PIRU POLICY INNOVATION AND EVALUATION RESEARCH UNIT

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

Results from the fourth survey (autumn 2019) of Pioneer Key Informants

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Summary

The Integrated Care and Support Pioneer programme, initiated by the then 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 generally believed to be better met when the different parts of the health and social care system work in an integrated way. A first Wave (W1) of 14 Pioneers was announced in November 2013 and joined by 11 Wave 2 (W2) Pioneers in January 2015.

PIRU began a long-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 work streams over a five-year period, one of which is to conduct annual surveys of key informants (mainly senior managers) from the Pioneers.

The first key informant survey took place in spring 2016, the second in spring/summer 2017 and the third in autumn 2018. A paper looking at the progress of the Pioneers using results from the first three surveys was published in 2019 (Erens et al, 2019b). This report describes findings from the fourth key informant survey, which was carried out in autumn/winter 2019, which was about one and a half years after the Pioneer programme formally ended in March 2018.

Overall, 67 key informants from 22 (of the 25) former Pioneer sites completed the survey, split between Clinical Commissioning Groups (CCGs) (n=10), Local Authorities (n=23), NHS Trust providers (n=18) and other organisations (which includes the voluntary sector and Healthwatch) (n=16). There were 46 informants from the 14 W1 sites and 21 from the 11 W2 sites.

By the time of this key informant survey in autumn 2019, it was almost six years since the establishment of the Wave 1 Pioneers and nearly five years for Wave 2 Pioneers. The majority of informants reported progress since the start of the Pioneer programme in meeting key integration objectives, but, as in each of the previous surveys, there were very few reports of 'substantial' progress being made. However, informants who had a longer-term view of local integration activities were more likely to report progress.

As in previous surveys, 'good working relationships', 'strong local leadership', and 'local providers actively involved' were said to be key facilitators, while having 'local voluntary organisations actively involved' increased in importance as a facilitator over the last three surveys.

Over time, most barriers showed a reduction in the percentage of informants saying they were 'very significant'. This may be because local areas have developed 'workarounds' to these barriers or perhaps it simply reflects a realisation that integration needs to be achieved irrespective of barriers. Despite this finding on barriers, and while progress in integrating health and social care services was reported to be continuing, the rate of progress was still perceived to be slow.

1. Background

This report describes the fourth survey of key informants from the 25 sites selected by the government as 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: drive change at 'scale and pace'; 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, an NHS England account manager, and the opportunity to participate in regular conference-like meetings, but only very limited additional funding (initially £20,000 per site, later supplemented with a further £90,000 each). This limited support from NHS England stopped when the programme formally ended in March 2018.

PIRU has been evaluating the Pioneers since January 2014, and our long-term evaluation aims to assess the extent to which all of the Pioneers were 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 Sustainability & Transformation Partnerships (STP) and Integrated Care Systems (ICS); the extent to which barriers have been overcome; and the degree of progress in meeting their key integration objectives.

The first key informant survey took place between April and June 2016 and was reported on in April 2017 (Erens et al, 2017a). The second survey took place between June and September 2017 and was reported on in October 2018 (Erens et al, 2018). The third survey was carried out between September and November 2018 and was reported on in September 2019 (Erens et al, 2019a). This fourth and final key informant survey took place between October and January 2020. Since the third and fourth key informant surveys took place after the Pioneer programme ended in March 2018, the questionnaires in both those surveys asked about all integrated health and social care activities in the key informants' 'former Pioneer sites'.

This report describes results from the fourth survey, including trends in key variables as reported by key informants. An earlier examination of trends over the first three surveys was published in 2019 in the *Journal of Integrated Care* (Erens et al, 2019b). Over the next year, the research team will be carrying out further analyses and reporting using data from the key informant surveys, including integrating survey results with findings from other elements of the Pioneer evaluation.

2. The 2019 key informant survey design

As in the previous key informant surveys, we aimed to include a spread of respondents, 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) within each of the former Pioneer sites. Our starting point was to update the list of key informants invited to take part in the third (2018) survey, which had itself been updated from lists compiled in the previous (2016 and 2017) surveys. The lead contact we had for each former Pioneer site was approached to update the list of key informants they (or the main contact at the time) had provided for the 2018 survey. 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 relevant steering groups with responsibility for local health and social care integration activities (whereas in previous years we asked for members of the Pioneer Steering Group/Board).
- 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 obtained for 22 of the former Pioneer sites. For the three sites that were not updated, we used the mailing list from 2018. As a result of these approaches, the sample list consisted of 427 individuals. The range in the number of individuals included per site on the list varied from four (in South Somerset) to 33 (in Cheshire), but most sites provided between 10 and 20 names. The disparity in the number of survey invitations sent out per site is partly explained by the differences in the size and complexity of the former Pioneer sites (e.g. whereas the NW London Pioneer area included seven LAs and eight CCGs, other sites such as Cornwall included just one LA and one CCG).

As in previous surveys, we 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). Since they would not necessarily know who was already on our list, many of the individuals nominated by informants had already been identified. In the end, we sent out survey invitations to eight additional individuals suggested by survey informants.

As with all previous key informant surveys, the 2019 survey was conducted through an online questionnaire. It covered many of the same topics included in 2016, 2017 and 2018 so that progress over time could be monitored. Those topics replicated from earlier surveys comprised: key outcomes/objectives expected from integrating health and social care; progress to date in achieving these outcomes; barriers and facilitators to integration; their top priority over the next 12 months; and the biggest challenges over the next 12 months. New questions on multi-disciplinary teams (MDTs) were added, asking whether they had community-based MDTs in their area and, if they did, what types of staff and services were linked to the MDTs. The majority of the questions were pre-coded, with a few open-ended questions requiring informants to type in their answers. The questionnaire took 15.3 minutes to complete on average (mean length after excluding outliers). A copy of the questionnaire is provided in the Appendix.

An initial email invitation was sent on 11th October 2019 to the 322 individuals on mailing lists that had been updated by then, with the remainder receiving their initial emails a week later on 18th October. Four reminder emails were sent over the course of the fieldwork period between October and December 2019. In total, 426 email invitations were sent (excluding 9 emails which 'bounced').

At the end of the data collection period (mid-December 2019), 63 key informants had started the survey, but eight had not completed enough of the questionnaire to be included in the final dataset, leaving 55 questionnaires eligible for analysis and reporting. When data analysis began in January 2020, however, we noticed that a very high percentage (over half) of sample members had apparently opted-out of the survey. (This compares with an opt-out rate in previous surveys of about 2%.) Further investigation determined that the opt-outs were restricted to informants with an 'nhs.net' email address and that, in fact, *all* key informants with this email address had opted-out. It appears that the IT security systems used by the 'nhs.net' email domain resulted in the opt-out option included in the survey invitation email being automatically triggered. While it was still possible for these sample members to click on the survey link to complete the questionnaire when they initially received it, they had not been sent any of the reminder emails because they were listed as opt-outs by the survey administration software.

As the informants listed as opt-outs had received only the initial email invitation and no reminders, we decided to extend the data collection period and send an additional reminder to all key informants with an 'nhs.net' email address. This was sent on 23rd January 2020, and it resulted in a further 12 key informants completing the survey, giving a total of 67 questionnaires eligible for analysis. This equates to a 'response rate' of only 16% based on the initial mailing list, which is much lower than in the earlier surveys. (In 2016, 98 key informants' responses were included in the data analysis, with a response rate of 29%; the numbers for 2017 were 105 and 22% respectively; and for 2018, they were 85 and 19%). While the response rate for the 2019 survey is low, it is not particularly surprising, given that the Integrated Care Pioneer programme ended over one and a half years before the 2019 survey began, perhaps resulting in the survey seeming less pertinent to individuals on our sample list. It is also worth noting that response was similar in both 2018 and 2019 for LA informants (as shown in Table 3.3 below), but it was much lower for informants with 'nhs.net' email addresses (i.e. those from CCGs and NHS providers), suggesting that the difficulty we encountered sending reminders to this group is likely to have had an adverse impact on our final response rate.

Although the response rate has fallen in each of the four survey years, the value of a response rate for a survey of this kind is questionable. 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; 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 key informant's position within the organisation (Hughes and Preski 1997). Moreover, most of our survey questions were not asking for strictly factual information but for informants' own views (e.g. on the importance of particular barriers or facilitators to integration). It was certainly possible, therefore, that key informants within the same Pioneer – or even within the same organisation – would not necessarily express the same views. Such limitations must be kept in mind when interpreting the results below.

Another potential limitation is the extent to which our 2019 sample list actually included all key individuals involved in integration activities in the former Pioneer sites; in fact, 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 sample of 67 key informants includes a reasonable range of individuals across former 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 (aside from Healthwatch or patient representatives on integration boards). We also obtained responses from key informants in 22 of the original 25 Pioneer sites.

The biggest limitation of having only 67 completed questionnaires is the restrictions it places on examining responses within sub-groups, in particular for comparing types of organisation, as was done for the three previous survey reports. Unlike in previous reports where we compared CCG informants with those from NHS providers and from LAs, for this report we have combined informants from CCGs and NHS providers in order to compare them with LAs. However, the number of informants in each of these groups is still very small, so comparisons between categories need to be treated with caution.

3. Characteristics of the key informant sample

In 2019, the achieved sample included at least one key informant from 22 of the 25 former Pioneers sites (with Airedale, Wharfdale & Craven, Blackpool & Fylde Coast and Nottingham City providing no returns) (Table 3.1).

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

Pioneer	Pioneer wave	2016 survey	2017 survey	2018 survey	2019 survey
		N	N	N	N
Airedale, Wharfdale & Craven	2	1	0	2	0
Barnsley	1	3	2	5	7
Blackpool & Fylde Coast	2	3	3	0	0
Camden	2	3	5	5	4
Cheshire	1	5	4	4	4
Cornwall	1	4	1	0	3
East London (WEL)	1	7	7	7	5
Greater Manchester	2	3	3	5	1
Greenwich	1	3	4	4	3
Islington	1	4	5	3	2
Kent	1	5	17	4	1
Leeds	1	5	6	6	7
Nottingham City	2	4	1	1	0
Nottingham County	2	6	14	4	5
North West London	1	9	3	6	3
Sheffield	2	2	4	2	2
South Devon & Torbay	1	3	3	3	2
South Somerset	2	3	1	2	1
South Tyneside	1	6	4	6	4
Southend	1	3	2	1	1
Staffordshire & Stoke	1	1	2	1	1
Vale of York	2	1	3	3	1
Wakefield	2	7	5	5	5
West Norfolk	2	4	4	2	2
Worcestershire	1	3	2	4	3
Total		98	105	85	67

About two-thirds of key informants in 2019 were from the 14 Wave 1 Pioneers (n=46), while 21 were from Wave 2 sites (Table 3.2)

Table 3.2: Number of key informants in Pioneer wave by survey year

Pioneer wave	2016 survey	2017 survey	2018 survey	2019 survey
	N	N	N	N
Wave 1	61	62	54	46
Wave 2	37	43	31	21

The type of organisations key informants worked for is shown in Table 3.3. 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 from Healthwatch or other patient/service user representatives, other voluntary/community organisations and private

providers. Compared with the earlier surveys, in 2019 there were relatively fewer responses from CCG key informants. The analyses in this report combines key informants from CCGs with those from NHS providers (n=28) to make comparisons with informants from LAs (n=23).

Table 3.3: Number of key informants in each type of organisation by survey year

Organisation type	2016 survey	2017 survey	2018 survey	2019 survey
	N	N	N	N
Clinical Commissioning Group (CCG)	26	22	27	10
Local Authority (LA) (includes joint appointments with CCG)[1]	24	33	22	23
NHS provider (e.g. primary care, acute trust)	23	22	24	18
Other (e.g. Healthwatch, voluntary organisation, private provider)	25	28	12	16

[1]Informants with joint appointments between LAs and CCGs were included with LAs, based on them all having LA rather than 'nhs.net' email addresses.

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

Table 3.4: Job title of key informants by survey year

Job title	2016 survey	2017 survey	2018 survey	2019 survey
	N	N	N	N
Pioneer lead/other local integration lead/coordinator	22	19	16	13
Chief Executive[1]	17	19	6	7
Director/assistant director	29	30	24	23
Locality manager	4	4	5	2
Commissioning officer[2]	1	7	1	1
Other senior manager	16	14	20	14
Health care professional (clinical)	5	7	10	5
Health/social care professional (non-clinical)	1	0	0	0
Other (including lay representatives)	3	5	3	2

[1] The majority of Chief Executives in each survey 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.

Less than two in five key informants (38%) said they had been in their current post since the start of the Pioneer programme, that is for 5 years or more, although the vast majority (84%) had been working in the local area for at least 5 years (Table 3.5), so were likely to have had considerable knowledge about integration activities within their local area and about relationships between partners. This report compares survey results for informants who have been in their current post for less than 5 years (n=41) with those in post for 5 years or more (n=26).

Table 3.5: Years worked in: a) Pioneer area and b) current post (2019)

Years	a) Pioneer area	b) Current post
	N	N
Less than 1 year	3	6
1 to less than 2 years	2	15
2 to less than 3 years	2	6
3 to less than 4 years	3	9
4 to less than 5 years	1	5
5 years or more	56	26

During the analysis for this final survey, we added a new comparison looking at Pioneers that are in 'more or less deprived' areas within England. We derived our categories using the English Index of Multiple Deprivation (IMD) 2019 ranking for the CCG(s) involved in each Pioneer site. The IMD 2019 provides an overall measure of relative deprivation which combines data from seven domains (including income deprivation, employment deprivation, crime, etc) (McLennan et al, 2019).

The 'more' deprived Pioneers are those in the bottom third of the IMD CCG rankings, while the 'less' deprived sites are those in the top two-thirds of the IMD rankings. Several Pioneers contain multiple CCGs, in which case the Pioneer was classified based on whether the majority of CCGs in their area were more or less deprived. The categorisation of sites is:

More deprived Pioneers (bottom third of CCGs)	**Less deprived Pioneers (top two-thirds of CCGs)**
Barnsley	Airedale, Wharfdale & Craven
Blackpool	Camden
Cornwall	Cheshire
East London	Kent
Greater Manchester	Leeds
Greenwich	Nottingham County
Islington	North West London
Nottingham City	Sheffield
South Tyneside	South Devon & Torbay
Southend	South Somerset
Staffordshire & Stoke	Vale of York
Wakefield	Worcestershire
West Norfolk	

In terms of numbers of key informants for analysis purposes, the less deprived category of Pioneers includes 35 informants, and the more deprived category includes 32.

4. Objectives of integrating services and progress in meeting objectives

Key objectives of health and social care integration activities
In the 2017, 2018 and 2019 surveys (but not 2016), informants were shown a list of eight 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. Responses for the three survey years are shown in Table 4.1.

The top selection in every survey was the same ('patients/service users experiencing more joined-up services'), although the likelihood of selecting this option decreased by 18 percentage points (from 76% to 58%) between the 2018 and 2019 surveys. The next most common selection was 'reducing unplanned hospital admissions', which was consistently selected by around half of key informants in each survey year. The third and fourth most common selections in 2019 showed opposite trajectories over this three year period: whereas 'improving quality of care' increased by 12 percentage points, from 39% in 2017 to 51% in 2019, 'patients/service users being better able to manage their own care' decreased by a similar amount over this period, from 54% in 2017 to 37% in 2019.

The remaining four objectives were largely consistent over the survey years, with 'improving quality of life' and 'reducing patient/service user costs' being the fifth and sixth most likely selections in all three surveys, and 'service accessibility' and 'patients having a greater say in their care' being the least likely selections in each of the surveys.

Table 4.1: 'Most important' objectives/outcomes of local integration activities by survey year

'Most important' objectives/outcomes	**2017 survey**	**2018 survey**	**2019 survey**
	%	**%**	**%**
Patients/service users experiencing more joined up services.	65	76	58
Reducing unplanned hospital admissions.	52	51	54
Improving quality of care for patients/service users.	39	48	51
Patients/service users being better able to manage their own care and health.	54	46	37
Improving quality of life for patients/service users.	23	34	36
Reducing, on average, per patient/service user health and social care costs.	35	26	30
Services becoming more accessible to patients/service users.	10	15	18
Patients/service users having a greater say in the care they receive.	11	7	12

Columns add to more than 100%, as informants were asked to select the three most important objectives/outcomes.
Bases: 2017=105; 2018=85; 2019=67.

Bearing in mind the proviso on small sample sizes, there appear to be some differences in emphasis between CCG/NHS and LA informants, with the latter most likely to select 'joined up services' (70% compared with 57% of CCG/NHS informants), and the former most likely to select 'improving quality of care' (64% compared with 48% of LA informants) (Table 4.2). 'Reducing costs' was more likely to be selected by LA than CCG/NHS informants (39% compared with 18%), while the opposite pattern was found for 'accessible services (21% for CCG/NHS providers and 4% for LAs).

Table 4.2: 'Most important' objectives/outcomes of local integration activities by organisation type (2019)

'Most important' objectives/outcomes	CCG/NHS	LA	Other
	%	%	%
Patients/service users experiencing more joined up services.	57	70	44
Reducing unplanned hospital admissions.	57	43	63
Improving quality of care for patients/service users.	64	48	31
Patients/service users being better able to manage their own care and health.	39	39	31
Improving quality of life for patients/service users.	32	43	31
Reducing, on average, per patient/service user health and social care costs.	18	39	38
Services becoming more accessible to patients/service users.	21	4	31
Patients/service users having a greater say in the care they receive.	11	4	25

Columns add to more than 100%, as informants were asked to select the 3 most important objectives/outcomes.
Bases: CCG/NHS=28; LA=23; Other=16.

As shown in Table 4.3, objectives did not vary much according to the length of time informants were in their current job, except that those who had been in post for less than 5 years were twice as likely to select 'reducing costs" as those who had been in post for 5+ years (37% compared with 19%). A similar discrepancy was found by level of deprivation, with informants from the less deprived areas twice as likely to select 'reducing per patient/service user costs' as those from more deprived areas (40% compared with 19%). Informants in more deprived areas were more likely to mention 'accessible services' (31% compared with only 6% of those in less deprived areas).

Table 4.3: 'Most important' objectives/outcomes of local integration activities by years in current job and level of deprivation (2019)

'Most important' objectives/outcomes	Years in current job		Deprivation level	
	Less than 5 years	5+ years	Less deprived	More deprived
	%	%	%	%
Patients/service users experiencing more joined up services.	59	58	66	50
Reducing unplanned hospital admissions.	55	54	49	59
Improving quality of care for patients/service users.	46	58	49	53
Patients/service users being better able to manage their own care and health.	37	38	40	34
Improving quality of life for patients/service users.	37	35	40	31
Reducing, on average, per patient/service user health and social care costs.	37	19	40	19
Services becoming more accessible to patients/service users.	20	15	6	31
Patients/service users having a greater say in the care they receive.	7	19	9	16

Columns add to more than 100%, as informants were asked to select the 3 most important objectives/outcomes.
Bases: Less than 5 years=41; 5+ years=26; Less deprived=35; More deprived=32.

Informants were also asked whether there were any other objectives or outcomes that they considered to be as, or more, important than those listed. The other objectives mentioned included: building stronger and more resilient communities; reducing isolation; reducing instances of falls; and reducing waiting times for GP appointments.

Progress in meeting key objectives

Informants were then asked to give a broad assessment of how much progress there had been in their area in meeting these objectives/outcomes *since they became a Pioneer*. They could choose one of four responses: 'substantial progress'; 'some progress'; 'no progress'; 'don't know/not applicable'. As shown in Table 4.4, at least four in five informants reported 'substantial' or 'some' progress for four objectives, while over 70% reported 'substantial' or 'some' progress for three objectives. The outlier was 'reducing per patient/service user costs', where only around half (53%) reported any progress (with another 18% saying they did not know). However, there were very few reports of 'substantial' progress for any of the objectives, with most informants reporting only 'some' progress (which is similar to reports of progress in the three previous surveys).

Table 4.4: Progress of the Pioneer programme in meeting key objectives/outcomes (2019)

Objectives/outcomes		**Substantial**	**Some**	**None**	**Don't know**
Patients/service users are now able to experience services that are more joined up.	**%**	22	67	9	1
The quality of care for patients/service users has improved.	**%**	13	72	12	3
The quality of life for patients/service users has improved.	**%**	9	72	15	4
Patients/service users are now better able to manage their own care and health.	**%**	6	73	13	7
Patients/service users now have a greater say in the care they receive.	**%**	8	67	19	6
Services are now more accessible to patients/service users.	**%**	9	64	21	6
Unplanned admissions have reduced.	**%**	6	69	21	4
On average, per patient/service user health and social care costs have decreased.	**%**	4	49	28	18

Base=67.

As Tables 4.5 and 4.6 show, reports of progress were similar across organisation type, length of time in current job and deprivation level of the Pioneers. For six of the eight objectives, informants who had been in their current job for 5+ years were somewhat more likely to report substantial/some progress than were those in post for less than 5 years (most notably in relation to 'reducing costs'), although the differences were generally small.

Table 4.5: 'Substantial/some' progress in meeting key objectives/outcomes of local integration activities by organisation type (2019)

'Most important' objectives/outcomes	CCG/ NHS	LA	Other
	%	%	%
Patients/service users experiencing more joined up services.	93	100	69
Reducing unplanned hospital admissions.	79	83	56
Improving quality of care for patients/service users.	89	91	69
Patients/service users being better able to manage their own care and health.	75	87	75
Improving quality of life for patients/service users.	79	83	81
Reducing, on average, per patient/service user health and social care costs.	61	52	42
Services becoming more accessible to patients/service users.	71	87	56
Patients/service users having a greater say in the care they receive.	75	83	63

Columns add to more than 100%, as informants were asked to select the 3 most important objectives/outcomes.
Bases: CCG/NHS=28; LA=23; Other=16.

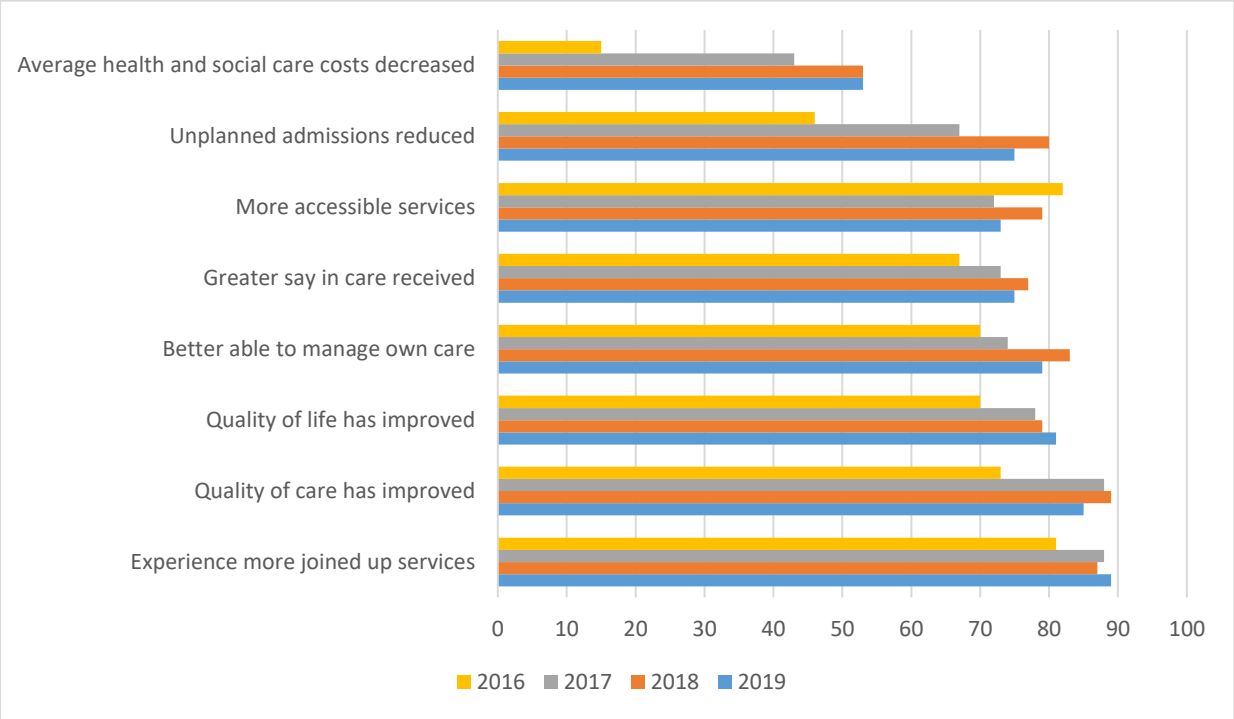
Table 4.6: 'Substantial/some' progress in meeting key objectives/outcomes of local integration activities by years in current job and level of deprivation (2019)

'Most important' objectives/outcomes	Years in current job		Deprivation level	
	Less than 5 years	5+ years	Less deprived	More deprived
	%	%	%	%
Patients/service users experiencing more joined up services.	93	85	94	84
Reducing unplanned hospital admissions.	71	81	77	72
Improving quality of care for patients/service users.	85	85	83	88
Patients/service users being better able to manage their own care and health.	76	85	80	78
Improving quality of life for patients/service users.	76	88	77	84
Reducing, on average, per patient/service user health and social care costs.	49	62	51	56
Services becoming more accessible to patients/service users.	70	77	69	78
Patients/service users having a greater say in the care they receive.	73	77	77	72

Columns add to more than 100%, as informants were asked to select the 3 most important objectives/outcomes.
Bases: Less than 5 years=34; 5+ years=21; Less deprived=29; More deprived=26.

Not surprisingly, Figure 4.1 shows key informants were more likely to report 'substantial' or 'some progress' in 2019 than they were in the first year of the survey (2016) for all objectives, except for 'more accessible services'. Generally, the trend was for more progress to be reported over time, although a number of objectives showed slightly lower reports of progress in 2019 than in the previous year.

Figure 4.1: 'Substantial/some' progress in meeting objectives/outcomes as a result of integration activities by survey year (%)



Bases: 2016=97; 2017=98; 2018=80; 2019=67.

Community-based multi-disciplinary teams (MDTs)
Since the evaluation team had decided to look at multi-disciplinary teams (MDTs) in more detail, the 2019 survey included new questions on whether their area had established any community-based MDTs which include staff from both local health and social care services. Those who reported having MDTs were shown a list of initiatives and asked whether they were part of or linked to their MDTs, whether there were different models of MDTs in their area, and whether there were plans to align the MDTs with the general practices that comprise each of the local Primary Care Networks (PCNs).

The vast majority of informants reported their area having community-based MDTs (88%), with 3% saying they were planning MDTs. The remaining 8% either did not know or gave other answers (including that they had had MDTs but no longer did so). For those with MDTs, two-thirds (66%) of informants said their area had different models of MDTs, 24% said there was only one model, and 10% did not know.

Based on all informants who reported the establishment of local MDTs (n=59), the responses given to initiatives included in the MDTs were:

Initiative	**%**
Voluntary sector provides services	85
Care navigators/coordinators	78
Social prescribing	75
Shared patient records	61
Community hubs	47
Generic care workers	29
Shared health & social care budgets	25
Shared IT systems	19
None of the above	2
Don't know	3

Half (49%) said there were plans to align their MDT with their PCNs, 37% said they were already aligned, 5% said there were no plans to align, and 9% did not know.

5. Barriers to integration between health and social care

The 2019 survey presented informants with a list of 13 barriers and asked whether each one had been a 'very, 'fairly' or 'not a significant barrier' over the past 12 months. Eight of the 13 barriers were identified as very or fairly significant by half or more informants, and four barriers by more than four in five informants. Three of the top four barriers related to financial constraints or increased demand for services or resources.

Table 5.1: Barriers to integration (2019)

	Very significant	Fairly significant	Not significant	Don't know
	%	%	%	%
Significant financial constraints within the local health and social care economy.	44	44	6	6
Increased demand for existing services.	32	54	10	5
Incompatible IT systems make it difficult to share patient/ service user information	31	52	14	3
Too many competing demands for time or resources reducing the focus on working together.	34	48	13	5
Shortages of frontline staff with the right skills.	22	48	25	5
The different cultures of the partner organisations.	17	53	27	3
Information governance regulations making it difficult to share patient/ service user information.	19	44	29	8
Working out realistic financial savings that could be achieved.	27	34	23	16
Acute services that are not fully engaged with our integrated care programme.	14	33	44	9
Primary Care Networks (PCNs) not aligning with existing integration initiatives.	6	28	58	8
High turnover of managers or other staff.	9	25	53	13
Insufficient leadership of our integrated care programme.	5	27	63	6
GPs not fully committed to our integrated care programme.	3	27	64	6

Base = 64.

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. Overall, 16 key informants mentioned other barriers including: a lack of willingness to integrate (e.g. because of differing structures across partners) (6 responses); changes in the landscape or in priorities (eg, CCGs merging, PCNs) (6); workforce issues (2); competition within the system (2); insufficient/ incompatible infrastructure (1); and lack of a longer-term vision (1).

As Table 5.2 shows, 'significant financial constraints' was more likely to be mentioned by LAs than by CCG/NHS providers (57% versus 36%), while the latter were more likely to mention 'increased demand for services' (36% versus 19%).

Table 5.2: 'Very significant' barriers to integration by organisation type (2019)

'Very significant' barrier	CCG/NHS	LA	Other
	%	%	%
Significant financial constraints within the local health and social care economy.	36	57	40
Increased demand for existing services.	36	19	43
Incompatible IT systems make it difficult to share patient/ service user information	32	24	40
Too many competing demands for time or resources reducing the focus on working together.	36	33	33
Shortages of frontline staff with the right skills.	21	14	33
The different cultures of the partner organisations.	18	19	13
Information governance regulations making it difficult to share patient/ service user information.	14	19	29
Working out realistic financial savings that could be achieved.	29	33	13
Acute services that are not fully engaged with our integrated care programme.	21	10	7
Primary Care Networks (PCNs) not aligning with existing integration initiatives.	4	10	7
High turnover of managers or other staff.	7	5	20
Insufficient leadership of our integrated care programme.	4	5	7
GPs not fully committed to our integrated care programme.	4	-	7

Bases: CCG/NHS=28; LA=21; Other=15.

There were more differences on barriers being 'very significant' according to how long informants had been in their current job, with more recent arrivals (less than 5 years) more likely than longer-term job holders (5+years) to highlight 'incompatible IT systems' (41% versus 16%), while the latter were more likely to mention 'competing demands for time/resources' (48% versus 26%) and 'significant financial constraints' (52% versus 38%) (Table 5.3). Informants from less deprived areas were more likely than those from more deprived sites to mention 'significant financial constraints' (56% versus 30%), and 'working out realistic financial savings' (35% versus 17%) (Table 5.3).

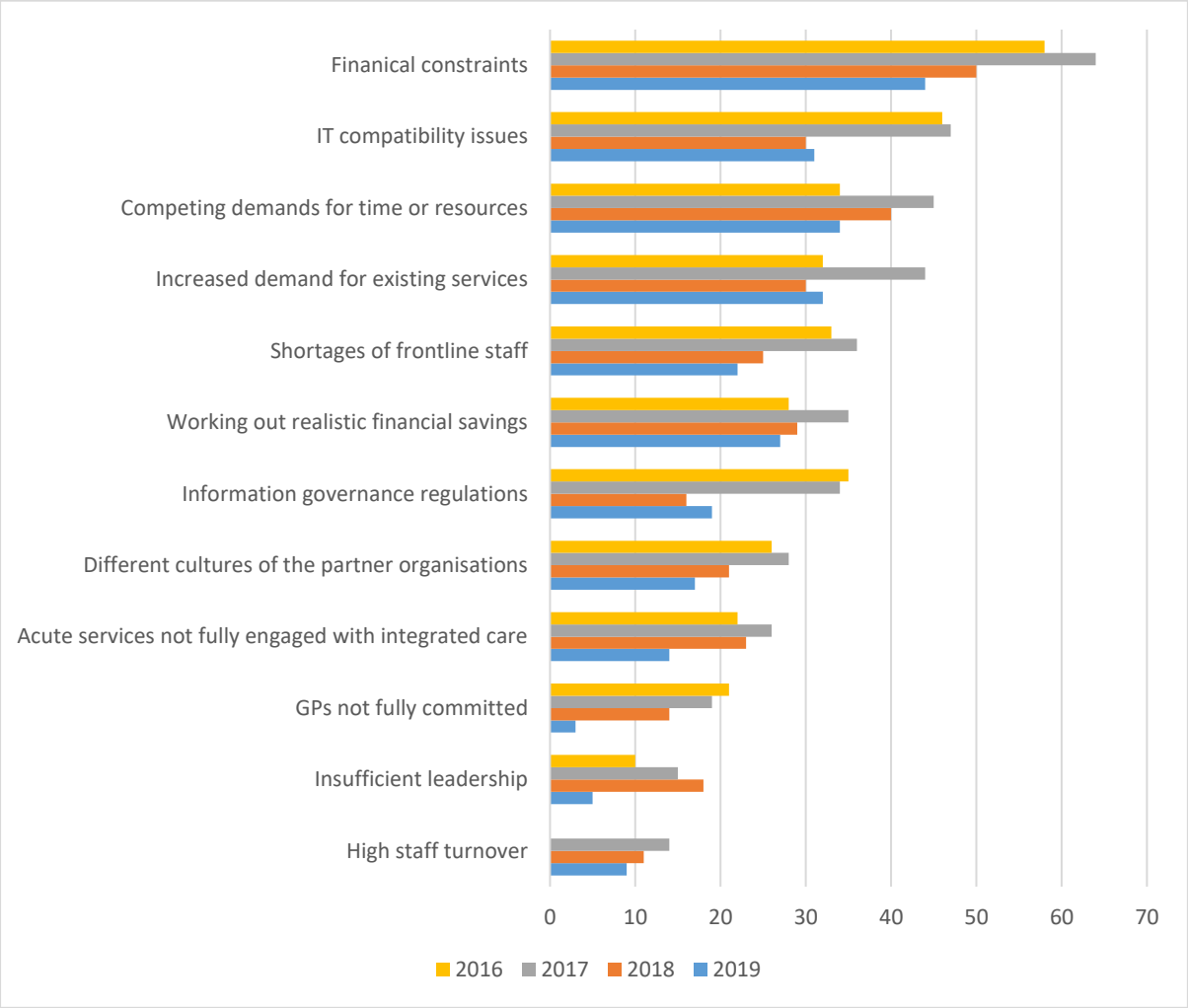
Table 5.3: 'Very significant' barriers to integration by years in current job and level of deprivation (2019)

'Very significant' barrier	Years in current job		Deprivation level	
	Less than 5 years	5+ years	Less deprived	More deprived
	%	%	%	%
Significant financial constraints within the local health and social care economy.	38	52	56	30
Incompatible IT systems make it difficult to share patient/ service user information	41	16	26	37
Too many competing demands for time or resources reducing the focus on working together.	26	48	38	30
Shortages of frontline staff with the right skills.	23	20	21	23
Working out realistic financial savings that could be achieved.	26	28	35	17
Increased demand for existing services.	29	36	27	37
Information governance regulations making it difficult to share patient/ service user information.	18	20	21	17
The different cultures of the partner organisations.	21	12	18	17
Primary Care Networks (PCNs) not aligning with existing integration initiatives.	8	4	6	7
Acute services that are not fully engaged with our integrated care programme.	10	20	12	17
GPs not fully committed to our integrated care programme.	3	4	-	7
Insufficient leadership of our integrated care programme.	5	4	6	3
High turnover of managers or other staff.	13	4	9	10

Bases: Less than 5 years=39; 5+ years=25; Less deprived=34; More deprived=30.

Twelve of the barriers were asked in all four survey years. Bearing in mind that the majority of key informants differ in each of the surveys, the results show a fairly consistent reduction for nine of the items in the percentages reporting the barriers to be 'very significant' over the past three years (Figure 5.1). Two of the other three barriers ('IT compatibility' and 'IG regulations') show little change since 2018, but both are much lower than in the first survey in 2016. The barrier 'increased demand for services' was fairly constant across three of the four years.

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



Bases: 2016=97; 2017=98; 2018=80; 2019=64.

6. Facilitators of health and social care integration

The 2019 survey presented informants with a list of 13 potential facilitators. 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. All 13 were mentioned by a majority of the informants as being 'very' or 'fairly important' facilitators, although nearly all (97%) informants mentioned 'good working relationships' as important, compared with only 59% mentioning having a 'monitoring system' (Table 6.1). Three of the facilitators stood out as being 'very' important: 'good working relationships' (78% said this was 'very' important); 'strong local leadership' (70%); and 'local providers actively involved' (68%).

Table 6.1: Facilitators of integration (2019)

	Very important	Fairly important	Not very important	Not at all important	Don't know
	%	%	%	%	%
Building, maintaining and reinforcing good working relationships between key local partners.	78	19	-	-	3
Having strong leadership at local level.	70	22	2	2	5
Having local providers actively involved in integrated care initiatives/activities.	68	22	3	2	5
Having key local voluntary organisations actively involved in integrated care initiatives/activities.	59	30	8	-	3
Having local champions to progress work locally or convince others of the benefits.	41	41	10	2	6
Having a 'bottom up' approach, with staff driving change/developing the framework.	49	29	13	2	8
Planning the local Primary Care Networks (PCNs).	33	44	11	2	10
Obtaining feedback from patients/service users/ carers	34	42	13	2	9
Training staff in integrated ways of working	42	31	20	-	6
Involving patients/service users/carers in co-design of the interventions/activities.	38	33	22	3	3
Having a relatively simple health and social care economy (eg, one local authority and one CCG with co-terminus boundaries).	48	21	17	8	6
Developing local plans to become an Integrated Care System.	35	30	19	8	8
Having a monitoring/evaluation system	23	36	31	2	8

Base=64.

Informants were also asked whether there were any other facilitators that had been important in supporting local integration activities in the last 12 months. Some of the other facilitators mentioned included: having public health involved (3 responses); workforce development (1); linked health and social care records (1); having monitoring in place (1); patient/public engagement (1); a shared vision (1); and place-based/neighbourhood teams (1).

Although informants from LAs were generally more likely than those from CCGs/NHS providers to say facilitators were 'very important', they ranked facilitators in a broadly similar order of importance (Table 6.2). Two exceptions were: 'obtaining feedback from users' which was much more likely to be considered 'very important' by LA than CCG/NHS informants (52% versus 18%), as was 'a relatively simple health and social care economy' (75% versus 32%).

Table 6.2 'Very important' facilitator of integration by organisation type (2019)

'Very important' facilitator	CCG/ NHS	LA	Other
	%	%	%
Building, maintaining and reinforcing good working relationships between key local partners.	75	81	80
Having strong leadership at local level.	61	81	73
Having local providers actively involved in integrated care initiatives/activities.	68	80	53
Having key local voluntary organisations actively involved in integrated care initiatives/activities.	43	65	80
Having local champions to progress work locally or convince others of the benefits.	32	55	40
Having a 'bottom up' approach, with staff driving change/developing the framework.	54	55	33
Planning the local Primary Care Networks (PCNs).	36	35	27
Obtaining feedback from patients/service users/ carers	18	52	40
Training staff in integrated ways of working	32	62	33
Involving patients/service users/carers in co-design of the interventions/activities.	25	55	40
Having a relatively simple health and social care economy (eg, one local authority and one CCG with co-terminus boundaries).	32	75	40
Developing local plans to become an Integrated Care System.	21	33	64
Having a monitoring/evaluation system	18	24	33

Bases: CCG/NHS=28; LA=21; Other=15.

Responses were similar for years in current job and deprivation level (Table 6.3), with a few exceptions: those in their job for less than 5 years were more likely to say 'involving users in co-design' (45% and 58% respectively) and 'having a bottom-up approach with staff' were very important facilitators than were those with 5+ years in their job (28% and 36% respectively). Informants from more deprived areas were more likely to mention 'having local voluntary organisations involved' and 'developing plans for ICS' (73% and 48% respectively) than were those from less deprived areas (45% and 24% respectively).

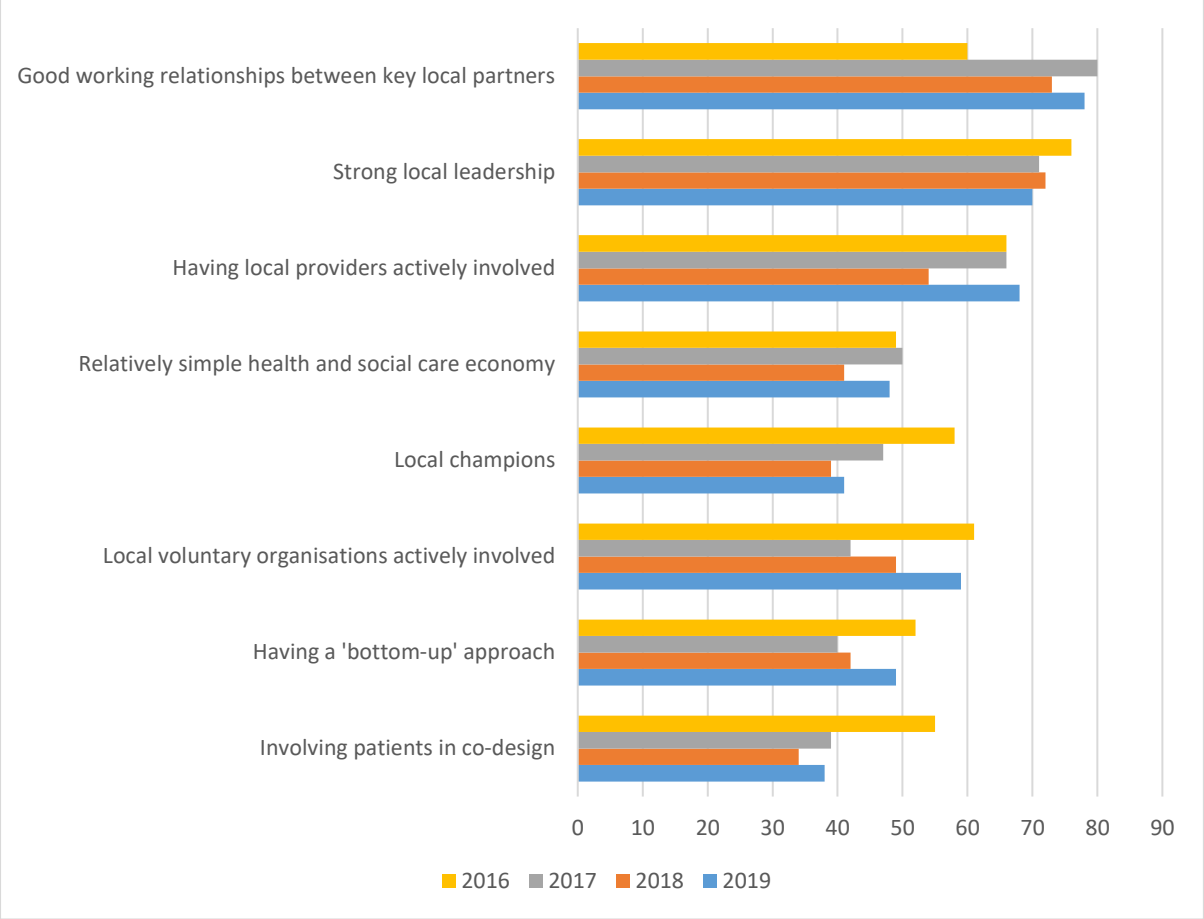
Table 6.3 'Very important' facilitator of integration by years in current job and level of deprivation (2019)

'Very important' facilitator	Years in current job		Deprivation level	
	Less than 5 years	5+ years	Less deprived	More deprived
	%	%	%	%
Having strong leadership at local level.	64	80	68	73
Having local providers actively involved in integrated care initiatives/activities.	68	68	73	63
Having key local voluntary organisations actively involved in integrated care initiatives/activities.	63	52	45	73
Building, maintaining and reinforcing good working relationships between key local partners.	79	76	74	83
Having local champions to progress work locally or convince others of the benefits.	42	40	48	33
Involving patients/service users/carers in co-design of the interventions/activities.	45	28	36	40
Having a 'bottom up' approach, with staff driving change/developing the framework.	58	36	48	50
Developing local plans to become an Integrated Care System.	33	38	24	48
Planning the local Primary Care Networks (PCNs).	37	28	30	37
Having a relatively simple health and social care economy (eg, one local authority and one CCG with co-terminus boundaries).	47	48	42	53
Obtaining feedback from patients/service users/ carers	41	24	32	37
Training staff in integrated ways of working	44	40	44	40
Having a monitoring/evaluation system	26	20	24	23

Bases: Less than 5 years=39; 5+ years=25; Less deprived=34; More deprived=30.

Figure 6.1 shows the percentage ranking each of the eight facilitators asked in all four surveys as 'very important'. The trends over time for facilitators are quite mixed, even after leaving aside fluctuations where only one year appears out of place. Three facilitators tend to show an increase over time ('good working relationships'; 'involve local voluntary organisations'; 'bottom-up approach'). 'Local champions' and 'involving patients in co-design' show a slight decrease over time (although less so for the latter), and the other two facilitators were quite stable over the four-year period.

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



Bases: 2016=97; 2017=98; 2018=80; 2019=64.

7. The next 12 months

In an open-ended question, informants were asked to type in what they considered to be the top priority for their integrated care programme over the next 12 months. The responses were coded from the open text, and are shown in Table 7.1. Informants most often referred to the continued implementation of specific local initiatives (35%). Aligning with PCNs or local place-based teams was next most commonly mentioned (15%), followed by workforce training (13%) and improving inter-organisational cooperation (11%).

Table 7.1: Top priority for local integrated care programme over next 12 months by type of organisation (2019)

	CCG/NHS	LA	All
	%	%	%
Continue implementation (of specific local initiative)	26	50	35
Align with PCN/place-based teams	13	17	15
Workforce training/motivation	22	6	13
Improve inter-organisational cooperation	4	6	11
Involve users / voluntary sector	-	8	9
Address financial challenges	17	-	7
Avoid challenges that distract from IC	4	17	7
Data sharing	4	6	7
Develop local leadership / vision	9	-	6
Share learning/emphasise achievements	9	-	6
Joint commissioning/pool resources	4	11	6
Evaluate integration initiatives/evidence impact	9	-	4
Focus on mental health	-	6	2
Redesign pathways	4	-	2
Increase involvement of LA/social care	-	6	2
Other	-	6	4

Bases: CCG/NHS=23; LA=18; All=54. Results for 'Other' organisations are not shown separately due to the very small base, but are included in the results for 'All' organisations.

Another open-ended question asked informants what they thought was the biggest challenge to overcome in the next 12 months in order to meet their top priority. The open text was coded, with the results shown in Table 7.2. The most common answer was financial pressures, mentioned by nearly half (45%) of informants. The next most common response was overcoming professional/ organisational boundaries (28%), followed by having conflicting priorities (13%), motivating the workforce (11%), and IT/IG issues (11%).

Table 7.2: Biggest challenge to overcome in next 12 months by type of organisation (2019)

	CCG/NHS	LA	All
	%	%	%
Financial pressures	46	44	45
Overcoming professional/ organisational boundaries/ agendas	42	22	28
Conflicting priorities/lack of support from centre	4	22	13
Workforce motivation/engagement	4	11	11
IT/IG issues	13	6	11
Engaging all organisations	13	-	9
Effective leadership	8	6	8
Staff shortages	4	6	6
Design effective commissioning	-	-	2
Other answers	-	11	6

Bases: CCG/NHS=24; LA=18; All=53. Results for 'Other' organisations are not shown separately due to the very small base, but are included in the results for 'All' organisations.

8. Conclusions

The fourth and final key informant survey was carried out in autumn 2019, six years after the start of the Wave 1 Pioneers and nearly five years since the Wave 2 Pioneers were established. Results from the first three key informant surveys have been published individually in reports following each survey (available on the PIRU website (http://piru.lshtm.ac.uk/projects/current-projects/integrated-care-pioneers-evaluation.html#pane3) and in two open access articles in the *Journal of Integrated Care* (Erens et al 2019b; Erens et al 2017b).

More detailed analysis of the four key informant surveys, including trends over time, will be integrated with analyses from other parts of our evaluation of the Pioneer programme for publication in future reports and academic journal articles. This report, therefore, sought to provide only a brief description of the results of the 2019 survey and to highlight a few key developments over the course of the four-year survey period. The key findings include:

- While the most important objectives of integration activities largely remained the same over the survey period, there were some shifts of emphasis, including a reduction in the percentages of informants identifying 'more joined up services' and 'patients managing own care', and increases in the percentages choosing 'improving quality of care' and 'improving quality of life'.
- 'Reducing patient costs' was twice as likely to be mentioned by informants in less deprived areas than by those in more deprived areas (40% versus 19%), while the latter were much more likely to mention 'services becoming more accessible' (6% versus 31%).
- While most informants in 2019 reported progress in meeting their objectives since the start of the Pioneer programme, there were very few reports of 'substantial' progress. Informants who had been in their current job for five years or more were somewhat more likely to report progress than those with fewer years in post (but the differences were not very large). The trend over the four surveys was an increasing proportion of informants reporting progress for most of the objectives.
- Nearly all informants (88%) said their area had established community-based multi-disciplinary teams (MDTs), and these teams most often included voluntary sector service providers (85% of those reporting MDTs), care navigators (78%), and social prescribing (75%).
- Continuing the trend of the previous surveys, nine of the 12 barriers asked about in all survey years had a lower percentage of informants saying they were 'very significant' barriers in the 2019 survey than in the 2016 survey. In all survey years, 'significant financial constraints' was reported to be the most significant barrier.
- The most important facilitators in 2019 were 'good working relationships', 'strong local leadership', 'local providers actively involved' and 'local voluntary organisations actively involved'. The involvement of voluntary organisations increased over the last three surveys and was particularly pronounced in more deprived areas.

In conclusion, key informants were less likely to mention most barriers as being 'very significant' in 2019 than in 2016, perhaps due to staff finding 'workarounds' or simply as a result of an increasing focus on integration regardless of barriers. Despite this reduction in identification of barriers, progress in integrating health and social care services, while continuing, appears to remain slow with few reports of significant progress over the past five or six years.

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Appendix: Pioneer key informant survey 2019 questionnaire

Health & Social Care Integration: Key Informant Survey 2019

This is the fourth survey of key informants within the 25 sites that originally took part in the Integrated Care & Support Pioneer Programme. This series of surveys is part of a long-term evaluation (2016 to 2020) carried out by the Policy Innovation & Evaluation Research Unit (PIRU) at the London School of Hygiene & Tropical Medicine (LSHTM) of the progress of health and social care integration activities in these areas.

The survey asks about **all** integrated health and social care activities in your local area. As in previous years, we are approaching key managers, professionals and others involved in health and social care integration activities in the former Pioneer sites in order to obtain their views on how integration is progressing and what recent developments there have been. Results from the previous three surveys have been presented to NHS England and the Department of Health and Social Care, as well as to other managers and researchers concerned with integrating services. 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 local 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 local area will be identified when we report on the survey results.

The survey should take about **12 minutes** to complete. If you can't complete it in one sitting, your answers will be saved so you can return to it at another time.

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

If you have any questions or comments about the survey, please contact Bob.Erens@lshtm.ac.uk (0207 927 2784) or Mustafa.Al-Haboubi@lshtm.ac.uk (0207 299 4815).

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)

Q3 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 Acute Trust (6)
- ❍ NHS Mental Health Trust (7)
- ❍ NHS Community Health Services Trust (8)
- ❍ Care Trust (9)
- ❍ Voluntary or Community Organisation (10)
- ❍ General Practice / Other Primary Care provider (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) _____

Q4 Which of the following job titles best describes your own situation within this organisation? *Select more than one if appropriate.*

- ❑ Local Integration/ Transformation Lead/ Coordinator (1)
- ❑ Chief Executive/ Accountable Officer (2)
- ❑ Director/ Assistant Director (3)
- ❑ Locality Manager (4)
- ❑ Commissioning Officer / Manager (5)
- ❑ Finance Officer (6)
- ❑ Other Senior Manager (7)
- ❑ Programme Manager (8)
- ❑ Operational Manager (9)
- ❑ Health Care Professional (Clinical) (10)
- ❑ Health or Social Care Professional (Non-clinical) (11)
- ❑ Other (please type in) (12) _____

Q5 How long have you been in your current post? *Please type in years and months*.

	Type in number (1)
Years (2)	
Months (3)	

Q6 And how long have you been working in this local area? *Please type in years and months.*

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

Progress

Q7 Below are eight 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 most important objectives/outcomes that have shaped 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)
- ❑ Reducing unplanned hospital admissions. (3)
- ❑ Patients / service users experiencing services that are more 'joined up'. (4)
- ❑ Reducing, on average, per patient / service user health and social care costs. (5)
- ❑ Patients / service users having a greater say in the care they receive. (6)
- ❑ Services becoming more accessible to patients / service users. (7)
- ❑ Patients/service users being better able to manage their own care and health. (8)

Q8 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.*

Q9 As a result of local health and social care integration initiatives since your area became an Integrated Care Pioneer in ${e://Field/Wave}, how much progress 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)	❍	❍	❍	❍
Improving **quality of life** for patients / service users. (2)	❍	❍	❍	❍
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)	❍	❍	❍	❍
Patients / service users being better able to manage their own care and health. (10)	❍	❍	❍	❍

Q10 Has your area implemented any community-based multi-disciplinary teams (MDTs) which include staff from both local health and adult social care services?

- ❍ Yes, currently we have MDTs involving staff from both local health and adult social care services (1)
- ❍ No, currently we don't have such MDTs, but are planning to (2)
- ❍ No, currently we don't have such MDTs, and have no plans to (3)
- ❍ Other (please type in) (4) _____
- ❍ Don't know (5)

Display This Question:

If Q10 = Yes, currently we have MDTs involving staff from both local health and adult social care services

Q11 Which, if any, of the following initiatives, types of staff, or services are part of, or linked to, the community-based MDTs in your local area?
Please tick all that apply

- ❑ Social prescribing (such as, volunteering; befriending; swimming/walking or other sports; arts-related activities; etc.) (1)
- ❑ Care navigators / care coordinators (2)
- ❑ Generic care workers (3)
- ❑ Shared patient records (4)
- ❑ Shared IT systems (5)
- ❑ Shared / pooled health and social care budgets (6)
- ❑ Community hubs (7)
- ❑ The local voluntary sector to help provide services (eg, social prescribing, etc.)(8)
- ❑ None of the above (9)
- ❑ Don't know (10)

Display This Question:

If Q10 = Yes, currently we have MDTs involving staff from both local health and adult social care services

Q12 Are there different models or types of community-based MDTs that involve staff from both local health and adult social care services in your area?

- ❍ No, there is only one model / type of local community-based MDT (1)
- ❍ Yes, there are different models / types of local community-based MDT (2)
- ❍ Other (please type in) (3) _____
- ❍ Don't know (4)

Display This Question:

If Q10 = Yes, currently we have MDTs involving staff from both local health and adult social care services

Q13 If there is a local name given to the MDTs in your area, what are they called?
Please type in all the names if more than one model / type

_____

_____

Display This Question:

If Q10 = Yes, currently we have MDTs involving staff from both local health and adult social care services

Q14 Are there plans for the community-based MDTs to be aligned with the general practices that comprise each of the local Primary Care Networks (PCNs)?

- ❍ Yes, there are plans to align MDTs with local PCNs (1)
- ❍ No, there are no current plans to align MDTs with local PCNs (2)
- ❍ MDTs are already aligned with local PCNs (3)
- ❍ Other (Please type in) (4) _____
- ❍ Don't know (5)

Display This Question:

If Q10 = Yes, currently we have MDTs involving staff from both local health and adult social care services

Q15 We would like to speak to staff who have an important role to play in your local community-based MDTs. Could you please suggest a few names of staff we could speak to about your local MDTs? (Please suggest staff for each different MDT model / type if appropriate).

*Please type below the **names, email addresses** and **phone numbers** (if known) of any individuals you would like to nominate.*

Q16 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 health and social care integration 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)	❍	❍	❍	❍
GPs not fully committed to our integrated care programme. (2)	❍	❍	❍	❍
Significant financial constraints within the local health and social care economy. (3)	❍	❍	❍	❍
Too many competing demands for time or resources reducing the focus on working together. (4)	❍	❍	❍	❍
Acute services that are not fully engaged with our integrated care programme. (5)	❍	❍	❍	❍
Information governance regulations making it difficult to share patient / service user information. (6)	❍	❍	❍	❍
Incompatible IT systems making it difficult to share patient / service user information. (7)	❍	❍	❍	❍
Insufficient leadership of our integrated care programme. (8)	❍	❍	❍	❍
High turnover of managers or other staff. (9)	❍	❍	❍	❍
Working out realistic financial savings that could be achieved. (10)	❍	❍	❍	❍

Shortages of frontline staff with the right skills. (12)	❍	❍	❍	❍
Increased demand for existing services. (13)	❍	❍	❍	❍
Primary Care Networks (PCNs) not aligning with existing integration initiatives. (15)	❍	❍	❍	❍

Q17 *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.

Q18 **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)
Building, maintaining and reinforcing good working relationships between key local partners. (2)	❍	❍	❍	❍	❍
Having strong leadership at local level. (3)	❍	❍	❍	❍	❍
Having local champions to progress work locally or convince others of the benefits. (4)	❍	❍	❍	❍	❍
Involving patients / service users / carers in co-design of the interventions / activities. (5)	❍	❍	❍	❍	❍
Having a relatively simple health and social care economy (for example, one Local Authority and one CCG with co-terminous boundaries). (6)	❍	❍	❍	❍	❍
Having local providers actively involved in integrated care initiatives / activities. (7)	❍	❍	❍	❍	❍
Having key local voluntary organisations actively involved in integrated care initiatives / activities. (8)	❍	❍	❍	❍	❍

Having a 'bottom up' approach, with staff driving change/ developing the framework. (9)	❍	❍	❍	❍	❍
Obtaining feedback from patients / service users / carers. (12)	❍	❍	❍	❍	❍
Training staff in integrated ways of working. (11)	❍	❍	❍	❍	❍
Having a monitoring / evaluation system. (1)	❍	❍	❍	❍	❍
Developing local plans to become an Integrated Care System. (10)	❍	❍	❍	❍	❍
Planning the local Primary Care Networks (PCNs). (13)	❍	❍	❍	❍	❍

Q19 *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.

_____

_____

_____

The next 12 months

Q20 What do you consider the **top priority** for your integrated health and social care programme over the next 12 months? *Please type in*

_____

_____

_____

Q21 What will be the **biggest challenge** to overcome in the next 12 months in order to meet this priority? *Please type in*

_____

_____

Q22 Are there any key stakeholders in your local 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 local health and social care integration activities. *Please type in* below the names **and email addresses** of any individuals you would like to nominate.

_____

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Q23 *Finally, please type in* any comments you would like to make about how national policies have helped or hindered your local integration activities in the last 12 months.

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