



Integrated Care Pioneers: One Year On

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Contents

Contents	3
1 Foreword	3
2 What is the pioneer programme?	5
2.1 The case for integrated care.....	5
2.2 Introducing the pioneers	6
3 What have the pioneers learnt in their first year?	8
3.1 Pioneer care models and approaches.....	8
3.1.1 Developing person-centred models of coordinated care.....	8
3.1.2 Building integrated systems around a person's needs and wishes	9
3.1.3 Shifting the system to preventative action and stronger communities...	11
3.2 Enablers and barriers to pioneers' work	13
3.2.1 Systems leadership and governance	13
3.2.2 Public involvement and coproduction.....	14
3.2.3 Workforce transformation.....	15
3.2.4 Information governance and informatics	16
3.2.5 New payment approaches	17
3.2.6 New commissioning, contracting and provider models	18
3.2.7 Capturing, sharing and evaluating learning.....	19
4 Are the pioneers making a difference?	21
4.1 Demonstrating the case for integrated care.....	21
4.2 Identifying and addressing the barriers to integrated care.....	23
5 Where next?	25
6 Further resources	27

1 Foreword

Fourteen localities were selected in November 2013 as integrated care pioneers to develop innovative ways to coordinate care around people's needs. They set out to test how we could provide more support at home and earlier treatment in the community, how we could help people to be healthier for longer, how health and care services could work more closely together. Our commitment was to work with them nationally to realise their ambitions.

We are delighted to introduce this report which sets out the pioneers' successes and challenges during the year. Though only a little over a year into the programme, the pioneers are starting to identify the models and concepts that work. The diversity of their ambitions and context has been one of the programme's strengths, enabling different approaches to produce different results, and so increasing our knowledge of what works. They are already starting to make a real difference for their communities, with examples of older people being kept out of hospital, people with chronic poor health helped to maximise their health and wellbeing, and communities empowered to be healthier.

As well as making progress locally, the pioneers are working together to identify the problems and barriers holding them back. We have learnt that addressing these issues is difficult work, with few quick fixes. By their very nature, some of the issues are not straightforward to resolve, such as the information governance challenges of sharing information between organisations to improve care planning and delivery.

We remain fully committed to supporting the pioneer programme in the year ahead. We now need to accelerate progress at national level to unlock barriers to allow integration to flourish at local level. We look forward too to welcoming 11 further localities to join the pioneer programme as it expands with a second wave. They will bring new experiences and ideas to further enhance and expand our collective knowledge and further implementation of integrated care across the country. The pioneers programme will complement the work on specific new models of care set out in the NHS Forward View.

This annual report sets out the achievements, challenges and learning from the first year of the programme. We look forward to working together with the pioneers in the year ahead as they continue to drive forward the delivery of integrated care.



A handwritten signature in black ink, appearing to read 'Norman Lamb'.

Norman Lamb MP,
Minister of State for Care and
Support



A handwritten signature in black ink, appearing to read 'Ian Dodge'.

Ian Dodge, National
Director for Commissioning
Strategy, NHS England;
co-chair Pioneer Support Group



A handwritten signature in black ink, appearing to read 'Frances Martin'.

Frances Martin, Integrated
Commissioning Director
(Adult Services),
Worcestershire; co-chair
Pioneer Support Group

2 What is the pioneer Programme?

Many health and care organisations around the country are working together to improve people's health, wellbeing and experience of care. In May 2013, a collaborative of national partners invited the most ambitious and innovative of these local areas to volunteer to pioneer new approaches to providing care and support which is coordinated around people's needs.

Following a rigorous application process, 14 localities, from a field of over 100 applicants, were chosen by an independent panel of UK and international experts to become Integrated Care and Support Pioneers. Their objective was to lead the way in documenting change and sharing learning so that efforts can be scaled up at a national level.

The national stakeholders, through the Integrated Care and Support Collaborative publication [Our Shared Commitment](#), pledged to support local areas across the country to develop these integrated approaches at scale and pace. This included supporting the pioneers to address the barriers preventing everyone benefiting from joined-up, coordinated care. This report sets out what has happened – and been learnt – since the programme was launched in December 2013. It provides learning from the national programme approach as well as more detailed evidence from pioneers themselves.

2.1 The case for integrated care

The case for change has been widely discussed and understood. The number of people in England who have health problems requiring both health and social care is increasing. The Department of Health estimates that, over the next 20 years, the percentage of people over 85 will double. This means there are likely to be more people with more than one health problem, who will be more likely to require a combination of health and care services. Public expectations of what health and care services can and should deliver continue to rise too, yet resources are under greater strain, which means we cannot continue to deliver health and care services in the way we currently do.

We know that if a person's health is managed holistically, if illness can be prevented, if a person is involved in decisions about their care, not only is that person's experience of care and outcomes better, it also means less pressure on the system. There is broad consensus in creating a system of integrated care and support, one which will work better when it is built around the needs of the individual, is joined up and proactive, and which gets the most out of every penny spent. There is growing evidence too that moving from episodic care to more joined-up approaches, delivered at the right time in the right place, can bring efficiencies as well as improved patient experiences and quality of care.

The programme set out to test ways to make health and care services work together to provide better support at home and earlier treatment in the community to prevent people needing emergency care in hospital or admission to care homes. It is built on the narrative of integrated care developed by National Voices with widespread input

from patients and practitioners across the system. The programme, however, is also underpinned by agreement that integrated care and support is not the end – it is only a means to achieving high-quality, compassionate care resulting in improved health and wellbeing and a better experience for patients and service users, and their carers and families.

The programme's central objective is to accelerate the scale and pace of change, but with this ambition comes the recognition that these issues include some of the most long-standing barriers and intractable challenges, ones which have bedevilled local and national policymakers for decades. There is a temptation, too, to think of integrated care as the silver bullet which will close funding gaps or solve demographic or performance challenges.

It is widely understood that the reality of integrating services is challenging and messy, with different accountabilities, priorities, pressures and needs creating tensions across any given health and care economy. The pioneers were chosen to help overcome these barriers, supported by national stakeholders. Through their individual endeavours they are bringing consensus to the system changes needed to provide the care their communities need and deserve. In some areas there has been tangible progress already, in others success has been harder to secure, particularly where the system has proven less responsive than anticipated, or where localities have complex health and financial challenges.

The pioneer programme was established to test the most innovative ideas, to take risks and to show the system changes necessary to deliver quality care within a sustainable system. It does not offer quick fixes but is an ambitious programme which is providing significant insights. This report seeks to set out this learning so far.

2.2 Introducing the pioneers

The pioneers encompass a broad range of health and care economies, ranging from large urban populations in cities such as Leeds or London to the rural counties of Worcestershire, Staffordshire and Cheshire. They span the country from Cornwall to Southend, from South Tyneside to Kent. Their size and make-up range from some 2 million residents within north west London or the million in some of the most deprived parts of east London, to the diverse populations of Islington and Greenwich, from northern towns such as Barnsley, to the dispersed rural communities of South Devon and Torbay.

The populations of each pioneer encompass many needs, with the full spectrum of demographic, financial, performance and socio-economic pressures present. The configurations of health economies also vary, from those pioneers with a large trust covering the whole locality, while other pioneers are working in a fragmented provider landscape. Some are financially sustainable health and care systems; others face significant deficits or workforce challenges.

The pioneers were also chosen for their different approaches to transformation, with some focusing on new commissioning models, and others developing community capacity or testing novel provider partnerships. They vary too in terms of scale and scope of projects, with some focusing on integrating the pathway for one condition to

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those looking at specific population cohorts or fully integrated health and social care systems. Some programmes also build on projects established a number of years ago whereas others are more emergent.

Shortly after the programme launched, the 14 pioneers were joined by West Norfolk, which was awarded an advanced supporter status in recognition of its ambitions and activity in integrating local provision within the context of a challenged health economy and hospital trust in special measures.

Each pioneer has prepared a profile setting out its vision, objectives and local context, with a summary of achievements, challenges and learning over the first year of the programme. There are also additional case studies and examples throughout this report. Click on the links below to access each profile:

[Barnsley](#)

[Cheshire](#)

[Cornwall and Isles of Scilly](#)

[Greenwich](#)

[Islington](#)

[Kent](#)

[Leeds](#)

[North West London](#)

[South Devon and Torbay](#)

[Southend on Sea](#)

[South Tyneside](#)

[Stoke and North Staffordshire](#)

[WELC \(Waltham Forest, East London and the City\)](#)

[West Norfolk](#)

[Worcestershire](#)

3 What have the pioneers learnt in their first year?

The pioneers are testing a range of care models, working across the boundaries between primary, community, secondary, mental and social care. Most are focused on developing integrated services for population groups at high risk of a hospital admission or dependency on formal care. These groups include frail older people and people with more than one chronic condition such as hypertension or diabetes. As these services are rolled out, the pioneers are extending them to other population groups or localities.

This chapter explores some of these approaches, as well as common themes and barriers, in more detail. It is highlighted that this report does not seek to capture the full breadth and depth of the pioneers' work, and that every pioneer has experienced a wider range of approaches and barriers than listed here. The individual profiles (see links on previous page) contain further information, as well as contact details.

3.1 Pioneer care models and approaches

In this section, you will find a range of examples and case studies which set out the integrated care models being tested by the pioneers.

3.1.1 Developing person-centred models of coordinated care

3.1.1.1 Use of National Voices' narrative – the 'I statements'

A core tool in enabling the pioneers to develop services built around an individual is the [National Voices' narrative for integrated care](#) – the 'I statements'. These describe a care model from the perspective of the patient, and can be used in a number of ways to support partnerships between staff and patients, such as to frame conversations about a patient's care, as well as to measure the success of that care or to inform service redesign around local needs.

Over the course of the year, National Voices with Think Local Act Personal and other national agencies and patient groups have developed additional narratives that explore what integrated care looks like for specific groups, including those with dementia, carers, people using mental health services, older people, people near the end of life, and children and young people with complex needs.

The statements provide a powerful motivator for change, in enabling practitioners to see care from the point of view of the patient and so articulating why change is necessary. Pioneers point to challenges in holding on to the sense of common purpose and motivation as changes to working practices and the workforce are implemented, suggesting the need to revisit and reinforce the case for change. The pioneers note too the challenges in enabling practitioners to move from being a 'fixer' to a 'facilitator' of care, and of treating people needing care as their equals. South Tyneside is helping to change both staff and residents' perceptions through linking these developments with its approach to developing residents' capacity to manage their own health, including ensuring that both staff and residents know what local support is available.

To read another example, see the following case study:

- [Greenwich's use of 'I statements' to coordinate Tom's care](#)

3.1.1.2 Multi-disciplinary working

As described in the pioneer's individual profiles, all are developing new ways for practitioners to work together around the individual. Although exact team configurations vary according to local need, typical features of an integrated care model include the use of joint assessment and care planning, with accountability resting with a lead professional.

Single points of referral or access are common too, often maximising the use of technology. Cornwall, for example, developed a 'community line' which is manned by volunteers and provides a trusted link between local multi-disciplinary teams, key workers and local resources. South Devon and Torbay is also developing a single point of access with a unified call centre, services directory, e-hub and website.

To read more examples, see the following case studies:

- [Kent's integrated discharge team which brings together practitioners from across health and care services](#)
- [Greenwich's approach to building the team around the person, encompassing health and care services](#)
- [Southend's single point of access to its integrated community care teams](#)
- [Islington's N19 pilot, which includes social care and community health services](#)

3.1.2 Building integrated systems around a person's needs and wishes

Typically, the pioneers develop their model around one locality or group of people with similar needs – for example Islington's locality model has developed from a pilot in the N19 postcode area, while Greenwich's integrated teams grew from supporting frail older people.

3.1.2.1 Enhancing primary and community care

A central objective across the pioneers is shifting care from hospitals to locations nearer to people's homes. This includes developing community hubs around GP practices which can offer a broader range of services, as well as investing in more community health and care services to help avoid the need for hospital care. It also means making services available for more hours or in more locations, as well as increasing self-care approaches. South Tyneside's focus on increasing its residents' capacity to manage their own health is being built into developments for integrated teams, and its community and urgent care hubs.

To read more examples, see the following case studies:

- [North West London's support to early adopter projects through an expert panel](#)

- [Islington's approach to developing a locality model of integrated health and care](#)
- [Leeds' work to create an integrated community health and social care service based around neighbourhoods](#)

In several localities, GP practices are joining together into networks to enable the delivery of a wider range of services for their population. In some pioneers, these GP networks are progressing to become legal bodies, which, as they mature, will hold contracts and deliver services collectively. In North West London for example nearly 300 practices covering 1.4 million patients are joining to create provider networks. Similarly, the GPs in Tower Hamlets, which is part of WELC, are contracted through a single partnership and integrated specification. The reconfiguration in Greenwich has extended to encompass all health and care services in one locality, and is leading to the retendering of home care services to better align these with the integrated teams, enabling closer working.

Many pioneers are developing primary or community care hubs which focus on population groups at greater risk of hospitalisation. Southend, for example, is focusing on frail older people who have several chronic conditions because this group accounts for a disproportionate number of emergency admissions, particularly those in care homes.

To read more examples, see the following case studies:

- [South Devon and Torbay's coordinated support for frail older people through its Newton Abbot Hub](#)
- [Worcestershire's care planning which has improved the quality of care for care home residents](#)
- [Barnsley's expansion of personal budgets to people with diabetes](#)

3.1.2.2 Services to help avoid hospital admission

The models typically include interventions which help avoid hospital admissions, such as the use of rapid response or virtual wards. Leeds has established an integrated health and care community bed unit, while Worcestershire's 'GPs in ambulances' scheme involves GPs working alongside paramedics where a patient would be better cared for by a GP rather than in hospital.

To read more examples, see the following case studies:

- [West Norfolk's hospital at home service which provides 'virtual ward' support to very vulnerable residents](#)
- [Kent's establishment of an enhanced integrated rapid response service, which works closely with the ambulance service](#)
- [South Devon and Torbay's Corner Retreat Crisis House for intensive short-stay provision to help avoid hospital admission](#)

Where hospitalisation is unavoidable, integrated discharge arrangements and enhanced reablement services are proving effective interventions to shorten lengths

of stay in hospital, maximise independence on discharge and reduce the need for future hospitalisation.

To read some examples, see the following case studies:

- [Kent's proactive reablement service, a multi-disciplinary team supporting recovery](#)
- [Worcestershire's integrated patient flow and clinical triage centre to streamline hospital discharge](#)
- [Cheshire's approach to developing transitional care models including recovery and rehabilitation services](#)

3.1.3 Shifting the system to preventative action and stronger communities

The importance of prevention is now well understood. The pioneers' care models aim to increase people's ability to manage their own health, for example through increasing patients' access to information, encouraging them to make healthier choices or involving them in decisions about their own care, which research shows increases wellbeing and satisfaction.

Southend has invested in a number of preventative programmes to raise awareness around unhealthy choices. It has included children's services within its integrated commissioning model, so all commissioning is viewed from an integrated care perspective. It is also developing six community based centres in deprived localities as part of a 10-year £40m Big Lottery programme, with a significant focus on education and prevention from an early age.

3.1.3.1 Strengthening self-care and building community capacity

Many of the pioneers are investing in voluntary and community services which are helping people to stay healthy and support each other to do so. An underpinning rationale for Barnsley's programme is to 'invert the triangle' to shift behaviours and cultures towards prevention and early intervention.

To read more examples, see the following case studies:

- [West Norfolk's LILY \(Living Independently in Later Life\) programme, an online directory and call centre service](#)
- [WELC's self-management approaches which target support for those most at risk of hospital admission](#)

A crucial factor in the success of many of the pioneers' programmes has been empowering patients and the community. Islington has rolled out patient 'activation' measures to understand its population better and so target interventions more effectively. Barnsley has developed community organisers, while South Tyneside's self-care programme is being designed and shaped by ongoing engagement with staff and residents.

To read more examples, see the following case studies:

- [South Tyneside's approach to engage its community to 'change the conversation' around self-care](#)
- [South Devon and Torbay's use of social prescribing to increase individual's wellbeing and independence](#)

The voluntary sector also has a critical role to play. West Norfolk commissions care navigators from local voluntary groups. Similarly Islington has developed a voluntary sector based locality navigator service to provide low-level support, advice and signposting to community services. In Cornwall, an Age UK worker is seconded into the multi-disciplinary assessment team to work alongside a GP, district nurse and social workers.

To read more examples, see the following case studies:

- [Staffordshire's partnership with a national voluntary organisation as a strategic partner for change](#)
- [Cornwall's development of volunteers to afford them parity of esteem](#)

Another critical enabler is the use of technology. Some 7,000 people use Barnsley's telecare services, for example, and it recently launched an online portal to provide access to a wide range of information and services. Kent's innovation hub, which was launched in December 2013, connects stakeholders across the county, and has won an EU award for its innovation. Cornwall has developed a 'knowledge bucket' as a central online store of stories, news, resources and reports. It hopes to extend this with free Skype calls for people supported by the programme.

To read another example, see the following case study:

- [Leeds' use of technology to enable 'citizen-driven' health](#)

Many pioneers are also ensuring that mental health services are incorporated into their plans, because people with mental health concerns have poorer health and reduced quality of life. This is also in line with broader policy commitments around achieving parity of esteem for mental and physical health, and recognises the interplay between the two.

Greenwich, for example, has redesigned mental health care pathways so that services can be delivered through local integrated structures. Islington has also developed an integrated liaison and assessment team which provides access to mental health assessment and treatment in A+E and on the wards. South Devon and Torbay has well-established integrated mental and physical health services. Recent innovations include a multi-agency integrated psychological therapies group, GP link workers between GP surgeries and community mental health teams, and a single point of referral for mental health support.

Dementia services are another priority focus for several pioneers. South Tyneside has invested significantly, including a £30m partnership between the council and local NHS foundation trust to house all dementia services in one new facility. Kent, meanwhile, continues to develop its dementia-friendly communities, including through intergenerational activity between schools and care homes.

3.2 Enablers and barriers to pioneers' work

A central programme was set up to coordinate and facilitate help from national agencies and direct programme support from NHS England. Each pioneer also received some funding to support their work. In addition, in response to challenges around how to connect local and national agencies effectively, a 'senior sponsor' from a national partner agency was paired with each pioneer to provide a route to highlight and if necessary escalate issues.

Over the course of the programme's first year, the pioneers have identified common themes building on the barriers identified in *Our Shared Commitment*. They have requested support from national partners as well as working together to better understand the issues and test potential solutions. These themes have developed into workstreams, each with programme leadership and contributions from pioneers and national stakeholders.

3.2.1 Systems leadership and governance

Overwhelming evidence indicates that the key to successful transformation is strong relationships which enable leaders to overcome organisational boundaries for the benefits of the whole system. Where it is working well, it is not because of changes imposed nationally. It is through local leaders at all levels – clinicians, health and care workers, managers and patients – taking bold steps to move away from traditional ways of working which may benefit their own organisation but be to the detriment of the whole system.

Each pioneer has been offered support from the national Systems Leadership programme, which aims to create system-wide change through leadership development and cross-boundary collaboration. The programme is managed by The Leadership Centre, which is an alliance of national bodies across health, care and other public services, and service users. Each pioneer is provided with direct ongoing support from an 'enabler', who is a leadership development specialist and, in many cases, an experienced senior leader in the sector. The support has included on-site coaching and facilitation to develop the leadership behaviours and relationships necessary to transform local systems.

For example in Kent, the enabler work has led to a series of workstreams with lead officers to support the development of a locality-led approach to integrated care. Similarly in Leeds, the work is supporting the development of a workforce strategy, and has also underpinned conversations with national regulators about the use of tariffs. Another example is in Islington, where local leaders have acknowledged the importance of the enabler in making possible the difficult but necessary conversations that have underpinned their progress towards implementing their 'test and learn' sites across the borough.

Pioneers point to a crucial first step being to identify the leaders in the system who can engender change – and these are not necessarily the most senior people in an organisation. It is vital too to engage the workforce at an early stage. The pioneers all stress the importance of developing a common language and sense of purpose, and of reinforcing this through extensive communications. They point to the value of

creating a compelling story with which everyone at all levels can engage, as well as regular communications to emphasise messages and maintain momentum.

The pioneers highlight the importance of creating space to have the kinds of difficult conversations identified above, especially where relationships are friendly which can inhibit challenge around thorny issues. Some have found too that stakeholders vary in their commitment, with some prioritising integrated care and others not. They emphasise the value of using an independent change agent, who can ‘hold a mirror’ to local leaders to encourage thinking outside organisational silos. Many have recognised that their ‘good relationships’ masked underlying tensions that were only exposed once the thorny issues were placed on the table. Their experiences demonstrate how collaborative working on a shared problem as well as developing common performance measures or funding all help to create shared purpose. North West London, for example, shares funding allocations across inner and outer London boroughs to create greater financial equity.

Strong governance arrangements are essential too, ensuring widespread membership and commitment. This includes from providers as well as patients. Staffordshire’s governance arrangements include independent advice and oversight, including an external national expert advisory group bringing together academic, provider and patient groups. The role of health and wellbeing boards is seen as offering potential although their capacity to assume a leadership role has varied. Many of the pioneers acknowledged that their local boards were galvanised through developing local Better Care Fund (BCF) plans, which required collaboration to develop new ways of working, including difficult conversations around funding. The BCF, although it diverted capacity over the year, has also spurred some localities to be more ambitious, or has provided an enabler for local visions.

3.2.2 Public involvement and coproduction

Developing care which is truly built around people requires more than consulting them about their experiences or what services they need. The pioneers are testing ways to involve people in designing the services around them, from planning through to delivery and auditing their effectiveness. They all point to the power of working in partnership with residents, noting that a user voice gives system leaders a mandate for change.

Greenwich, for example, has worked with local residents, using the framework of National Voices’ ‘I statements’, to identify what matters most to local people to help shape its vision and resulting plan. It has found that using the I statements as a basis for care planning has provided a powerful mechanism to explore the system and unlock and reconfigure work in a different way that addresses the individual’s personal goals as well as their clinical needs.

Most of the pioneers are developing a local set of ‘I statements’, which can also be used to measure the effectiveness of interventions or to underpin service reconfigurations. Islington, for example, has used them to frame the development of its locality offer. Cheshire, meanwhile, is using its set of ‘I statements’ to evaluate the impact on patients of its IT connecting project.

West Norfolk has consulted widely to support the development of its whole-system sustainability initiative, including discussion sessions with local groups. It is also seeking to recruit local champions to advocate for its prevention initiatives. Public involvement is also central to Southend's prevention and engagement activity, with a range of projects including social prescribing, patient 'activation' measures and a 'Talking Health' project. WELC is also exploring the use of patient 'activation' measures, and is involved in the national integrated care PROM pilot.

Many ensure patients are involved as equals in decision-making through representation in governance arrangements. Islington has a well-established Making It Real programme, which includes a board co-chaired by the chair of the borough's Personal Budgets Network and its adult social care director. Similarly, WELC has patient representation on its integrated care boards, and South Devon and Torbay has equal voice for local people on its JoinedUp board, which oversees its transformation programmes. In North West London, a dedicated workstream called Embedding Partnerships ensures that lay partners are involved at all levels of the pioneer programme and that co-production is the underlying principle for all work taken forward.

To read more examples, see the following case studies:

- [North West London's development of lay partners in co-designing its transformation](#)
- [Staffordshire's approach to co-design with people who have experience of services](#)
- [Staffordshire's patient champions' stories](#)

3.2.3 Workforce transformation

Integrated care requires professionals to work in new ways, for example, in multi-disciplinary settings where trusting colleagues and being able to work collaboratively is essential. A group of pioneers, supported by among others Skills for Care, Public Health England and Health Education England, are exploring how to reshape the workforce to one that is able to deliver care in new ways focusing on patients as partners in their care.

This includes identifying and overcoming common issues, such as the challenges of understanding what local workforce profiles look like now, and how these will need to change to meet the needs of the future. Profiling includes understanding the age of the workforce and local factors, such as pressures on recruitment and retention in certain professions. Pioneers and national partners are exploring how to develop new approaches to recruitment to attract people with the right skills and behaviours as well as ways of training and supporting staff to promote retention.

West Norfolk has developed the 'alliance way' to articulate common values, while across Cheshire, investment in integrated teams includes using learning networks, action learning and an 'academy' to support cultural and behavioural change.

To read another example, see the following case study:

- [Islington's approach to developing the workforce through a community education provider network](#)

National partners are also supporting the pioneers through the provision of expertise and development of resources. Skills for Care launched *Principles for Workforce Integration*, a 'how to' guide describing key principles to underpin transformations, including checklists, potential models and practical guidance. Health Education England has also piloted inter-professional packages and developed modules to upskill staff across the frontline, such as in understanding mental health and communication skills. This work is in early stages, with a focus for next year including testing new roles and skills, for example hybrid job roles for non-clinical staff or specialist GP roles. WELC has developed new roles, including a senior case manager to oversee the needs of very high risk patients, while other pioneers have focused on developing existing roles, such as in Greenwich.

3.2.4 Information governance and informatics

One of the first networks established by the pioneers was around informatics, to take forward issues in relation to technology and information sharing, a critical enabler to integrated care. Through the network, which is chaired by Leeds, the pioneers have prioritised eight projects which focus on how technology and information governance can enable the delivery of integrated care. The network is also active in sharing best practice from local areas. Each project has a pioneer lead who works alongside a national lead to help drive progress. These are also supported by a dedicated programme manager to create and maintain momentum.

A number of the pioneers are testing shared care records which enable patients and staff to access information which is timely, accessible, comprehensive and secure, where you tell your story only once. Leeds has led these developments through the informatics network.

To read more examples, see the following case studies:

- [Barnsley's holistic care project which is uniting health and care data through a single hub](#)
- [Cheshire's work to establish a pan-Cheshire integrated digital care record](#)
- [West Norfolk's Eclipse Live programme to share information across the locality](#)

Effective information sharing is also essential to service reconfigurations, systems leadership and work to profile the health needs of local populations. At a programme level, key barriers were identified through a 'deep dive' into two pioneer sites, South Tyneside and Southend. This sought to develop an in-depth understanding of the issues facing commissioners and providers across health and care who wanted to develop joined-up approaches. It was led by the Department of Health and involved national partners and pioneers working together to understand issues and develop solutions. For South Tyneside, no barriers were identified from this visit because the focus was on direct care.

Southend's deep dive surfaced a common challenge, however. This is around profiling patients' needs holistically through linking health and care data – barriers

include data confidentiality that precludes linking key data sets. To support a national solution, Southend took the lead in applying for permission to set aside the common law duty of confidentiality in order to share its data across local organisations. The intention was to develop a template on which other localities could then build.

To read about Southend's application and other examples, see the following case studies:

- [Information governance and Southend's s251 application](#)
- [Worcestershire's approach to profiling its population's health needs](#)

This barrier has proved to be one of the most intractable issues. A lot of work has been done over the year and it is disappointing that a resolution has not yet been found. National partners, the pioneers and the programme's leadership are prioritising identifying solutions that can be shared with localities. We await the government response on the future of safe havens and are working with Department of Health, NHS England and IG Alliance to ensure there is clarity around barriers and to present available options to areas.

3.2.5 New payment approaches

Another commonly cited barrier to integrating care around the individual is the way services are funded, with providers paid either on block or per activity rather than outcome, a formula which has created disincentives and distortions in the current system. Monitor, alongside other national partners, has actively supported the pioneers to explore flexible payment approaches which pool available funding for a population group, so that their needs are addressed holistically by one or more provider. The collaboration includes intensive support on-site to address key challenges, including how to identify population cohorts, understand the costs of the services they receive, and develop agreements between providers on how to share financial gains and losses.

To read more about this work, see the following case studies:

- [North West London's approach to developing capitated budgets](#)
- [WELC's development of capitated budgets](#)

Learning from this work includes acknowledgement that local areas need strong information sharing, governance and outcomes measurement arrangements, particularly to identify and track changes in outcomes for local people.

Monitor has also established an integrated care payment forum, in which pioneers and other leading edge localities, such as those engaged in the Year of Care programme, can identify common issues, share learning and best practice, and collaborate on solutions.

The collaboration between pioneers and national agencies has led to the publication, by Monitor, of a suite of guidance and supporting documents on payment approaches in November 2014, including a care spend estimation tool. The pioneers will continue to support this work, with plans to shadow test these new payment approaches in 2015.

3.2.6 New commissioning, contracting and provider models

Many pioneers are testing new ways to commission or contract services, such as developing integrated specifications for a specific disease, population group or locality. Staffordshire is developing an ambitious programme to develop integrated pathways built around improving patient outcomes and away from a series of disparate treatment episodes. It is demonstrating the value of strong governance arrangements to manage the complexity of working across six NHS commissioners.

Personal budgets offer another mechanism to personalise and coordinate services around individuals. These tools have a well-established track record in social care, and are increasingly being used for the health needs of residents needing health and care services.

A number of pioneers are establishing integrated commissioning teams. Many pioneers have also used the pooling arrangements through the BCF to further their integrated care ambitions. In Worcestershire, BCF planning led to the creation of an integrated commissioning unit. Many pioneers point to the challenges of fragmented accountabilities, noting the need for common values and performance measures to underpin joint activity. Islington is implementing a value based commissioning approach across three population groups (frail older people, diabetes and mental illness). This involved reorganising services around these needs, with care provided by a multi-disciplinary team, and the value measured in health outcomes.

To read more examples, see the following case studies:

- [Southend's development of an integrated commissioning service](#)
- [WELC's development of an integrated specification supported by a single partnership of local providers](#)

These innovations often require providers to work together in different ways, and a number of pioneers are trailblazing the creation of new organisations or groupings which span several sectors. For example, Devon and Torbay has proposed the merger of its community trust and acute trust to create an integrated care organisation. Others, such as North West London, are planning for implementation of accountable care partnerships, bringing together GP networks and other providers which will take on the capitated budget and joint accountability for the outcomes of a given population group. Another example is in West Norfolk, which is exploring the development of a 'health campus' to create a sustainable future for its small district general hospital, which is in financial distress.

At a programme level, the 'art of the possible' was explored through a one-day conference, led by WELC, which itself is a leader in this area. This reinforced the need for systems leadership to develop a common purpose, although pioneers also point to the financial pressures of developing new arrangements while keeping 'business as usual' going. Learning includes ensuring that providers are supported and encouraged. North West London, for example, uses block contracts with incentives around integrated care to provide financial stability for providers while enabling the shift of services into the community.

3.2.7 Capturing, sharing and evaluating learning

Underpinning the programme is the need to capture and share learning. The pioneers collectively come together to share and learn from each other at 'assemblies', at which national stakeholders and other leading edge localities also contribute. These other localities include the Public Service Transformation Network, which includes localities testing integrated health and care provision, such as Greater Manchester and Sheffield.

The pioneer assemblies are complemented throughout the year with regional or thematic events, such as workshops on BCF developments or financial modelling. In addition, the pioneers have also developed networks based on localities – for example Leeds, North West London and Greater Manchester have developed a three-way network which began from informal conversations around their similar demographic and system pressures. Kent, through its innovation hub, has incorporated social media, using tweet chats for example to promote learning and engagement. More broadly, learning is disseminated via the online platform ICASE, and collaborative tools such as webinars and Google hangouts. It is recognised, however, that the online platform has not been as effective as pioneers need, and it is being redeveloped to be more accessible, intuitive and flexible.

The Department of Health is developing a phased approach to independently evaluating the programme. An early evaluation of the vision, scope, objectives and plans of the pioneers will be complemented by a longer-term evaluation that will consider the impact of the programme in the context of the government's wider integrated care policy programme. The first phase will report later this year, with the second phase currently in development. The central programme is also exploring options to enable the dissemination of learning, in real time, of what works in delivering quality integrated care. This will seek to take an iterative approach to monitoring progress to drive improvements and ensure quicker dissemination of learning, particularly in exploring the quality and economic impacts of integrated care.

Each pioneer has also established its own evaluation programme. Islington, for example, has included patient and staff surveys as well as the 'hard' measures around outcomes and outputs, in its evaluation for its locality offer developments. WELC has engaged a researcher in residence to support the programme to better use established research evidence. The pioneers are also learning from other examples of best practice. When Southend began developing its integrated commissioning function, it reviewed the evidence base to understand the most effective approaches. This has become a comprehensive library which provides an enduring resource for practitioners.

The shared themes and learning from local evaluations are being identified by a group of pioneers, supported by a working group of national agencies and leading academic and policy institutions. This group is led by Public Health England. Key learning includes the importance of widespread engagement, and of using examples of what works, including positive stories to engage and motivate stakeholders. They highlight the need for clear governance arrangements, noting that using shared metrics helps to build common purpose. Staffordshire, for example, has developed an outcomes framework which describes the outcomes its transformation programme is intended to secure over ten years, with payment linked to performance. The

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pioneers also point to the challenges of measuring patients' experience, which are compounded by a lack of nationally consistent measures.

To read more examples, see the following case studies:

- [Cornwall's approach to developing an evaluation framework linked to outcomes](#)
- [South Tyneside's evaluation framework for its self-care programme](#)

The work to capture and share learning includes working across the growing range of integrated care initiatives at national and local level. The pioneers are often involved in other programmes such as the Year of Care, Prime Minister's Challenge Fund and Seven Day Services programme. Another is the Integrated Personal Commissioning programme, which is preparing for a full launch in April. This will include a focus on developing financial models to underpin personalisation approaches, with pioneers sharing in this learning and development. Although there are challenges in managing the multiple reporting requirements, these programmes also bring opportunities to access further resources or expertise and to collectively further knowledge of and evidence on integrated models of care.

4 Are the pioneers making a difference?

The intense focus, over a range of places and issues, has clarified the opportunities and barriers to improved outcomes through integrated care.

4.1 Demonstrating the case for integrated care

In just the first year, the pioneers are showing how integrated care, albeit not yet at significant scale, can improve their communities' health and experience of care. These improvements have often focused on reducing the number of times people require hospitalisation, which eases pressure on the system. An evaluation by Cornwall of one of its pilot sites, in Penwith, for example, has shown the number of people being admitted to hospital falling by nearly 50% – this builds on a 40% fall achieved in Newquay. In addition, the evaluation showed that quality of life indicators increased by 18%, and with a return on investment estimated at 4:1.

Kent has found similar success through its Proactive Care service, with the first group of 134 patients experiencing a 55% reduction in non-elective admissions alongside improved patient experience. Savings so far are estimated to exceed £200,000. Greenwich, meanwhile, found its integrated health and care teams brought a 35% reduction in admissions to care homes in their first year.

A key focus for many of the pioneers has been targeted support to reduce admissions from care homes, through investment in community and voluntary sector provision, and proactive case management. South Devon and Torbay has reduced the number of people living in residential and nursing care homes, as well as securing a fall of nearly 10% over the past year to date in the number of emergency admissions from care homes. Worcestershire's introduction of proactive case management of care home residents has supported a fall of 23% in A+E attendance from care homes, with savings estimated to be some £700,000.

Many pioneers are also demonstrating improving patient experience of care, for example in Islington, which has increased patient satisfaction with their care and with feeling supported to manage their own health. It is also improving care through, for example, its integrated liaison and assessment team, which is halving the length of stay for its patients and cutting by three-quarters their readmission rate. Through more effective case management, each WELC borough expects net savings of between £8m and £17m by 2017/18 through reducing emergency admissions. Southend is also investing in extra care housing specifically for residents with dementia, which is anticipated to achieve efficiencies of £200,000 a year. This builds on reductions in residential care placements, which have been achieved through, among other initiatives, the adaption of over 175 homes to support greater independence at home.

These impacts, along with others described in this report and elsewhere, build a persuasive case for how, and why, to develop person-centred, coordinated care. Through this work, the pioneers have reinforced the strategic case for integrated care, and helped to inform the Forward View's new models of care. The multi-speciality community provider model, for example, has resonance with learning from the pioneer programme.

Similarly, the BCF framework also built on the work of the pioneers. Fund requirements for the identification of lead professionals, care coordination, joint assessment and single care records are features developed by the pioneers to support their integrated care models. Moreover, the fund requires the pooling of health and care budgets for investment in community and social care – with many of these services tested and proved effective by pioneers, including admissions avoidance provision, such as rapid response teams or virtual wards, as well as integrated discharge teams and reablement services. Indeed, in terms of expenditure on BCF plans, the pioneers are investing more heavily in community care services, placing nearly 50% more proportionally than the national average.

Early analysis across the pioneers' BCF plans is also demonstrating a high level of ambition, with the collective group pooling around 40% more than the minimum sums required by national guidance – amounting to just over £1bn in total. They are also showing greater ambition than national averages on most of the fund's metrics, particularly around delayed transfers, which is nearly double the national average, and residential admissions. Only four pioneer areas have set a target below the national expectation of 3.5% for reduction in emergency admissions. Collectively, more than 33,000 emergency admissions, some 35,000 days and nearly 800 residential admissions are anticipated to be saved, all which are proportionally equal or greater than national averages.

In addition the development of the BCF programme built on Greenwich's involvement as a fast-track locality as well as the financial modelling of Tri-borough, which comprises three of the local authorities in North West London. The model underpins the development of an integrated community independence service, which is central to its BCF plans, and is demonstrating with strong evidence that the shift towards a higher community patient base by reducing hospital and care home admissions will result in both short and long-term savings to the health economy of the Tri-borough, bringing predicted net savings of some £3m in 2015/16.

To read more about the model, see the following case study:

- [The CIS financial model and its example of integration](#)

Greenwich's integrated health and care teams were evaluated to have brought about a productivity saving of over 5% in health services in its first 12 months of operation. The social care budget was reduced by £900,000. Although early indications, these findings are beginning to demonstrate that integrated care can improve value and secure savings, helping to put organisations on a sustainable footing as well as improve the quality of care in order to improve the health and experience of care. This is particularly for more vulnerable people including frail older people and those with chronic conditions.

As the programme moves into its second year, and plans are further implemented, the pioneers will continue to test and develop the economic case for integrated care, including through implementing their BCF plans. They have proven so far that the changes the system seeks to make can be realised through the integration of health and care, and by reconfiguring services away from hospitals. The collective work of

the pioneers and national partners is also helping to persuade the public of the need to reconfigure services, and it is expected this work will remain a focus over the coming year, particularly as changes and increases in demand place further pressure on the system's sustainability and heighten the need for change.

4.2 Identifying and addressing the barriers to integrated care

Key to the pioneers' first year has been their work around the enablers of and barriers to integrated care. They are leading the development of new organisational forms as well as new ways to pay for services through a single budget built around the needs of local people. Issues around developing system leadership behaviours, and workforce capacities and capabilities are also progressing well as pioneers push ahead with implementation.

The pioneers are showing too how to integrate data around the needs of individual patients, to provide seamless, timely information about their needs. The barrier around sharing information in order to profile the needs of local populations remains, however, and will be a priority for resolution in the year ahead. The difficulties unblocking this barrier highlight that system-wide challenges take time to resolve and national partners need to understand the implication of policy change to avoid unintended consequences, and to ensure sustainability of change.

Many of the year's achievements are also just the first steps in a longer journey – for example the development of local approaches to new payment models will be further developed over the coming year by shadow testing them. Many of the benefits, too, can seem intangible at this early point, with impact measured in the new relationships formed, the trust established or the mindsets changed. In addition, it is true that investing in a sustainable future for health and care services may take a lifetime to fully see the impact.

This year's advances have been built on collaborative working between national and local agencies. This includes the pioneer assemblies, where national and local representatives have come together to discuss common issues and set shared objectives around the support programme. The establishment of a pioneer support group, comprising leaders from the pioneers and national stakeholders, has also improved lines of sight and accountability across the system. Some of the pioneers highlight too that the role of senior sponsor has proved another successful way to access help from national partners. They, and their senior sponsor, point to how it has helped to build relationships between their agencies, has raised the visibility of integrated care issues within national organisations and has enabled the sponsor to champion local issues on behalf of their pioneer in national circles.

It has been a key learning point from the first year, however, that progress is quicker and more widespread when the support offered to pioneers is more structured and targeted. The initial model of providing programme management support equally across sites did not adequately reflect and respond to the targeted of the pioneers' challenges and context. This has led to support being more targeted to local need and to a greater use of specialist expertise. This includes where one national partner provides concentrated support for a handful of sites on a specific challenge, with processes to cascade learning across the programme. For example, Monitor has

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worked intensively with those at the leading edge of developing capitated models, with the learning from this shared through the integrated care payment forum, which is a wider group of localities at an earlier stage of the capitation journey. Collectively, this work has accelerated understanding of the issues and led to the publication of draft payment models and case study examples to support system-wide change.

This targeted model is also making greater use of peer-to-peer support, which has proved effective across the programme to collectively problem solve and share learning, for example through the informatics network and the shared workforce programme. It will be important in the second year to continue to build on these approaches, particularly with the expansion of the programme and strengthening alignment with the vanguard localities testing the Forward View new models of care.

A key challenge for the second year is in how best to disseminate learning from local solutions that can be replicable across the country – a challenge for many system transformations, not just integrated care. National and local stakeholders also recognise the lost opportunities from not disseminating learning across the system as effectively as had been intended. ICASE, the online platform, is being overhauled, and a range of toolkits, case studies and other resources are planned to help share what the pioneers have learnt more widely. This also includes influencing policymakers up to and after the general election, including the new government's policy and spending commitments.

As the pioneers move into their second year, they are building plans for the future knowing that service transformation will require ongoing commitment and leadership. The pioneers can, rightly, point to success in demonstrating the underlying need to integrate health and social care, and how to transform local systems to respond to the needs of today's population. They, too, with national partners, look forward to making further progress in the year ahead.

5 Where next?

The second year of any programme has challenges in maintaining momentum and building on early successes. This year too will bring many changes including a general election, subsequent spending round and ongoing implementation of transformational programmes.

The pioneers, as described throughout this report, are demonstrating that integrated care takes time to deliver but that it is a proven critical component of sustainable health and care systems.

The programme's second wave of pioneers is set to widen the range and depth of localities testing innovative approaches. NHS England, along with other national partners, remains committed to supporting and enabling the pioneers to realise their ambitions at scale and pace. This includes accelerating the diffusion of learning to date, particularly the lessons from the first year. The pioneers will seek to not only build these lessons into their own programmes, but also to promote messages more widely so as to inform other localities' practices as well as national programmes. This will be achieved through strengthening communities of practice as well as continuing to work collaboratively around thematic issues, with peer support across pioneers and Forward View vanguard sites intended to enable wider and quicker cascading of lessons and experiences.

As the number of pioneer sites expand in 2015, it will be important to be able to frame key issues and challenges clearly so that partners can work together to find paths to resolution. There may also be the case for bringing new national partners into the discussion more actively. Developing a new workforce, for example, will take several years not only to plan but more importantly to deliver the outcomes. Thinking about how the royal colleges can support syllabus change means bringing in key and influential partners which can work with pioneers to identify required changes and then negotiate these at a national level.

National stakeholders recognise too the need to strengthen the support offered from the centre to accelerate progress, with more targeted support tailored to individual pioneer's needs and for this to be shared with Forward View vanguard sites. National agencies have also committed to resolving the barriers around effective information sharing including IT interoperability, as well as testing new payment approaches, contracting and commissioning models, and furthering workforce developments.

For the pioneers, priorities for the year ahead also include implementing the next steps in their local plans, with many developing or embedding changes on the ground. This includes how to maximise the impact and benefit of other initiatives, including the BCF, primary care co-commissioning and integrated personal commissioning, among others. The pioneers recognise that these are central to system transformation, and as such offer opportunities to further the ambitions of each pioneer programme. Their work also supports wider ambitions around strengthening system resilience, for example, or addressing the quality agenda. This includes activity in response to Winterbourne View or the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report), where person-centred approaches are helping to lead to better quality of care.

OFFICIAL

The reality of transformation in times of financial restraint and rising demand will continue to feature significantly in the year ahead. It is recognised that there is further work needed to develop the evidence base around the economic benefits of integrated care, and this is a workstream which the pioneers will develop and prioritise over the coming year. Another is to develop a common language around measuring the impact on people's experiences of care and their health and wellbeing. This too is an area which national stakeholders are exploring through the development of nationally consistent measures.

The value of integrated care is in more than just financial terms, with the pioneers demonstrating the value of joint working in improving staff productivity and morale, and, fundamentally, improving the quality of care for their residents. As the programme progresses, a focus will continue to be how to develop the capabilities and capacity of system leaders at all levels, and how to engage and motivate staff, patients and the wider community to work together to create proactive, joined-up health and care which improves people's health, wellbeing and experience.

6 Further resources

Association of Directors of Adult Social Services: <http://www.adass.org.uk/home/>

Association of Directors of Children's Services: <http://www.adcs.org.uk/>

Care Quality Commission: <http://www.cqc.org.uk/>

Centre for Excellence in Information Sharing: <http://informationsharing.org.uk/>

Department of Health: <https://www.gov.uk/government/organisations/department-of-health>

Health Education England: <http://hee.nhs.uk/>

Local Government Association: <http://www.local.gov.uk/>

Monitor: <https://www.gov.uk/government/organisations/monitor>

NHS England: <http://www.england.nhs.uk/>

National Institute for Health and Care Excellence: <http://www.nice.org.uk/>

National Voices: <http://www.nationalvoices.org.uk/>

Public Health England: <https://www.gov.uk/government/organisations/public-health-england>

Social Care Institute for Excellence: <http://www.scie.org.uk/>

Think Local Act Personal: <http://www.thinklocalactpersonal.org.uk/>