneers Programme (2015-2020)

Results from the second survey (spring/summer 2017) of Pioneer Key Informants

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Summary

The Integrated Care and Support Pioneer programme, initiated by the Coalition Government to run over a five-year period (2013-18), aimed to improve the quality, effectiveness and cost-effectiveness of care for people whose needs are best met when the different parts of the health and social care system work in an integrated way. The 14 Wave 1 (W1) Pioneers which were announced in November 2013 were joined by a further 11 Wave 2 (W2) Pioneers in January 2015.

Following an 18-month early evaluation of the W1 Pioneers, PIRU began a longer-term evaluation in July 2015 to assess the extent to which the 25 Pioneers were successful in providing better coordinated care, including improved patient experience and outcomes, in a cost-effective way. The evaluation consists of a number of strands carried out over a five-year period, one of which is to carry out annual surveys of key informants (mainly senior managers) from the Pioneers in order to capture their perceptions of the factors helping or hindering their pursuit of integrated care, progress over time, and whether the Pioneers' objectives and desired outcomes are being achieved.

This report describes findings from the second survey of key informants, which was carried out between June and September 2017. (The first key informant survey took place in spring 2016.) Overall, 105 key informants from the 25 sites completed the survey, split between Clinical Commissioning Groups (CCGs) (n=22), Local Authorities (n=33), NHS Trust providers (n=22) and other organisations (which includes the voluntary sector and Healthwatch) (n=28). There were 62 informants from the 14 W1 sites and 43 from the 11 W2 sites.

Over 3½ years (2½ years for W2 sites) into the Pioneer programme, the vast majority of informants reported 'some' progress toward meeting ten widely understood objectives of integrated care, but few reported 'substantial' progress. The highest was 15% of informants who reported 'substantial' progress in patients/service users experiencing more joined up services. The highest reports of 'no' progress were for the two objectives of reducing unplanned hospital admissions (23%) and reducing average per patient/service user health and social care costs (30%).

A number of 'very significant' barriers to integration were identified, including: financial constraints in the local health and social care economy (64%); incompatible IT systems preventing sharing of patient/service user information between health and social care agencies (47%); competing demands for time and resources (45%); and increased demand for existing services (40%). Of the 13 barriers asked about in both survey years, the percentages of informants saying they were 'very significant' in 2017 were very similar to those in 2016, suggesting that little progress has been made in resolving these issues, at least as perceived by local informants.

In contrast to the barriers, many of the facilitators included in both surveys were much less likely in 2017 to have been mentioned as important than in 2016. For example, the National Voices 'I Statements' (which set out what service users could expect by way of coordinated care and which motivated the Pioneer programme) were said to be 'very important' nearly twice as often in 2016 as in 2017 (49% and 27%, respectively); involving patients in service design declined from 55% to 39% between surveys; the involvement of local voluntary organisations fell from 61% to 42%. The one facilitator that showed a large increase in mentions since 2016 (from 60% to 80% in 2017) was building, maintaining and reinforcing good working relationships between local partners.

The persistence of barriers to integration, many of which are outside local control, is likely to explain the relatively slow progress reported in meeting integration objectives. While local financial constraints and increased demand for services highlight the importance of better integrating services in order to improve patient experience and outcomes in a more cost-effective way, they also provide a context in which the integration of services becomes more difficult to achieve.

1. Background

This is the second survey of key informants from the 25 sites chosen by the government to be Integrated Care Pioneers: 14 Wave 1 sites were announced in November 2013 (Department of Health, November 2013) and 11 Wave 2 sites in January 2015 (Department of Health, 2015). 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 make central to their plans the Narrative on patient-centred care developed by National Voices and Think Local Act Personal's Making it Real (Department of Health, May 2013). 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).

PIRU has been evaluating the Pioneers since January 2014, and our long-term evaluation aims to assess the extent to which all Pioneers are successful in providing 'person-centred coordinated care', including improved outcomes and quality of care, in a cost-effective way. The evaluation consists of several elements, one of which is to understand the experiences of those implementing service change in the 25 sites. One method for achieving this aim is to collect data over time by carrying out surveys among 'key' Pioneer staff and other local stakeholders, in order to capture their perceptions of: the factors helping/hindering their pursuit of integrated care, including national policy such as the Better Care Fund (BCF); the extent to which barriers have been overcome; and the degree of progress in meeting their original goals.

The first key informant survey took place between April and June 2016 and was reported on in April 2017 (Erens et al, 2017). This report describes results from the second survey, which took place from June to September 2017.

2. The 2017 key informant survey design

As in the first key informant survey, we aimed to include a spread of respondents within each Pioneer, including at least one person from participating CCGs and one from participating local authorities (LAs), as well as one person from other important local partners (e.g. local acute hospital, community health service provider, voluntary sector). Our starting point was to update the list of key informants invited to take part in the first survey in spring 2016. The leads for each Pioneer were asked to update the list of key informants they (or the main contact at the time) provided for their Pioneer site. As well as removing names of individuals no longer involved and checking that email addresses were up-to-date, our contacts were asked to include new individuals so that our contact list for each site would include:

- At least one representative of each of the partner organisations involved in local health and social care integration activities.
- All members of the Pioneer Steering Group/Board, or the Board with responsibility for local health and social care integration activity (even if it was not Pioneer-specific).
- Any other senior stakeholders who played an important role in local health and social care integration activities.
- Any patient/service user representatives who provided an important lay perspective on developing or implementing local health and social care integration activities.

Updated lists were provided for 19 of the 25 Pioneer sites. In the other 6 Pioneers, we used the list provided for the 2016 survey.

As a result of these approaches, the sample list consisted of 445 individuals, 378 on the 19 updated lists and 67 on lists that had not been updated since 2016. The range in the number of individuals included on the list varied hugely by Pioneer, from 6 in 3 sites (Airedale, Sheffield and Worcestershire) to 57 in Nottingham County and 66 in Kent. The wide disparity in the number of survey invitations sent out per Pioneer is partly explained by whether the list included names from the local integration steering group/board (and the size of that group/board), along with the size and complexity of the Pioneer site (e.g. while the Kent Pioneer includes only one local authority, it covers 9 CCGs). Where a list of steering group/board members was provided, it may have included a number of individuals who were only marginally involved in Pioneer activities, which may of course have had some bearing on the likelihood of these individuals responding to the survey.

Unlike the 2016 survey, we also asked all individuals who completed the questionnaire whether there were any other key local stakeholders who they thought should be invited to take part in the survey (and, if so, to provide both their names and email addresses). Of course, most of them would not necessarily know who was already on our list, and many of the individuals nominated by informants were already included. In the end, we sent out survey invitations to an extra 37 individuals suggested by survey informants. Added to the original sample list, this resulted in 482 survey invitations being sent out.

The 2017 survey was conducted through an online questionnaire (as in 2016) which covered many of the same topics included in the first survey: informant characteristics (and whether they had changed organisation or job title since first survey); whether the term 'Pioneer' was still relevant locally; barriers and facilitators to integration; key outcomes/objectives expected from integrating health and social care; progress to date in achieving these outcomes (and when significant progress is expected); the helpfulness (or otherwise) of other national policies to integrating services; and priorities over the next 12 months. The majority of the questions were pre-coded, with a few open-

ended questions requiring informants to type in their answers. The questionnaire took about 25 minutes on average to complete. A copy of the questionnaire is provided in the Appendix.

After an initial email invitation was sent to all the original 445 individuals on the mailing list, four reminder emails were sent over the course of the fieldwork period (originally scheduled to finish at the end of July, but extended to late-September in order to send out a final reminder after the end of the summer holiday period). The 37 individuals nominated by informants were added to the mailing list throughout the course of fieldwork; all were sent an initial invitation to take part along with the September reminder (and those nominated in the early stages of data collection were sent one or two additional reminders).

Overall, 118 key informants started the survey, but 13 had not completed enough of the questionnaire to be included in the final dataset, leaving 105 questionnaires eligible for analysis and reporting. This equates to a 'response rate' of 22% based on the whole mailing list of 482 individuals. (The 2016 survey included 98 key informants and achieved a response rate of 29%). As mentioned above, not all the lists had been updated and so were a year out of date; also, a number of the individuals on the larger lists are likely to have been only marginally involved (if at all) in local Pioneer activities. For these reasons, we do not believe a 'response rate' is particularly relevant or meaningful for the survey.

This view is supported in the academic literature. Since key informant surveys are not asking individuals to report on their own behaviour or role within their organisations, but rather to provide data about their organisation based on their own specialised knowledge, it is not necessary for key informant surveys to obtain a 'representative sample'. Instead, the aim is to purposively select individuals who are able to shed light on the key topics included in the study (Hughes and Preski 1997; Seidler 1974; Von Korff et al 1992). Of course, there is a risk of bias using key informant surveys, irrespective of the 'response rate', which can derive from several sources, such as errors of recall or differences in knowledge or access to information which may result from the informant's position within the organisation (Hughes and Preski 1997). Such limitations must be kept in mind when interpreting the results of our key informant survey.

Another potential limitation is that our initial sample list does not provide 'complete' coverage of all key individuals involved in the 25 Pioneers; indeed, no such sample list could ever be definitive given the difficulties in delineating the precise organisational boundaries of individual Pioneers and their integrated care initiatives. In practice, our achieved survey sample of 105 key informants includes a good range of individuals across Pioneer sites in terms of the two separate waves of Pioneers, the partner organisations involved in Pioneer activities, and level of staff seniority, given that we only included managers in the first two surveys (aside from Healthwatch or patient representatives on Pioneer boards/committees).

In the following sections, we compare responses from four types of organisations (CCG, Local Authority, NHS provider and Other organisations). While key informant surveys do not aim to provide statistically robust results, the unrepresentative nature of the sample, along with the small sample sizes for these four organisation types ($n = 22, 33, 22$ and 28 respectively), are another limitation that should be borne in mind when making comparisons between them.

3. Characteristics of the key informant sample

In 2017, the achieved sample included at least one key informant from all Pioneers aside from Airedale; the relatively high number of key informants from Kent and Nottingham County is due to the much higher number of individuals included on the key informant lists provided by the main contacts in those two Pioneers (Table 3.1).

Table 3.1: Number of key informants for each Pioneer by survey year

Pioneer	Pioneer wave	2016 survey: completed questionnaires	2017 survey: completed questionnaires
		N	N
Airedale, Wharfedale & Craven	2	1	0
Barnsley	1	3	2
Blackpool and Fylde Coast	2	3	3
Camden	2	3	5
Cheshire	1	5	4
Cornwall	1	4	1
East London (WEL)	1	7	7
Greater Manchester	2	3	3
Greenwich	1	3	4
Islington	1	4	5
Kent	1	5	17
Leeds	1	5	6
Nottingham City	2	4	1
Nottingham County	2	6	14
North West London	1	9	3
Sheffield	2	2	4
South Devon & Torbay	1	3	3
South Somerset	2	3	1
South Tyneside	1	6	4
Southend	1	3	2
Staffordshire & Stoke	1	1	2
Vale of York	2	1	3
Wakefield	2	7	5
West Norfolk	2	4	4
Worcestershire	1	3	2
Total		98	105

Of the 105 key informants, 36 also completed the first survey in 2016, while 69 were new informants in 2017.

About three-fifths of key informants were from the 14 Wave 1 Pioneers, the rest from Wave 2 sites (Table 3.2)

Table 3.2: Pioneer wave by survey year

Pioneer wave	2016 survey	2017 survey
	N	N
Wave 1	61	62
Wave 2	37	43

The types of organisations informants worked for is shown in Table 3.3, after grouping for analysis purposes. Compared with the 2016 survey, there were slightly fewer informants from CCGs in 2017, slightly more in the 'Other' category, and around one-third more LA informants. The 'NHS provider' category includes informants from primary care, acute/community/mental health trusts and integrated care organisations. The 'Other' category includes a mix of informants, mainly from Healthwatch or other patient/service user representatives, but also includes a few informants from other voluntary/community organisations and from private providers. The diversity of these two categories is not ideal for the purposes of analysis, but were combined in this way because of the very small numbers of each type of organisation included within them.

Table 3.3: Type of organisation by survey year

Organisation type	2016 survey	2017 survey
	N	N
Clinical Commissioning Group (CCG)	26	22
Local Authority (LA)	24	33
NHS provider (eg, primary care, acute trust)	23	22
Other (eg, Healthwatch representative, voluntary organisation, private provider)	25	28

Key informants were generally senior managers, but also included some practising health professionals who also had some involvement in leading or governing the Pioneer (Table 3.4).

Table 3.4: Job title by survey year

Job title	2016 survey	2017 survey
	N	N
Pioneer lead/other local integration lead/coordinator	22	19
Chief Executive ¹	17	19
Director/assistant director	29	30
Locality manager	4	4
Commissioning officer ²	1	7
Other senior manager	16	14
Health care professional (clinical)	5	7
Health/social care professional (non-clinical)	1	0
Other (including lay representatives)	3	5

¹ The majority of Chief Executives were from Healthwatch or voluntary/community organisations.

² Since this refers to a specific job title, it is not necessarily representative of all respondents with commissioning responsibilities.

As in 2016, most were in a strategic role or in a combined strategic/operational role (Table 3.5).

Table 3.5: Role/responsibilities of current post by survey year

Role/responsibilities	2016 survey	2017 survey
	N	N
Strategic	60	51
Combined strategic/operational	30	39
Operational/service delivery/other	8	15

Half of informants (50%) had been in their current post for 3 or more years, while over two-thirds (68%) had been with their current organisation during that period and four in five (81%) had been working in their Pioneer area for 3+ years. So even though one in five informants (19%) were relatively new to their current job (i.e. had been in post for less than 1 year), the vast majority of informants were likely to have had considerable knowledge about their local area, including the recent history of integration and relationships between partners (Table 3.6).

Table 3.6: Years worked in: a) Pioneer area, b) current organisation and c) current post (2017 survey informants)

Years	a) Pioneer area	b) Current organisation	c) Current post
	N	N	N
Less than 1 year	7	11	20
1 to less than 2 years	4	11	15
2 to less than 3 years	9	11	17
3 to less than 4 years	8	8	11
4 years or more	77	64	42

4. Objectives of integrating services and progress in meeting objectives

Key objectives of health and social care integration activities

Informants were shown a list of 10 objectives or outcomes that integrated services often aim to achieve and were asked to select from the list the three objectives/outcomes that are 'most important' in shaping integrated health and social care services in their area. (This question was not asked in 2016.) Responses are shown in Table 4.1.

The top two selections were both patient/service-user-centred: patients/service users experiencing more joined-up services (65%), and patients/service users better managing their own health/care (54%). The only other objective mentioned by a majority of informants was the NHS focused performance (but still at least partially patient focused) objective of reducing unplanned hospital admissions (52%). Next most important was another patient/service user-centred objective, ie, improving quality of care for patients/service users (39%), followed by reducing patient/service user health and social care costs (35%). One in four informants selected improving quality of life for patients/service users (23%). None of the four remaining objectives was selected by more than about one in ten informants.

Table 4.1: 'Most important' objectives/outcomes of local integration activities by type of organisation (2017 survey)

'Most important' objectives/outcomes	CCG	Local authority	NHS provider	Other	All
	%	%	%	%	%
Patients/service users experiencing more joined up services.	55	58	73	75	65
Patients/service users being better able to manage their own care and health.	59	64	41	50	54
Reducing unplanned hospital admissions.	64	39	73	43	52
Improving quality of care for patients/service users.	27	39	41	46	39
Reducing, on average, per patient/service user health and social care costs.	50	39	23	29	35
Improving quality of life for patients/service users.	18	36	23	11	23
Patients/service users having a greater say in the care they receive.	9	9	9	14	11
Services becoming more accessible to patients/service users.	9	6	14	11	10
Improving experience for (informal) carers.	5	6	5	7	6
Patients/service users having greater awareness of the services available.	5	3	-	14	6

Columns add to more than 100%, as informants were asked to select the 3 most important objectives/outcomes.
Bases: CCG=22; LA=33; NHS Provider=22; Other=28; All=105.

There were some marked, even if unsurprising, differences in priorities between organisations. NHS providers and CCGs were much more likely than LAs to prioritise the reduction of unplanned hospital admissions (73%, 64% and 39% respectively). CCGs were more likely to prioritise cost reduction than LAs or NHS providers (50%, 39% and 23% respectively). NHS providers were the most likely to mention patients/service users experiencing more joined up services (73%), but were the least likely to mention patients/service users being better able to manage their own care (41%). LAs, on the other hand, were more likely than NHS providers or CCGs to prioritise improving quality of life for

patients/service users (36%, 23% and 18% respectively), and more likely than CCGs to mention improving quality of care (39% compared with 27%). Although not explicitly asked about in the survey, it seems there is the potential for the differing priorities of participating organisations to influence both the ease with which they can cooperate on integration activities and the likelihood of success of any joint activities, since they may be attempting to achieve different (and possibly conflicting or inconsistent) objectives.

Informants were asked whether there were any other objectives/outcomes not included in the list provided that they personally considered to be as (or more) important to their local integration activities. Twenty responses were given (some of which partly overlap with those included in the list), which covered objectives including: financial sustainability (4 responses); increasing involvement of the voluntary or community sectors in care provision (4); improving partnership working among organisations (3); patient centred care (3); reducing length of stay for inpatients (2) or length of time using community services (1); developing outcome measures (1); improving staff experience (1); and reducing health inequalities (1).

Progress in meeting key objectives

Informants were then asked to give a broad assessment of how much progress there had been in meeting these objectives/ outcomes since becoming a Pioneer. They could choose one of four responses: 'substantial progress'; 'some progress'; 'no progress'; 'don't know/not applicable'. As shown in Table 4.2, over two-thirds of informants reported 'substantial' or 'some' progress for all the objectives, aside from that of reducing per patient/ service user costs where only 43% reported any progress (although 27% said they did not know). However, there were very few reports of 'substantial' progress, with a majority of informants reporting only 'some' progress (which is similar to reports of progress in the 2016 survey).

Table 4.2: Progress of the Pioneer programme in meeting key objectives/outcomes (2017)

Objectives/outcomes		Substantial	Some	None	Don't know
Patients/service users are now able to experience services that are more joined up.	%	15	73	7	5
The quality of care for patients/service users has improved.	%	13	75	8	5
Services are now more accessible to patients/service users	%	9	63	16	13
The quality of life for patients/service users has improved.	%	5	73	12	11
The experience of (informal) carers has improved.	%	5	56	18	21
Patients/service users now have a greater say in the care they receive.	%	6	67	17	10
Patients/service users are now better able to manage their own care and health.	%	5	69	14	13
Patients/services users now have a greater awareness of the services available.	%	5	68	14	13
Unplanned admissions have reduced.	%	7	60	23	11
On average, per patient/service user health and social care costs have decreased.	%	3	40	30	27

Base=104.

For each objective where 'substantial' progress was reported, informants were asked what evidence or data was available to review progress. Overall, seven types of evidence or data were mentioned.

Feedback from patients, carers or patient representatives was the most common (30 mentions) type of evidence, followed by: patient/carer questionnaires (21); administrative data on reduced admissions (12); feedback from staff (7); an increase in use of voluntary services/home care (5); other types of routine data (2); and CQC data (1).

Informants who had not reported 'substantial' progress for a particular objective, which was the vast majority for all ten objectives (as shown in Table 4.2), were asked when they expected to see 'substantial' progress for that objective. (This question was not asked in the 2016 survey.) Table 4.3 shows the results.

Table 4.3: When 'substantial' progress for key objectives/outcomes expected to be achieved

Objectives/outcomes		Progress already achieved	By end of 2017	During 2018	During 2019	2020 or later	DK/NA
Patients/service users experiencing more joined up services.	%	15	11	43	13	7	11
Improved quality of care for patients/service users.	%	13	14	26	14	15	17
Services becoming more accessible to patients/service users.	%	9	14	33	16	12	16
Improved quality of life for patients/service users.	%	5	12	22	21	19	21
Improved experience for carers.	%	5	16	31	13	11	25
Patients/service users having a greater say in the care they receive.	%	6	16	35	14	9	20
Patients/service users being better able to manage their own care and health.	%	5	12	37	18	13	15
Patients/service users having greater awareness of the services available.	%	5	17	39	13	11	14
Reduced unplanned hospital admissions.	%	7	21	19	23	14	15
Reduced, on average, per patient/service user health and social care costs.	%	3	11	30	19	16	21

Base=103.

There was very little expectation of 'substantial' progress for any of the objectives by the end of the survey calendar year (2017). For seven of the ten objectives ('more joined up services'; 'improving quality of care'; 'more accessible services'; 'improving carer experience'; 'having greater say'; 'better managing own care'; 'greater awareness of services'), the highest proportion of informants expected to see 'substantial' progress by the end of 2018, albeit sometimes by only a slim margin.

It was not until 2019 or later that the highest proportion of informants thought there would be 'substantial' progress in meeting the other three objectives ('improving quality of life for patients/service users'; 'reducing unplanned hospital admissions'; and 'reducing per patient/service user health and social care costs'). Future surveys will look at the extent to which these anticipated changes are being realised.

Most important achievements of integrated care activities to date

Informants were asked to write in the most important achievements (up to three) of their local health and social care integration activities since becoming a Pioneer; 85% of informants provided at least one achievement. The written answers were coded by the research team.

Table 4.4: Most important achievements of local integration activities to date by type of organisation

'Most important achievements'	CCG	Local authority	NHS provider	Other	All
	%	%	%	%	%
Mentions of specific local initiatives/service models	83	86	58	52	71
Implementing new structures (e.g. joint commissioning)	44	45	42	61	48
Developing/planning new systems; changes in culture (across all types of organisation)	11	48	16	78	42
Improvements in specific outcomes (e.g. reducing unplanned admissions)	22	38	53	17	33
Improved coordination of frontline staff	11	21	58	13	25
Developing workforce/service providers	50	7	21	26	24
Sharing patient data; IT infrastructure improvements	33	24	21	4	20
Maintaining public/staff satisfaction/trust	-	10	16	-	7
Other answers	17	21	-	26	17
Don't know	6	-	-	9	3

Bases: CCG=19; LA=29; NHS Provider=19; Other=25; All=92.

Column percentages total more than 100%, as up to 3 responses could be given.

Overall, and for each type of organisation (except the 'Other' category, which consists mainly of patient/service user representatives), the most common response was to mention a particular local initiative (71% did so) as one of their major achievements. Aside from this response, however, informants from different organisations highlighted quite different achievements. For example, CCGs were the most likely to mention workforce development and sharing patient data as important achievements, while NHS providers were much more likely to mention improved coordination of frontline staff, and meeting specific outcomes (such as reductions in unplanned admissions). LAs, on the other hand, were much more likely to mention local planning or system re-design (ahead of implementation); this was also the most common response of informants from other organisations. This again highlights the very different perspectives of different actors in the system on integration activities.

5. Barriers to integration between health and social care

The 2017 survey presented informants with a list of 14 barriers and asked whether each one had been a ‘very, ‘fairly’ or ‘not a significant barrier’ over the past 12 months. (This was a sub-set of the 27 barriers asked about in the 2016 survey, with the less significant barriers excluded in 2017, along with one new barrier on high staff turnover.)

While ‘significant financial constraints’ was the top barrier for all types of organisations, there were some notable differences between organisation types in rating the other barriers (Table 5.1). For example, CCGs were more likely than LAs to highlight incompatible IT systems (53% vs 35%) and IG regulations (47% vs 35%) as a ‘very significant barrier’. LAs, on the other hand, were more likely than CCGs to highlight the different cultures of the organisations involved (35% vs 21%).

Table 5.1: Barriers to integration by organisation type

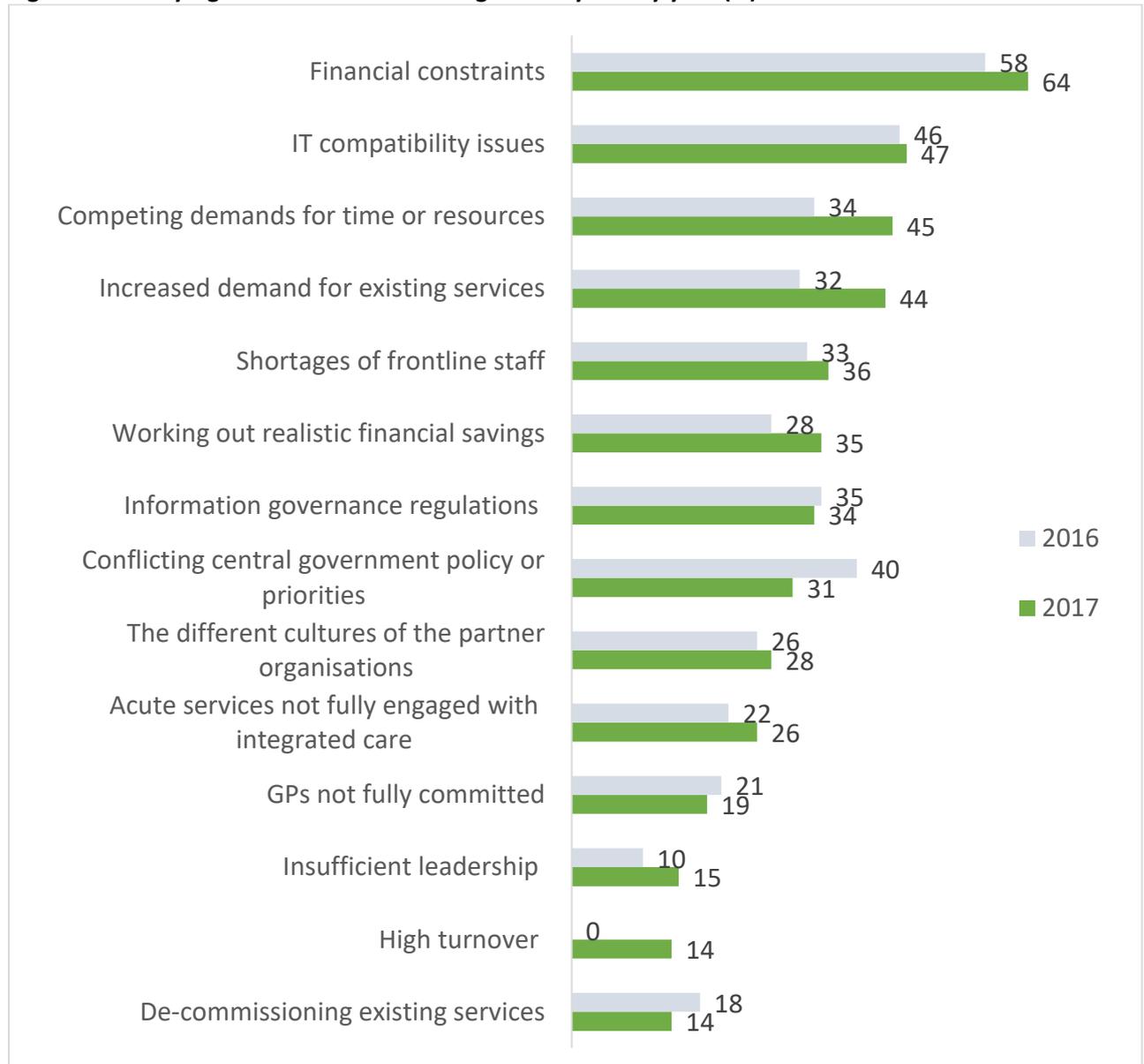
‘Very significant’ barrier	CCG	Local authority	NHS provider	Other	All
	%	%	%	%	%
Significant financial constraints within the local health and social care economy.	63	58	55	81	64
Incompatible IT systems make it difficult to share patient/ service user information	53	35	55	50	47
Too many competing demands for time or resources reducing the focus on working together.	53	42	45	42	45
Shortages of frontline staff with the right skills.	32	23	41	50	36
Working out realistic financial savings that could be achieved.	37	45	23	31	35
Increased demand for existing services.	53	48	27	46	44
Information governance regulations making it difficult to share patient/ service user information.	47	35	18	35	34
Conflicting central government policy or priorities.	26	26	27	42	31
The different cultures of the partner organisations.	21	35	23	27	28
Acute services that are not fully engaged with our integrated care programme.	32	23	23	27	26
GPs not fully committed to our integrated care programme.	21	10	27	23	19
Insufficient leadership of our integrated care programme.	26	13	9	15	15
De-commissioning existing services.	11	10	18	19	14
High turnover of managers or other staff.	11	10	14	23	14

Bases: CCG=19; LA=31; NHS Provider=22; Other=26; All=98.

Figure 5.1 shows the percentage of informants who reported the barrier to be ‘very significant’ in 2016 and in 2017. The biggest barrier in both years was ‘significant financial constraints’, with nearly two in three informants reporting this to be ‘very significant’ in 2017 (a small increase from the 58% reporting this in 2016). Otherwise, it is striking how similar the percentages are in the two surveys for the majority of the barriers. Half of the barriers were within five percentage points of each other

between survey years, and there were only two barriers where the percentages differed by more than ten percentage points, both of which had *increased* between 2016 and 2017: ‘too many competing demands for time or resources’ (from 34% to 45%) and ‘increased demand for existing services’ (from 32% to 44%). There was only one barrier that appeared to decrease between surveys, ie, ‘conflicting government policy’ (from 40% to 31%). While this may suggest that informants see central government as making progress in aligning its own policy responsibilities, the increasing percentage of those mentioning ‘financial constraints’ as a barrier suggests the opposite conclusion.

Figure 5.1: ‘Very significant’ barriers to integration by survey year (%)



Bases: 2016=97; 2017=98.

Informants were asked to say if there were any other significant barriers or challenges that affected their local integration activities in the last 12 months that were not included in the list. Around a dozen informants mentioned other barriers including: the different governance/legal structures of the partner organisations (6 responses); competition within the system impeding collaboration (3); difficulties measuring key outcomes (3); supporting bodies (e.g. CSUs, DSCROs) being understaffed (1); insufficient infrastructure to support integration (1); lack of a longer-term vision (1); and the complexity of the consultation process required to change a service (1).

6. Facilitators of health and social care integration

The 2017 survey presented informants with a list of 12 facilitators, a sub-set of the 16 facilitators asked about in 2016 (with the less frequent facilitators in 2016 not included in 2017). They were asked to rate each as a 'very', 'fairly', 'not very' or 'not at all important' facilitator (or enabler) in supporting integration activities in their area over the past 12 months.

There were some differences in facilitators between different types of organisations (Table 6.1). Informants who work in LAs were much less likely than those in CCGs or NHS providers to identify both 'having local providers' and 'local champions' as 'very important' facilitators, perhaps because LAs feel they already represent local voices, and NHS providers in particular will see themselves as the 'local providers'. LA informants also gave lower priority to the 'I Statements' than those in NHS providers. NHS providers were more likely than informants from other organisations to say 'building local relationships' is 'very important', and also gave higher ratings for a 'bottom up approach', the 'Pioneer bringing local partners together' and valuing the 'support provided by national partners'.

Table 6.1: Facilitators of integration by type of organisation

'Very important' facilitator	CCG	Local authority	NHS provider	Other	All
	%	%	%	%	%
Having strong leadership at local level.	68	74	65	73	71
Having local providers actively involved in integrated care initiatives/activities.	68	52	75	73	66
Having key local voluntary organisations actively involved in integrated care initiatives/activities.	42	39	45	42	42
Building, maintaining and reinforcing good working relationships between key local partners.	74	77	95	77	80
Having local champions to progress work locally or convince others of the benefits.	47	29	50	65	47
Involving patients/service users/carers in co-design of the interventions/activities.	37	32	35	52	39
Having a 'bottom up' approach, with staff driving change/developing the framework.	26	35	50	46	40
The 'I Statements' helping key local partners look at service provision from a patient/service user perspective.	21	13	30	46	27
Having a relatively simple health and social care economy (eg, one local authority and one CCG with co-terminus boundaries).	42	48	40	65	50
The Better Care Fund helping bring together commissioners from the LA and the CCG.	11	16	15	23	17
Being an 'Integrated Care Pioneer' helping bring together key local partners.	16	19	30	23	22
Support/expertise/advise provided by national partners (eg, NHS England, LGA).	5	10	20	12	11

Bases: CCG=19; LA=31; NHS Provider=20; Other=26; All=96.

Unlike for barriers, there were some differences between the survey years, with five of the 12 facilitators less likely to be rated as 'very important' by at least ten percentage points (Figure 6.1). The biggest differences were found in identifying the 'I Statements' as being 'very important' (with a decrease from from 49% in 2016 to 27% in 2017), followed by 'having local voluntary organisations

involved' (decreasing from 61% to 42%) and 'having patients/service users involved in co-design' (55% decreasing to 39%) in 2017. There was only one facilitator that showed a large increase between surveys, ie, 'building/maintaining good working relationships between local partners' (which increased from 60% to 80%).

Figure 6.1: 'Very important' facilitator of integration by survey year (%)



Bases: 2016=96; 2017=96.

As for barriers, informants were also asked whether there were any other facilitators that had been important in supporting local integration activities in the last 12 months. A handful of additional facilitators were mentioned including: workforce training/support (2 responses); the involvement of Healthwatch (1); involvement of researchers (1); and linked health and social care records (1).

7. Potential of national policies and national partners to support Pioneer activities

Informants were asked whether they thought each of 11 national policies are or would be ‘very’ or ‘fairly helpful’ or ‘very’ or ‘fairly unhelpful’ to delivering their integrated health and social care programme. Table 6.1 shows those answering ‘very/fairly helpful’ for each of the policies.

Generally, informants were very positive about these national policies, with a majority saying the policies are helpful for nine of the 11. Three policies were identified by over three in four informants as helpful: ‘extra £2bn funding for adult social care’ (84%); ‘New Models of Care’ (77%); and the ‘Five Year Forward View for Mental Health’ (76%). The policies least likely to be identified as helpful were ‘devolution of powers to LAs’ (40% helpful) and ‘NHS 7 day working’ (33% helpful).

Informants from different organisations expressed quite different views. For example, CCG informants were the most positive overall, with at least three in four identifying five of the policies as helpful, while NHS providers were the least positive, with only one policy (‘extra £2bn funding’) identified by at least three in four as helpful (85%). This same policy was the one most likely to be identified by LA informants as helpful (94%), whereas informants from CCGs and other organisations were most likely to identify the Five Year Forward View for Mental Health as helpful (100% and 77% respectively). NHS 7 day working was the least helpful policy for CCGs (37%), NHS providers (20%) and other informants (27%), while the least helpful for LAs was devolution (42%). Both modifying the purchaser-provider split and the Integrated Personal Commissioning (IPC) programme were much more likely to be identified as helpful to CCGs (89%) than to informants from any of the other organisation types (Table 7.1).

Table 7.1: Helpfulness of national policies for delivering integrated care programme by type of organisation

‘Very’/‘fairly helpful’	CCG	Local authority	NHS provider	Other	All
	%	%	%	%	%
Additional £2bn funding for adult social care over 3 years	79	94	85	77	84
Vanguards/New Models of Care/Five Year Forward View	84	84	65	73	77
Five Year Forward View for Mental Health	100	71	60	77	76
GP forward view	89	74	60	65	72
Care Act 2014	63	90	45	62	68
Modifying purchaser-provider roles (eg, ACOs)	89	58	45	65	64
Sustainability & Transformation Plans (STPs)	63	71	40	65	61
Better Care Fund (BCF)	53	67	55	50	57
Integrated Personal Commissioning (IPC) Programme	74	52	40	50	53
Devolution of powers to LAs	42	42	40	34	40
Government commitment to NHS 7-day working	37	45	20	27	33

Bases: CCG=19; LA=31; NHS Provider=20; Other=26; All=96.

As shown in Table 7.1, overall, three-fifths of informants said that Sustainability & Transformation Plans (STPs) were ‘very’ (18%) or ‘fairly’ (44%) helpful. Informants were asked to write in how STPs have been ‘helpful’ or ‘unhelpful’. By far the most common reason was that STPs brought stakeholders closer together and gave a strategic steer to local planning (76% of those finding STPs to be helpful). The next most common reason was that STPs made stakeholders focus on transformation (26%). No other reasons were mentioned by more than 1 informant; other reasons

included that the STP focused on data and intelligence, and the STP increased local accountability to the centre.

Only a small percentage of informants said STPs were ‘fairly’ (9%) or ‘very’ (4%) unhelpful. The two most common reasons written in for STPs being unhelpful were that STPs were a distraction and/or increased confusion locally, and that STPs did not engage frontline staff (both reasons mentioned by 6 informants). The next most common reason was that the STP footprint was not consistent with the Pioneer or other existing arrangements (4 informants). Other reasons mentioned by 1 or 2 informants included the lack of inclusion of LAs in the process and the minimal role for public engagement.

When asked how involved local government had been in developing their local STP, the large majority of informants said their LA(s) had been ‘very’ (33%) or ‘fairly’ (38%) involved, but still one in four informants said they had not been ‘very’ (24%) or ‘at all’ (1%) involved (with 3% saying it varied by LA) (Table 7.2). Informants from LAs were the most likely to say either that LAs were ‘very’ involved (46%) or ‘not very’ involved (29%).

Table 7.2: Involvement of LA in developing STP by organisation type

	CCG	LA	NHS Provider	Other	All
	%	%	%	%	%
Very involved	29	46	39	17	33
Fairly involved	41	25	46	48	38
Not very involved	18	29	15	26	24
Not at all involved	6	-	-	-	1
Other (e.g. varies by local authority)	-	-	-	4	3
DK	6	-	-	4	1

Bases: CCG=17; LA=28; NHS Provider=13; Other=23; All=81.

Informants were also asked an open ended question about what support from national partners would be most helpful to them over the next 12 months. Overall, informants were most likely to write in having more funding available and more coordinated/streamlined national policies (eg, a single regulator for integrated care, less paperwork) (both 20%). The three next most common responses were: more local discretion/accountability (16%); more guidance on/ facilitation of inter-organisational relationships (16%); and more sharing of evidence of good practice or what works (15%). Other types of support mentioned included: help with data sharing/governance (9%); moving to Accountable Care Organisations (9%); allowing sufficient time for changes to settle in (5%); and support for workforce-related issues (eg, staff motivation) (5%).

8. The next 12 months

Informants were asked to write in what they considered the top priority for their integrated care programme over the next 12 months (which differed slightly from the question included in the 2016 survey which asked for their *own* top priority). The responses are shown in Table 8.1

Half (50%) of informants referred to the continued implementation of specific local initiatives. Improving inter-organisational cooperation and developing an Accountable Care Organisation were mentioned by 17% and 16% of informants respectively, and dealing with financial challenges by 14%.

Table 8.1: Top priority for local integrated care programme over next 12 months by type of organisation

	CCG	LA	NHS Provider	Other	All
	%	%	%	%	%
Continue implementation (of specific local initiative)	32	57	69	44	50
Improve inter-organisational cooperation	21	10	6	28	17
Develop Accountable Care Organisation	32	13	-	16	16
Deal with financial challenges	21	13	19	8	14
Workforce/leadership development	26	7	13	8	12
Improve outcomes of interest	5	17	19	4	11
Scale down ambitions/ focus on realistic change	11	10	13	8	10
Increase patient involvement/adopt patient perspective	-	10	6	16	9
Joint commissioning/pool resources	16	13	-	-	8
Data sharing	11	3	-	4	4
Align with STP	5	3	-	4	3

Bases: CCG=19; LA=30; NHS Provider=16; Other=25; All=90.

When asked whether they thought they would be able to meet their top priority over the next year, about two-thirds of informants were confident they would: 10% were 'very confident', 53% were 'fairly confident', 29% were 'not very confident' and 8% were 'not at all confident'. These are almost identical to responses obtained to this question in 2016.

Informants were also asked what they thought was the biggest challenge to overcome in order to meet their top priority. By far the most common answer was financial pressures, mentioned by nearly half (45%) of informants (Table 8.2). The next most common response was engaging all stakeholders, which included providers, the workforce and patients/service users (25%); this was followed by conflicting priorities, eg, between different organisations or professional groups (21%), and having effective leadership for driving change (13%).

Table 8.2: Biggest challenge to overcome in next 12 months by type of organisation

	CCG	LA	NHS Provider	Other	All
	%	%	%	%	%
Financial pressures	42	43	67	36	45
Engaging all stakeholders at all levels	21	30	13	28	25
Conflicting priorities/agendas	21	30	20	16	22
Effective leadership	11	10	-	28	13
Staff shortages	-	7	20	8	8
Delivering care models/activities	-	7	7	4	4
Reorganisations	5	7	7	-	4
IT/IG issues	5	-	7	4	3
Other answers	11	7	-	4	6

Bases: CCG=19; LA=30; NHS Provider=15; Other=25; All=89.

When asked whether they thought working together between local health and social care organisations would become more or less difficult over the next 12 months, just over one-third (36%) of informants responded 'much' (11%) or 'somewhat' (25%) more difficult, 34% said 'somewhat' (28%) or 'much' (6%) less difficult, and 30% said it would be the same as now. These percentages are also very similar to those found in 2016.

Finally, informants were asked whether the term 'Integrated Care Pioneer' was still relevant for integration initiatives or activities in their area. Only about two in five (42%) agreed that the term was still relevant, which is only slightly higher than the percentage who disagreed (38%), with the rest unsure. The percentage agreeing with the statement is a significant reduction from the 60% who agreed in 2016, suggesting that local sites were continuing to move on from using the 'Pioneer' label (Table 8.3).

Table 8.3: Whether the term 'Integrated Care Pioneer' is still relevant for local integration initiatives by survey year

	2016 survey	2017 survey
	%	%
Strongly agree	16	19
Somewhat agree	44	23
Neither	20	20
Somewhat disagree	14	24
Strongly disagree	5	14

Bases: 2016=98; 2017=88.

Informants from LAs were much more likely than those from CCGs to agree that the 'Pioneer' term is still relevant (50% vs 32%). This is due to a halving of CCG informants agreeing with the statement between surveys: ie, compared with the 32% who agreed with the statement in 2017, 65% agreed with it in 2016. Agreeing with the statement also decreased among LA informants, but to a much lesser extent, from 58% to 50%. The greater reduction among CCG informants could be due to the number of new related-initiatives which have since originated in the NHS, such as STPs and Accountable Care Organisations (ACOs).

9. Responses of key informants who took part in both the 2016 and 2017 surveys

There were 36 key informants from the 2016 survey who also participated in the 2017 survey (which is 34% of the total of 105 informants in 2017). These 36 informants may provide a somewhat different perspective, since they have had a longer involvement within the local area than the full 2017 sample. For example, only 14% of these 36 informants have been in their current post for less than 2 years, compared with 35% of all 2017 informants. In fact, all but 1 of these 36 informants (97%) said they had spent three or more years working in their Pioneer area, so most if not all members of this sub-group are aware of the pre-Pioneer landscape. It is interesting therefore to look at how the views of this sub-group of informants have developed during the course of the Pioneer programme. The tables below compare their views between 2016 and 2017 on three key survey issues.

The first table (Table 9.1) looks at barriers identified as ‘very significant’ in 2016 and 2017. As with the full sample (reported in section 5), nine of the 13 barriers identified by this group of key informants are very similar in 2016 and 2017. Only one barrier shows a reduction between years (‘conflicting government policy’), whereas three show an increase over time of at least ten percentage points: ‘competing demands for resources’ (up 22 percentage points, which is twice the increase for the full sample shown in Figure 5.1); ‘increased demand for services (+13); and working out financial savings (+12).

Table 9.1: Barriers to integration by survey year for Key Informants who participated in both years

‘Very’ significant barrier for KIs in both surveys	2016 survey	2017 survey
	%	%
Significant financial constraints within the local health and social care economy.	56	64
Incompatible IT systems make it difficult to share patient/ service user information.	47	43
Too many competing demands for time or resources reducing the focus on working together.	22	44
Shortages of frontline staff with the right skills.	36	43
Working out realistic financial savings that could be achieved.	25	37
Increased demand for existing services.	33	46
Information governance regulations making it difficult to share patient/ service user information.	31	37
Conflicting central government policy or priorities.	42	31
The different cultures of the partner organisations.	28	26
Acute services that are not fully engaged with our integrated care programme.	22	23
GPs not fully committed to our integrated care programme.	25	26
Insufficient leadership of our integrated care programme.	11	17
De-commissioning existing services.	17	14

Base=36.

Also similar to the full sample (reported in section 6), the majority of the 12 facilitators we specified were reported to be diminishing in importance. Table 9.2 shows that only one facilitator was said to have increased in importance between surveys by at least ten percentage points (‘good working relationships’, +10), whereas seven decreased in importance in the last year, some by very large amounts: ‘having active voluntary organisations’ (minus 35 percentage points); ‘the Pioneer bringing partners together’ (-22); the ‘I Statements’ (-21); ‘patient co-design’ (-21); the ‘Better Care Fund’ (-

20); 'having a bottom up approach' (-13); and 'having local champions' (-10). It may be that some of the decline is due to specific facilitators no longer being required; for example, involving patients/service users in co-design may not be necessary after the intervention has been designed and is now being implemented.

Table 9.2 Facilitators of integration by survey year for Key Informants who participated in both years

'Very' important facilitator for KIs in both surveys	2016 survey	2017 survey
	%	%
Having strong leadership at local level.	72	66
Having local providers actively involved in integrated care initiatives/ activities.	67	60
Having key local voluntary organisations actively involved in integrated care initiatives/activities.	64	29
Building, maintaining and reinforcing good working relationships between key local partners.	67	77
Having local champions to progress work locally or convince others of the benefits.	56	46
Involving patients/service users/carers in co-design of the interventions/activities.	53	32
Having a 'bottom up' approach, with staff driving change/developing the framework.	47	34
The 'I Statements' helping key local partners look at service provision from a patient/service user perspective.	47	26
Having a relatively simple health and social care economy (e.g. one local authority and one CCG with co-terminus boundaries).	42	49
The Better Care Fund helping bring together commissioners from the LA and the CCG.	31	11
Being an 'Integrated Care Pioneer' helping bring together key local partners.	39	17
Support/expertise/advise provided by national partners (e.g. NHS England, LGA).	8	11

Base=36.

Despite this rather discouraging picture of significant barriers not being removed, and important facilitators less likely to be identified, it is perhaps surprising to find that this sub-group of informants were more likely than the full sample to identify progress being made for half of the objectives asked about (Table 9.3): ‘reduction in unplanned admissions’ (up 26 percentage points); ‘patients having a greater say in their care’ (+19); ‘reduction in average patient health/social care costs’ (+18); ‘more joined up services’ and ‘improved quality of care’ (both +16). This could be a result of the longer-term view and greater knowledge these key informants have of their Pioneer’s activities, or perhaps it is simply a reflection of their greater investment in local integration activities given their longer involvement.

Table 9.3: Progress of the Pioneer programme reported by Key Informants who participated in both years

‘Substantial’/ ‘some’ progress for KIs in both surveys	2016 survey	2017 survey
	%	%
Patients/service users are now able to experience services that are more joined up.	76	92
The quality of care for patients/service users has improved.	65	81
Services are now more accessible to patients/service users.	76	69
The quality of life for patients/service users has improved.	71	67
The experience of (informal) carers has improved.	50	56
Patients/service users now have a greater say in the care they receive.	56	75
Patients/service users are now better able to manage their own care and health.	62	69
Patients/services users now have a greater awareness of the services available.	68	69
Unplanned admissions have reduced.	35	61
On average, per patient/service user health and social care costs have decreased.	15	33

Base=36.

10. Conclusions

By the time of this key informant survey in summer 2017, the Wave 1 Pioneers had been in existence for some 3½ years, and the Wave 2 Pioneers for around 2½ years. In conjunction with the 2016 survey and four previous rounds of semi-structured interviews with key informants which began in spring 2014, the evaluation team is able to look at progress of the Pioneers over this period and to report on some of the key issues to do with health and social integration activities within these 25 areas.

First, it appears that, over the past 12 months, Pioneers have generally been moving from the planning to the implementation stage of their local integration activities, as identified in the achievements mentioned in the past year (see Table 4.4). How far such progress at the level of 'projects' is also part of wider systems transformation cannot be revealed directly by the survey data. However, the Pioneer programme was designed to promote more systems-wide change in a context where implementation had previously focused on individual projects with limited reference to wider systems.

Nonetheless, most informants reported 'some' progress in achieving many of their key integration objectives, although there were still few reports of 'substantial' progress having been made. Moreover, while progress was least likely to be reported for those outcomes where 'hard' evidence (ie, routine data) is available – namely, reduction in unplanned admissions and lower average user costs – these two outcomes did show significantly higher reports of progress than in 2016, at least among the sub-group of informants who participated in both surveys (see Table 9.3). Given that this sub-group has had a lengthy period of involvement in local integration activities and thus have a long-term view (which includes a period prior to becoming a Pioneer in most cases), this may be considered an encouraging sign. Moreover, our findings about the extent of progress being reported by survey informants should also be interpreted alongside the more widespread evidence in the literature that the implementation of integration initiatives is a lengthy process. This view is also echoed in our finding here that most informants were not expecting to see substantial progress for another year or more (Table 4.3).

Second, a further explanatory factor potentially accounting for this relatively slow progress is exactly the same as one we identified in the report on the 2016 survey, ie, the persistence of a large number of well-known barriers to integration. As shown in Table 4.1, the percentage of informants identifying a barrier as 'very significant' increased or stayed the same for 12 of the 13 barriers asked about in both 2016 and 2017, and decreased for only one barrier ('conflicting central government priorities'). Two of the barriers showed quite large increases since 2016: 'too many competing demands for time or resources' (up from 34% in 2016 to 45% in 2017) and 'increased demand for existing services' (from 32% to 44%). Two of the top three barriers in 2017 refer to constraints on resources or finances, with the other being incompatible IT systems making it difficult to share patient/service user information. This third barrier had been recognised right from the launch of the Pioneers, and it is discouraging to note that it still persists over three years later, despite various attempts, locally and nationally, to resolve it.

Turning to facilitators of integration, most of the 12 facilitators specified had stayed the same or declined in their influence since 2016. The biggest declines were in two facilitators that were initially seen as central to Pioneer plans, ie, taking a patient/service user perspective: 'involving patients/service users in co-design' declined from 55% to 39%, and 'the "I statements" helping look at services from a user's perspective' declined from 49% to 27%. Is this a sign that the initial enthusiasm for patient-centred care is now waning, or is the lower importance attributed to these facilitators a result of a greater local focus on whole system transformation rather than on particular

patient-centred initiatives, or is it simply due to the Pioneers moving over the past year from the planning stage of their initiatives to their implementation? Going forward, it will be interesting for the evaluation team to explore whether Pioneers are in fact moving away from taking a user perspective and the reasons for this (eg, perhaps because of increasing pressures on services). In addition, it will be important to explore how far the cultures and behaviours of frontline service delivery staff are being influenced by the principles and values of person-centred working. Two other facilitators mentioned less frequently in 2017 included the 'involvement of local voluntary organisations' (which fell from 61% in 2016 to 42% in 2017) and 'the support provided by NHS England' (from 18% to only 11%), which may be due to NHS England redeploying their resources to provide additional support to other initiatives such as the STPs or the New Care Model Vanguard.

Only one facilitator – 'building/maintaining good working relationships between local partners' – was reported to have become significantly more important, increasing from 60% to 80%. This may be due to the increasing focus on more collaborative forms of working, in some cases over much wider geographical areas, such as STPs and ACOs. That such cooperation between a diverse group of local stakeholders cannot be assumed as a given is highlighted by the differing objectives identified by different types of organisations for their local initiatives. For example, as shown in Table 4.1, some organisations will prioritise cost reductions (CCGs) or reducing unplanned admissions (CCGs and NHS providers), while others prioritise self-management of care (LAs) or users experiencing more joined up services (LAs and NHS providers). That different organisations have different priorities is not surprising. Given that some of the policy objectives being pursued are not always compatible, or may even be conflicting, it is to be expected that not all stakeholders feel equally engaged in local activities, depending on who is leading the activity and how its overall objectives are expressed.

In our previous reports, we referred to an 'integration paradox', ie, a context in which integration is increasingly important for improving user experience and outcomes in a cost-effective way, but which at the same time makes integration more difficult because of the increasing demand occurring during a period of tight financial resources. Our informants are keenly aware that these pressures have increased over the past year, and are likely to continue to increase in the immediate future, which leads to their recognition as the most significant barriers hampering their efforts to reach their integration objectives. Despite the continuing increase in demand for services and the intense financial pressures faced by local providers, progress is being made, integration initiatives are being implemented, and objectives are being (partially) met, even if not at the rapid rate at which policy-makers may wish. Given that financial pressures in local areas are not going to diminish any time soon, it remains to be seen whether this progress can continue at the same pace (or at all). Future rounds of the survey, along with other data collection activities carried out by the evaluation team, will continue to monitor the progress of these 25 sites over the next two years.

References

Department of Health. (2013, May) Letter inviting expressions of interest for health and social care integration 'pioneers'. <https://www.gov.uk/government/publications/social-care-integration-pioneers>

Department of Health. (2013, November) *Integration pioneers leading the way for health and care reform*, Press Release. <https://www.gov.uk/government/news/integration-pioneers-leading-the-way-for-health-and-care-reform--2>

Department of Health. (2015) Integrated health and social care programme expanded. <https://www.gov.uk/government/news/integrated-health-and-social-care-programme-expanded>

Erens B, Wistow G, Durand MA, Mounier-Jack S, Manacorda T, Douglas N, Hoomans T, Mays N. (2017) Evaluation of the integrated care and support Pioneers programme (2015-2020): results from the first survey (spring 2016) of Pioneer key informants. London: Policy Innovation Research Unit. <http://www.piru.ac.uk/assets/files/First%20key%20informant%20survey%20report.pdf>

Hughes LC, Preski S. (1997) Using key informant methods in organizational research: assessing for informant bias. *Research in Nursing & Health*, 20, 81-92.

Seidler J. (1974) On using informants: a technique for collecting quantitative data and controlling measurement error in organization analysis. *American Sociological Review*, 39(6), 816-831.

Von Korff, M., Wickizer, T., Maeser, J., O'Leary, P., Pearson, D. and Beery, W. (1992) Community Activation and Health Promotion: Identification of key organizations. *American Journal of Health Promotion*, 7, 110–117.

Appendix – 2017 Key Informant survey questionnaire

Q1

The Policy Innovation Research Unit (PIRU) at the London School of Hygiene & Tropical Medicine (LSHTM) is undertaking this survey as part of its evaluation of integration activities within the 25 sites selected as Integrated Care & Support Pioneers.

As in 2016, we are approaching key managers, professionals and others involved in health and social care integration activities in the Pioneer areas in order to obtain their views on how integration is progressing and what recent developments there have been. This is an opportunity for you to contribute directly to the national evidence base about integration by feeding back your experience of integration activities in your area and what has facilitated or hindered progress. Responses to the survey are strictly confidential. No-one outside the research team will be able to see your completed questionnaire or to identify your individual responses. No individual, organisation or Pioneer will be identified when we report on the survey results.

If you have any questions or comments about the survey, please contact Bob.Erens@lshtm.ac.uk (0207 927 2784) or Mary-Alison.Durand@lshtm.ac.uk (0207 927 2964).

The survey should take about 15 minutes to complete. If you can't complete it in one sitting, it will save your answers so you can return to it at another time.

Completing the survey is entirely voluntary and you may withdraw at any stage.

Thank you for your help with this important survey.

To continue with the survey, please click 'I agree to take part in the survey' below.

I agree to take part in the survey (1)

Q2 Your area became an Integrated Care Pioneer in $\{e://Field/Wave\}$. The questions in this survey refer to integrated health and social care activities in your area since that time. According to our records, the Integrated Care Pioneer area you work in is $\{e://Field/Pioneer\}$. Is that correct?

Yes, that is my Integrated Care Pioneer area (1)

No, I work in another area (Please type in area) (2) _____

Q3 In the first survey in spring 2016, you said you worked for $\{e://Field/Organisation\}$. Do you still work for the same organisation?

I work for the same organisation (1)

I now work for a different organisation (2)

Q4 Has your job title changed in the last year?

Same job title as last year (1)

New job title (2)

Q5 What type of organisation do you work for or represent? Please select one only.

- Clinical Commissioning Group (CCG) (1)
- Local Authority - Social Services (2)
- Local Authority - Public Health (3)
- Local Authority - Other (4)
- Joint appointment between CCG and Local Authority (5)
- NHS or Foundation Trust (acute) (6)
- Mental Health Trust (7)
- Community Health Trust (8)
- Care Trust (9)
- Voluntary or Community Organisation (10)
- General Practice / Primary Care (11)
- Private provider (please type in below) (12) _____
- Patient / service user / carer/ citizen (that is, not employed by any of the above organisations) (for example, Healthwatch member) (13)
- Other (please type in) (14) _____

Q6 Which of the following job titles best describes your own situation within this organisation?
Select more than one if appropriate.

- Pioneer Lead / Coordinator (1)
- Other Local Integration Lead / Coordinator (13)
- Chief Executive / Accountable Officer (2)
- Director / Assistant Director (3)
- Locality Manager (4)
- Commissioning Officer / Manager (5)
- Finance Officer (6)
- Other Senior Manager (7)
- Health Care Professional (Clinical) (8)
- Health or Social Care Professional (Non-clinical) (9)
- Other (please type in) (10) _____

Q7 Which statement below best describes the responsibilities of your post? Please select one only.

- Strategic, if you have responsibilities for planning and development of services, such as change management, commissioning, strategic development (1)
- Operational, if you have prime responsibility for service delivery (2)
- Combination of strategic and operational responsibilities (3)
- Direct / 'frontline' delivery of care or services to patients / service users (4)
- Other (please type in) (5) _____

Q8 How long have you been in your current post? Please type in years and months.

	Type in number (2)
Years (2)	
Months (3)	

Q9 How long have you been working with your current employer? Please type in years and months.

	Type in number (1)
Years (1)	
Months (2)	

Q10 And how long have you been working in the geographical area covered by your Integrated Care Pioneer? Please type in years and months.

	Type in number (1)
Years (1)	
Months (2)	

Q11 Progress Below are 10 objectives or outcomes that people involved in integrating health and social care services often aim to achieve. The relative importance of these objectives/outcomes depends on the specific integration initiatives being implemented. Please select from this list the 3 objectives/outcomes that, in practice, are most important in shaping the health and social care integration activities in your area. Please select up to 3 from the list

- Improving quality of care for patients / service users. (1)
- Improving quality of life for patients / service users. (2)
- Patients / service users having greater awareness of the services available. (3)
- Reducing unplanned hospital admissions. (4)
- Patients / service users experiencing services that are more 'joined up'. (5)
- Reducing, on average, per patient / service user health and social care costs. (6)
- Patients / service users having a greater say in the care they receive. (7)
- Services becoming more accessible to patients / service users. (8)
- Improving experience for (informal) carers. (9)
- Patients / service users being better able to manage their own care and health. (10)

Q12 If there are any objectives or outcomes not included in the list above that you personally consider to be as, or more, important to your integrated health and social care activities than the ones selected in the previous question, please type them in below.

Q13 Since becoming an Integrated Care Pioneer in $\{e://Field/Wave\}$, how much progress to date do you think there has been in...

	Substantial progress (1)	Some progress (2)	No progress (3)	Don't know / Not applicable (4)
Improving quality of care for patients / service users. (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Improving quality of life for patients / service users. (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Patients / service users having greater awareness of the services available. (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reducing unplanned hospital admissions. (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Patients / service users experiencing services that are more 'joined up'. (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reducing, on average, per patient / service user health and social care costs. (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Patients / service users having a greater say in the care they receive. (7)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Services becoming more accessible to patients / service users. (8)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Improving experience for (informal) carers. (9)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Patients / service users being better able to manage their own care and health. (10)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Q14 When do you expect there will be substantial progress in...

	During 2017 (1)	During 2018 (2)	During 2019 (3)	During 2020 or later (4)	Don't know / Not applicable (5)
Improving quality of care for patients / service users. (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Improving quality of life for patients / service users. (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Patients / service users having greater awareness of the services available. (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reducing unplanned hospital admissions. (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Patients / service users experiencing services that are more 'joined up'. (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reducing, on average, per patient / service user health and social care costs. (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Patients / service users having a greater say in the care they receive. (7)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Services becoming more accessible to patients / service users. (8)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Improving experience for (informal) carers. (9)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patients / service users being better able to manage their own care and health. (10)	○	○	○	○	○
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Q15 Since becoming an Integrated Care Pioneer in \${e://Field/Wave}, you said there has been substantial progress in the following objective/outcome(s). What data or evidence are you able to use to review progress in each of these (such as routine data, patient stories, patient surveys, anecdotes)? Please type in

- Improving quality of care for patients / service users. (1)
- Improving quality of life for patients / service users. (2)
- Patients / service users having greater awareness of the services available. (3)
- Reducing unplanned hospital admissions. (4)
- Patients / service users experiencing services that are more 'joined up'. (5)
- Reducing, on average, per patient / service user health and social care costs. (6)
- Patients / service users having a greater say in the care they receive. (7)
- Services becoming more accessible to patients / service users. (8)
- Improving experience for (informal) carers. (9)
- Patients / service users being better able to manage their own care and health. (10)

Q16 Since becoming an Integrated Care Pioneer in \${e://Field/Wave}, what have been the most important achievements of your local health and social care integration activities? Please type in up to 3 achievements.

- Most important (1)
- Second most important (2)
- Third most important (3)

Q17 Thinking of the working arrangements within your Integrated Care Pioneer programme, would you agree or disagree that working together between local health and social care organisations has been strengthened by being part of the local Pioneer programme?

- Strongly agree (1)
- Somewhat agree (2)
- Neither agree nor disagree (3)
- Somewhat disagree (4)
- Strongly disagree (5)
- Don't know (6)

Q18 The time period for the next few questions is the last 12 months. The following may be potential barriers to health and social care services working together effectively. For each statement, please indicate the extent to which these barriers or challenges may have affected your local integrated health and social care activities in the last 12 months.

	Very significant barrier (1)	Fairly significant barrier (2)	Not a significant barrier (3)	Don't know / Not applicable (4)
The different cultures of the partner organisations. (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
GPs not fully committed to our integrated care programme. (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Significant financial constraints within the local health and social care economy. (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Too many competing demands for time or resources reducing the focus on working together. (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Acute services that are not fully engaged with our integrated care programme. (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Information governance regulations making it difficult to share patient / service user information. (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Incompatible IT systems making it difficult to share patient / service user information. (7)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Insufficient leadership of our integrated care programme. (8)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High turnover of managers or other staff. (9)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Working out realistic financial savings that could be achieved. (10)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

De-commissioning existing services. (11)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shortages of frontline staff with the right skills. (12)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Increased demand for existing services. (13)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Conflicting central government policy or priorities. (14)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Q19 Please type in any other significant barriers or challenges that have affected your local integrated health and social care activities in the last 12 months that were not mentioned in the list above.

Q20 In the last 12 months, how important have the following enablers / facilitators been in supporting local health and social care integration activities?

	Very important (1)	Fairly important (2)	Not very important (3)	Not at all important (4)	Don't know (5)
The Better Care Fund (BCF) helping bring together commissioners from the Local Authority and the CCG. (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Building, maintaining and reinforcing good working relationships between key local partners. (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having strong leadership at local level. (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having local champions to progress work locally or convince others of the benefits. (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Involving patients / service users / carers in co-design of the interventions / activities. (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having a relatively simple health and social care economy (for example, one Local Authority and one CCG with co-terminous boundaries). (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having local providers actively involved in integrated care initiatives / activities. (7)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Having key local voluntary organisations actively involved in integrated care initiatives / activities. (8)	<input type="radio"/>				
Having a 'bottom up' approach, with staff driving change/ developing the framework. (9)	<input type="radio"/>				
The 'I Statements' helping key local partners look at service provision from a patient / service user perspective. (10)	<input type="radio"/>				
Support / expertise / advice provided by national partners (for example, NHS England, NHS Improvement, Local Government Association, etc). (11)	<input type="radio"/>				
Being an 'Integrated Care Pioneer' helping bring together key local partners. (12)	<input type="radio"/>				

Q21 Please type in any other enablers / facilitators that have been important in supporting local health and social care integration activities in the last 12 months that were not mentioned in the list above.

Q22 Do you think the following national policies are or will be helpful or unhelpful for delivering your integrated health and social care programme?

	Very helpful (1)	Fairly helpful (2)	Neither (3)	Fairly unhelpful (4)	Very unhelpful (5)	Don't know / Not applicable (6)
Better Care Fund (1)	<input type="radio"/>					
Five year forward view for mental health (2)	<input type="radio"/>					
GP forward view (3)	<input type="radio"/>					
NHS Five year forward view / Vanguards / New models of care (4)	<input type="radio"/>					
Sustainability and Transformation Plans (STPs) (5)	<input type="radio"/>					
Modifying purchaser-provider roles (e.g. Accountable Care Organisations, capitation payments) (7)	<input type="radio"/>					
Care Act 2014 (8)	<input type="radio"/>					
Integrated Personal Commissioning Programme (9)	<input type="radio"/>					
Devolution of powers to Local Authorities (e.g. DevoManc, Cornwall, etc.) (10)	<input type="radio"/>					
Government commitment to NHS 7-day working (11)	<input type="radio"/>					

Additional £2bn of funding for adult social care over next 3 years (12)	<input type="radio"/>					
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Q23 In what way have Sustainability and Transformation Plans (STPs) been [\\$q://QID30/ChoiceGroup/SelectedAnswers/5](#)? Please type in

Q24 Overall, how involved has local government been in developing the local Sustainability and Transformation Plan (STP)?

- Very involved (1)
- Fairly involved (2)
- Not very involved (3)
- Not at all involved (4)
- Other answer (type in) (5) _____
- Don't know (6)

Q25 Would you agree or disagree that the term "Integrated Care Pioneer" is still relevant or appropriate for the integration initiatives or activities in your area?

- Strongly agree (1)
- Somewhat agree (2)
- Neither agree nor disagree (3)
- Somewhat disagree (4)
- Strongly disagree (5)
- Don't know (6)

Q26 Last year, you were sent a link and password to access the 'high level indicators' on the PIRU website that were collated by the evaluation team. We would like some feedback on whether these indicators are useful to those involved in integration. Can we check, did you access the high level indicators on the PIRU website?

- Yes (1)
- No (2)
- Don't remember (3)

Q27 Although you were the only person in your area who could directly access and download the indicators on the PIRU website, we would like to know if these were shared with other local staff. Did you show or provide the indicators to any other staff within the area covered by your Pioneer?

- No-one else was shown or provided with the indicators (1)
- Yes, I showed or provided the indicators to: - 1 other staff member (2)
- 2 or more other staff members (3)
- Don't remember (4)

Q28 The next 12 months What do you consider the top priority for your integrated health and social care programme over the next 12 months? Please type in

Q29 How confident are you that your integrated health and social care programme will meet this priority over the next 12 months?

- Very confident (1)
- Fairly confident (2)
- Not very confident (3)
- Not at all confident (4)
- Don't know (5)

Q30 What will be the biggest challenge to overcome in the next 12 months in order to meet this priority? Please type in

Q31 Over the next year, do you expect working together between local health and social care organisations to become more difficult, less difficult, or to be about the same as now?

- Much more difficult (1)
- Somewhat more difficult (2)
- Somewhat less difficult (3)
- Much less difficult (4)
- Same as now (5)
- Don't know (6)

Q32 What support from the national partners would be most helpful to you over the next 12 months? Please type in

Q33 Are there any key stakeholders in your Pioneer area who you think we should invite to complete this questionnaire? We are looking for senior staff who have an important role to play in your Pioneer or other local health and social care integration activities. Please type in below the names and email addresses of any individuals you would like to nominate.

Q34 Please type in any other comments you would like to make about your integrated health and social care programme.