PIRU POLICY INNOVATION AND EVALUATION RESEARCH UNIT

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

Results from the fifth survey (autumn 2020) of Pioneer Key Informants: perceived effects of the Covid-19 pandemic on integration activities

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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 elements conducted over six years, one of which is an annual survey of key informants (mainly senior managers) from the Pioneer areas.

The first key informant survey took place in spring 2016, the second in spring/summer 2017, the third in autumn 2018 and the fourth in autumn 2019. A paper looking at the progress of the Pioneers using results from the first three surveys was published in 2019 (Erens et al, 2019b). Results from all the previous key informant surveys are available on the PIRU website (Erens et al 2017a; Erens et al 2018; Erens et al 2019a; Erens et al, 2020). The fourth key informant survey was the last one originally planned. However, the Covid-19 pandemic that began in England in early 2020 had such a significant impact on the provision of services at all levels of the health and care system, that the research team decided to carry out a fifth key informant survey in order to explore the effects of the pandemic on ongoing local integration activities within the 25 former Pioneer areas. This report describes findings from the fifth key informant survey carried out in autumn 2020, six to seven months after the first national lockdown on 23rd March 2020, and about two and a half years after the Pioneer programme had formally ended in March 2018. It provides a somewhat different focus than the earlier reports by looking specifically at the perceived effects of the Covid-19 pandemic on local integration activities.

Overall, 58 key informants from 22 (of the 25) former Pioneer sites completed the survey, split between Clinical Commissioning Groups (CCGs) (n=14), Local Authorities (n=11), NHS providers (n=27) and other organisations (which includes the voluntary sector and Healthwatch) (n=6). There were 35 informants from the 14 W1 sites and 23 from the 11 W2 sites.

As expected, the Covid-19 pandemic has had a profound impact on both the individuals and organisations involved in the planning, management and delivery of integrated health and social care services.

Many key informants identified positive impacts on integration activities during the pandemic including: highlighting, locally, the importance of providing ‘joined-up’ services and a ‘whole system’ approach to service development; increased recognition of the need to tackle health inequalities; strengthened strategic and operational relationships and improved communication between health, social care and voluntary and community services; and reduced barriers between services. There was some reported progress during the pandemic in meeting local integration objectives, such as reducing unplanned hospital admissions; helping patients/service users better manage their own care; and joining-up health and social care services.

On the other hand, key informants also identified some negative impacts on integration activities including: the demands placed on systems, services and staff by the pandemic; an increased staff workload leading to more stress and reduced wellbeing; reduced capacity to plan services because

of the immediate demands arising from the pandemic; and concerns about the current financial situation of health and care services, as well as uncertainties about future resources. The pandemic was said to have hindered progress with a number of key integration objectives, including improving the quality of care and quality of life for patients/service users; making services more accessible; and reducing average per patient/service user health and social care costs.

On balance, however, perceived progress towards increased integration at local system and individual organisational levels facilitated by the pandemic appeared to outweigh the impact of barriers to integration instigated by the pandemic. This suggests that the 'integration paradox' identified in our earlier reports – i.e. growing need and declining budgets simultaneously heightening integration imperatives and obstacles - was less in evidence. The exceptional systems shock generated by the pandemic, together with substantial resources targeted at long-established boundary issues, such as hospital discharge, seemed to have helped shift the balance in at least some circumstances away from siloed working and towards a recognition of the necessity for more collaborative working. Whether the positive developments will continue to be embedded and to outweigh the negative ones over time, however, remains to be seen, and was questioned by some of the key informants given the multiple ongoing pressures on systems, services and staff. Beneficial developments maybe more likely to be preserved if national and local policy-makers support the positive trends, and if sufficient financial resources, distributed equitably across health and social care, continue to be provided once the immediate threats of the pandemic begin to recede.

1. Background

This report describes the fifth 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 conferences and workshops. However, they were only provided with limited additional funding (initially £20,000 per site, later supplemented with a further £90,000 each). All support ceased when the programme formally ended in March 2018.

PIRU has been evaluating the Pioneers since January 2014, and our long-term evaluation which will be completed this year, aims to assess the extent to which the Pioneers were successful in making progress towards 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 subsequent developments in 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 key integration objectives.

The first key informant survey took place between April and June 2016 and was reported in April 2017 (Erens et al, 2017a). The second survey took place between June and September 2017 and was reported in October 2018 (Erens et al, 2018). The third survey was carried out between September and November 2018 and was reported in September 2019 (Erens et al, 2019a). The fourth key informant survey took place between October 2019 and January 2020, and was reported in April 2020 (Erens et al, 2020). The reports from the first four key informant surveys are available on the PIRU website (http://piru.lshtm.ac.uk/projects/current-projects/integrated-care-pioneers-evaluation.html#pane3) as well as in two open access articles in the *Journal of Integrated Care* (Erens et al 2019b; Erens et al 2017b).

The fourth survey was planned to be the final one in the original study design. However, the Covid-19 (coronavirus) pandemic started to take hold in England in early 2020, and led to the first national 'lockdown' on 23rd March. The pandemic had significant impacts on England's health and care system at all levels, and quickly placed substantial additional pressures on many health and care organisations and both managerial and clinical staff (e.g. from late-March to mid-April between 1500 and 3000 Covid-19 patients were being admitted to hospital every day (https://coronavirus.data.gov.uk/details/healthcare)). Given the urgent interest among practitioners and policy-makers in how health and care staff were affected by and dealt with the pandemic, the research team decided to carry out a fifth key informant survey to explore how the pandemic was impacting integration activities within the 25 former Pioneer areas. This fifth survey was carried out between September and October 2020, after the first lockdown had ended, but before the second wave of the pandemic, which intensified in the winter of 2020/21. While it repeated many of the key

questions included in the first four key informant surveys, it also added new questions investigating the impact of the Covid-19 pandemic on the progress and outcomes of local integration activities.

This report presents results from that fifth survey. As with earlier reports, it includes trends in key variables reported by key informants. However, the main focus of this report is to consider the impact of the Covid-19 pandemic on integration activities.

2. The 2020 key informant survey design

The 2020 key informant survey was developed as a potentially quick and efficient opportunity to examine the effect of the Covid-19 pandemic on local health and social care integration activities in the 25 former Pioneer areas in which the research team had been tracking developments over the previous six years. The aim was to start data collection soon after the initial lockdown measures were relaxed and when, it was hoped, health and care staff would be experiencing some easing in pressure from responding to Covid-19.

In the interest of accessing key informants as soon as possible, it was decided to re-use the 2019 key informant mailing list rather than update it, as this had proved a time-consuming process for the previous surveys. Our key informant lists included a spread of, mainly, senior managers and care practitioners covering CCGs, local authorities (LAs) and other important local partners in integration initiatives (e.g. local acute hospital, community health service provider, voluntary sector). Lead contacts were asked to ensure the list for their site included:

- 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 (during the formal life of the Pioneers, 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.

In 22 of the former Pioneer sites the list used for the 2020 survey was last updated in 2019, while for the other three sites the list was last updated in 2018. The list consisted of 427 individuals, with a wide range in the number of individuals included per site, varying from four (in South Somerset) to 33 (in Cheshire), but with most sites including between 10 and 20 individuals. This disparity in the number of individuals included in the list 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 with the four previous exercises, the 2020 survey was conducted through an online questionnaire. Although the main focus of the 2020 survey was to examine the effect of the pandemic on local integration activities, it also covered a number of topics included in the previous surveys so that progress and trends over time could be monitored. The replicated topics comprised: key outcomes/objectives expected from integrating health and social care; progress to date in achieving these outcomes; and barriers and facilitators to integration. As the 2018, 2019 and 2020 surveys took place after the Pioneer programme ended in March 2018, the questions referred to integrated health and social care activities in the 'former Pioneer sites'. In 2020, the new questions relating to the Covid-19 pandemic asked whether the pandemic: had changed respondents' views on the key outcomes/objectives of integrating services; had aided or hindered progress in achieving these outcomes; had created new barriers or helped facilitate integration activities; and had an impact on strategic and operational relationships, including the work of multi-disciplinary teams (MDTs). While the majority of the questions were pre-coded as in previous years, there were a number of open-ended questions requiring informants to type in their answers, including new questions about the impact of the pandemic. A copy of the questionnaire is provided in the Appendix.

An initial email invitation was sent on 25th September to the 427 individuals on the mailing list. Three reminder emails were sent on 2nd October, 22nd October and 5th November to those informants who had not completed the survey or had not opted-out of receiving reminders.

At the end of the data collection period, 70 key informants had started the survey, but 12 had not completed enough of the questionnaire to be included in the final dataset, leaving 58 questionnaires eligible for analysis and reporting. Although this is the lowest response for any of our key informant surveys (although it is only nine fewer than the 67 questionnaires returned in 2019), it is perhaps not unexpected given that the mailing list had not been updated and that potential respondents had been under significant pressure for over six months dealing with the pandemic.

As we have pointed out in previous reports, the value of a conventional "response rate" for assessing the completeness of response in 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 local system 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). The number of such people will inevitably vary between sites depending on their scale and complexity. 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 local system (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 extent to which the pandemic had hindered or facilitated integration activities). It was certainly possible, therefore, that key informants within the same site – or even within the same organisation – would not necessarily express the same views.

Another potential limitation is the extent to which our sample list 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 key informants over the years has included 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 a few clinicians who were also involved in a leadership role, and several Healthwatch or patient representatives on integration boards). We obtained responses from key informants in 22 of the original 25 Pioneer sites.

The biggest limitation of having only 58 completed questionnaires is the restrictions it places on examining responses within sub-groups, in particular for comparing types of organisations. Unlike in previous reports where we compared CCG informants with those from NHS providers and from LAs, for this report we are only able to show results for the sample as a whole. All these limitations must be kept in mind when interpreting the results.

3. Characteristics of the key informant sample

In 2020, the achieved sample included at least one key informant from 22 of the 25 former Pioneer sites (with Nottingham City, Southend and Staffordshire & Stoke 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	2020 survey
		N	N	N	N	N
Airedale, Wharfdale & Craven	2	1	0	2	0	1
Barnsley	1	3	2	5	7	1
Blackpool & Fylde Coast	2	3	3	0	0	1
Camden	2	3	5	5	4	6
Cheshire	1	5	4	4	4	2
Cornwall	1	4	1	0	3	5
East London (WEL)	1	7	7	7	5	4
Greater Manchester	2	3	3	5	1	1
Greenwich	1	3	4	4	3	3
Islington	1	4	5	3	2	6
Kent	1	5	17	4	1	1
Leeds	1	5	6	6	7	4
Nottingham City	2	4	1	1	0	0
Nottingham County	2	6	14	4	5	3
North West London	1	9	3	6	3	3
Sheffield	2	2	4	2	2	3
South Devon & Torbay	1	3	3	3	2	2
South Somerset	2	3	1	2	1	1
South Tyneside	1	6	4	6	4	2
Southend	1	3	2	1	1	0
Staffordshire & Stoke	1	1	2	1	1	0
Vale of York	2	1	3	3	1	2
Wakefield	2	7	5	5	5	3
West Norfolk	2	4	4	2	2	2
Worcestershire	1	3	2	4	3	2
Total		98	105	85	67	58

Thirty-five key informants in 2020 were from the 14 Wave 1 Pioneers, while 23 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	2020 survey
	N	N	N	N	
Wave 1	61	62	54	46	35
Wave 2	37	43	31	21	23

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 as well as integrated care organisations (ICOs). Compared with previous years, there are nearly twice as many informants in this category of NHS providers, which seems to partly reflect the trend towards increasing numbers of ICOs being created throughout the country as a result of national Government policy. It may also be that the focus of the 2020 survey on dealing with the pandemic was of greater interest to health professionals than the previous survey years. The 'Other' category includes a mix of informants from Healthwatch or other patient/service user representatives, other voluntary/community organisations and private providers.

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	2020 survey
	N	N	N	N	N
Clinical Commissioning Group (CCG)	26	22	27	10	14
Local Authority (LA) (includes joint appointments with CCG)[1]	24	33	22	23	11
NHS provider (e.g. primary care, acute trust)[2]	23	22	24	18	27
Other (e.g. Healthwatch, voluntary organisation, private provider)	25	28	12	16	6

[1]Informants with joint appointments between LAs and CCGs were included with LAs.
[2]NHS providers includes ICSs/ICOs/Care Trust and other health and care partnerships.

Key informants were generally senior managers, but in 2020 we had a much higher proportion of health care professionals (clinical) than in previous years, and fewer integration leads/coordinators, which may be a result of our not updating the mailing lists, given the high turnover we have seen in the latter group over the years (Table 3.4).

Table 3.4: Job title of key informants by survey year

Job title	2016 survey	2017 survey	2018 survey	2019 survey	2020 survey
	N	N	N	N	N
Pioneer lead/other local integration lead/coordinator	22	19	16	13	4
Chief Executive[1]	17	19	6	7	7
Director/assistant director	29	30	24	23	23
Locality manager	4	4	5	2	1
Commissioning officer[2]	1	7	1	1	1
Other senior manager	16	14	20	14	8
Health care professional (clinical)	5	7	10	5	11
Health/social care professional (non-clinical)	1	0	0	0	1
Other (including lay representatives)	3	5	3	2	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 key informants with commissioning responsibilities.

Slightly fewer than half of key informants (47%) said they had been in their current post for five years or more, although the vast majority (90%) had been working in the local area for at least five years (Table 3.5), so were likely to have had considerable knowledge about integration activities within their local area and about relationships between partners.

Table 3.5: Years worked in: a) Pioneer area and b) current post (2020)

Years	a) Local area	b) Current post[1]
	N	N
Less than 1 year	0	1
1 to less than 2 years	0	1
2 to less than 3 years	0	8
3 to less than 4 years	4	8
4 to less than 5 years	2	11
5 years or more	52	27

[1]Two cases are missing.

4. Trends over time for progress, barriers and facilitators

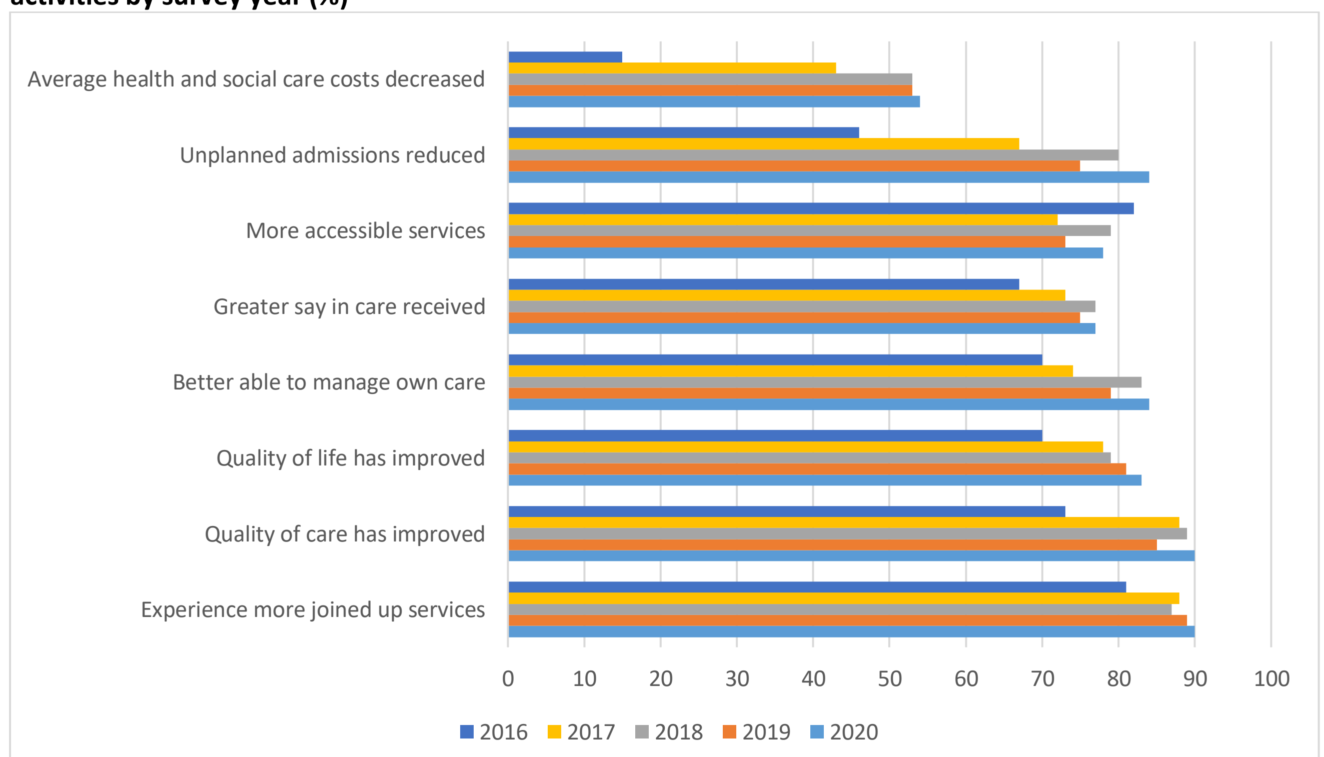
Before examining the impact of the Covid-19 pandemic on integration activities, this section looks at trends over time for the key questions that have been repeated over the five years of the key informant surveys.

Progress in meeting key objectives/outcomes
In the 2017 to 2020 surveys (but not in 2016 which was more focused on the establishment of the Pioneer programme), informants were provided with a list of eight objectives or outcomes integrated services are frequently designed to achieve and were asked to indicate degrees of progress in meeting them locally *since they became a Pioneer*. They could choose one of four responses: 'substantial progress'; 'some progress'; 'no progress'; 'don't know/not applicable'. The eight items were:

- Improving quality of care for patients/service users.
- Improving quality of life for patients/service users.
- Reducing unplanned hospital admissions.
- Patients/service users experiencing services that are more 'joined up'.
- Reducing, on average, per patient/service user health and social care costs.
- Patients/service users having a greater say in the care they receive.
- Services becoming more accessible to patients/service users.
- Patients/service users being better able to manage their own care and health.

Figure 4.1 shows that respondents generally reported gradual progress for most of these items. The one exception was 'more accessible services', which showed a small reduction, over this period.

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

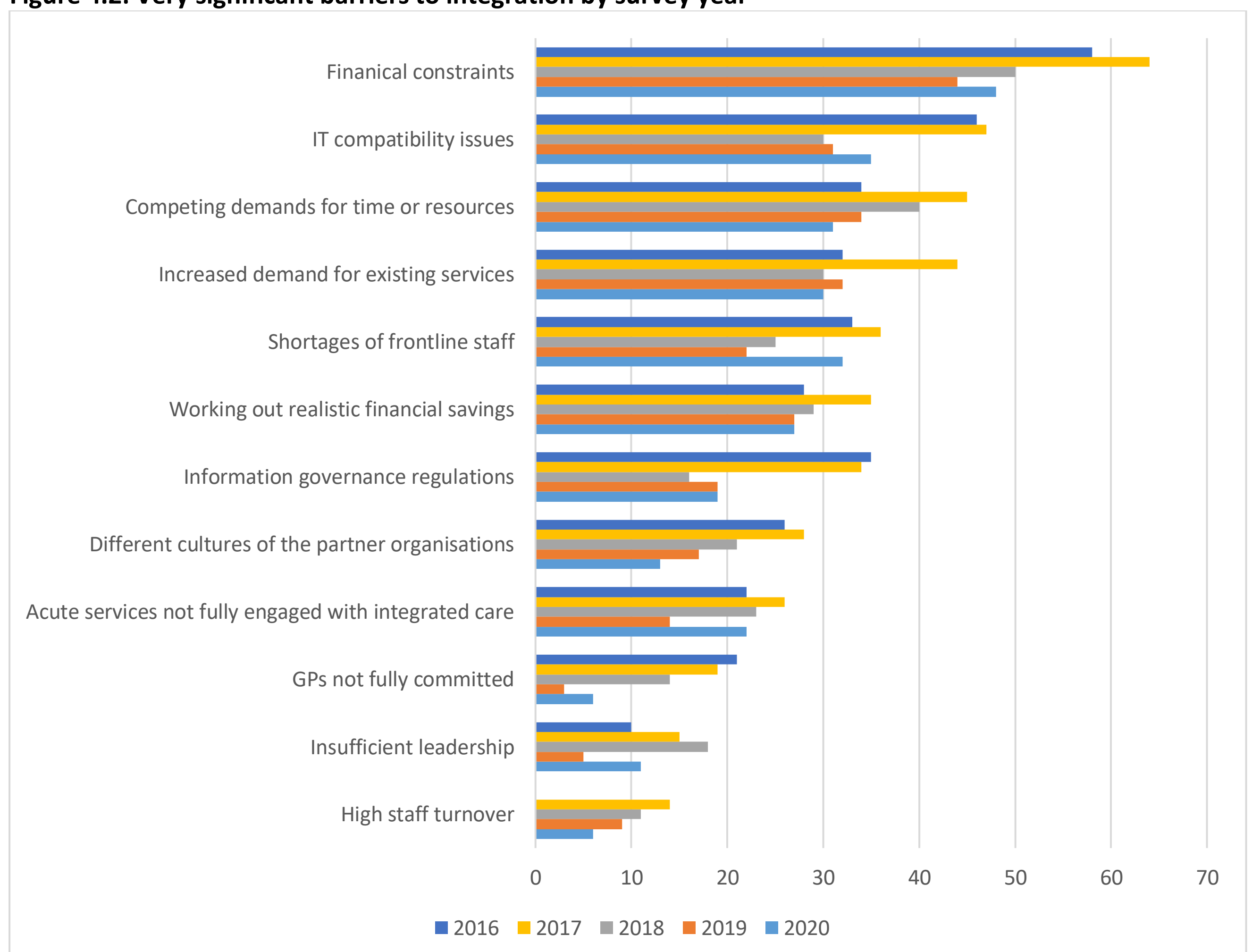


Barriers to integration
The 2020 survey presented informants with a list of 16 barriers (details of how these and any facilitators (see below) were identified are given in a previous report; Erens et al 2017a) and asked whether each one had been a 'very, 'fairly' or 'not a significant barrier' over the past 12 months. Twelve of the barriers were asked in all five 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 six of the items in the percentages reporting the barriers to be 'very significant' over the past five years (Figure 4.2): competing demands for time/resources; increased demand for existing services; working out realistic financial savings; different cultures of partner organisations; GPs not fully committed; and high staff turnover.

The other six barriers (financial constraints; information technology (IT) compatibility issues; shortages of frontline staff; information governance (IG) regulations; acute services not fully engaged; and insufficient leadership) show a small increase since 2019 (or 2018 in the case of IG regulations). Of these, three barriers (financial constraints; IT compatibility; and IG regulations) are much less likely to be mentioned than in the first survey in 2016, but the other three (shortages of frontline staff; acute services not fully engaged; and insufficient leadership) are at a similar level to that in 2016.

Figure 4.2: Very significant barriers to integration by survey year

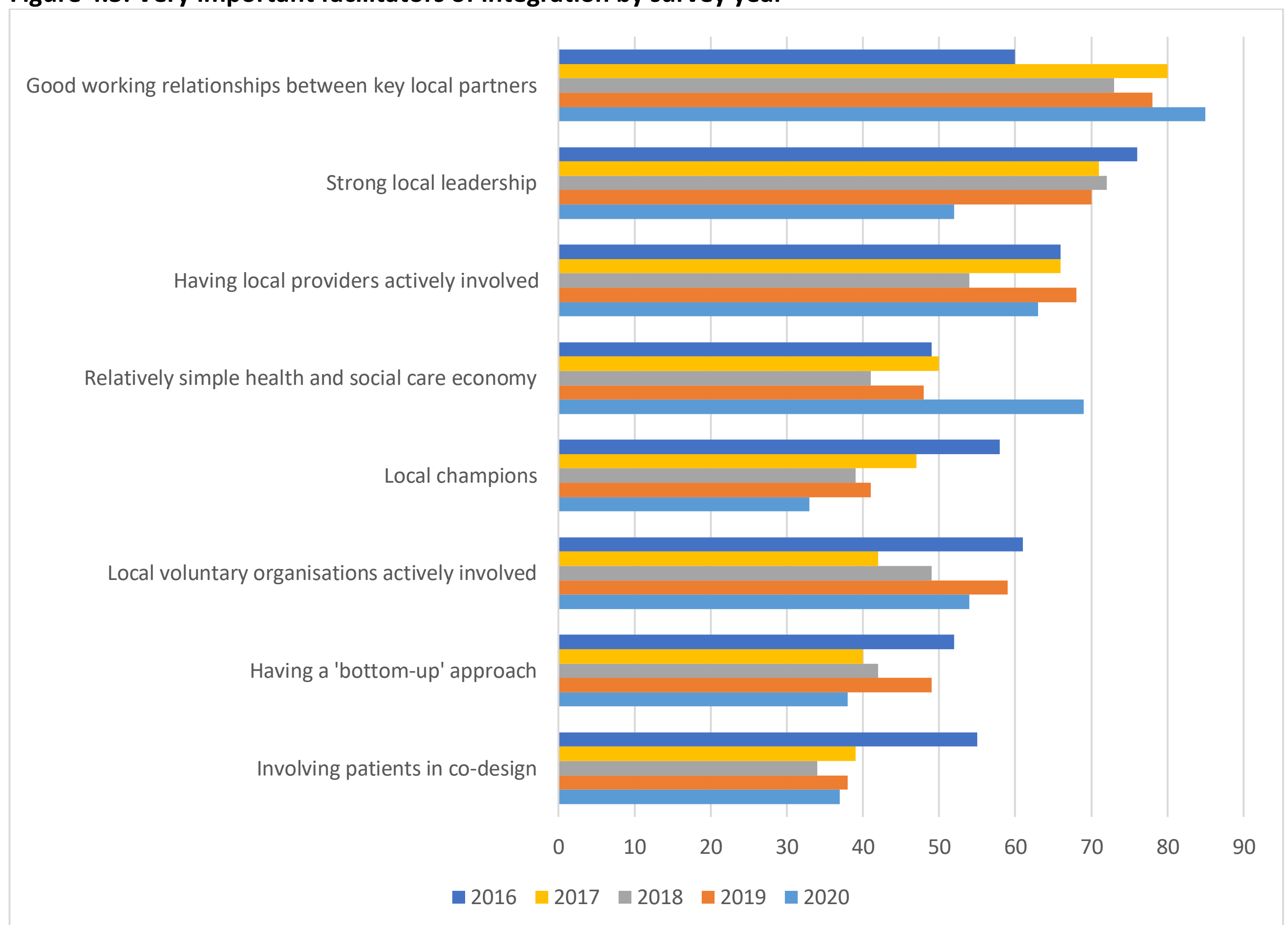


Facilitators of integration

The 2020 survey presented key 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) of integration locally over the past 12 months.

Figure 4.3 shows the percentage ranking each of the eight facilitators asked in all five 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. Two facilitators tend to show an increase over time (good working relationships between key local partners; relatively simple health and social care economy), with the latter showing the largest increase since the previous survey. Two other facilitators showed a similar pattern, but with a slight fall back in the most recent 2020 survey (local voluntary organisations actively involved; having a bottom-up approach). One facilitator (strong local leadership) showed a big drop since 2019, although before that it was pretty consistent between 2016-2019. Two facilitators (local champions; involving patients in co-design) show a reduction over time.

Figure 4.3: Very important facilitators of integration by survey year



5. Impact of Covid-19 pandemic on integration activities

The main objective of the 2020 key informant survey was to examine the impact of the Covid-19 pandemic on local integration activities. The questions examining this impact followed the outline of the questionnaire used in the earlier surveys and looked at the impact on: key informant's current job/role within their organisation; whether the pandemic changed views of the most important objectives/outcomes for integrating services; whether the pandemic aided or hindered progress in meeting key objectives/outcomes; whether the pandemic introduced new barriers or facilitators in integrating services; and whether the pandemic had any impacts on strategic or operational relationships between local health and social care services and on community-based multi-disciplinary teams. The questionnaire included a mixture of open and closed questions.

Changes in current post/role

Key informants were asked whether, as a result of the Covid-19 pandemic, their role had changed during 2020 or if they had had to take on new or additional responsibilities. One third (33%) of informants said there was no change in their role or responsibilities. The two-thirds (67%) who reported such a change were asked to describe it briefly. Of the 35 individuals who did so, several reported additional strategic roles which included, for example, taking responsibility for local population health management, system-wide, borough-wide, or local service (e.g. primary care) response planning and implementation, and developing more integrated approaches to local provision and delivery.

> *I have led a number of Covid related work areas and also been responsible for coordinating the borough response on Covid.* (KI29, CCG Director/Assistant Director)

New operational roles and responsibilities described included those related to procurement (e.g. of PPE, remote working and digital support equipment), overseeing staff redeployment, testing, shielding, setting up Red Zones in primary care, capacity building in specific teams, communicating information across sectors such as primary care or between sectors (e.g. community and acute), and coordinating activities related to staff welfare. A few key informants described taking on an operational 'lead role' in implementing new or expanding services, including an integrated discharge team and a Care at Home service. Three key informants reported spending more time than previously in clinical activities, while several others described the pandemic as leading to an increased number of meetings and/or committee memberships.

> *I provided operational leadership in setting up a care at home cell working with partners in primary care and LA and CCG and working across acute and community teams and with care homes/IS [independent Sector] to join up delivery and lead operational plans in response to COVID.* (KI46, NHS Provider Director/Assistant Director)

> *Supporting the response to COVID i.e. enhanced contact tracing, supporting the shielding population, dealing with queries etc.* (KI44, LA, Health or Social Care Professional (non-clinical))

Finally, a couple of key informants answered the question from an organisational perspective, reporting that the pandemic had had implications for the ways in which their services operated (e.g. in terms of pauses in aspects of strategic planning, no face-to-face appointments being offered to patients, etc.).

Changes to most important objectives/outcomes
Key informants were asked whether the Covid-19 pandemic had *changed* their views of the most important objectives/outcomes in shaping integration activities in their local area. Forty-three percent responded positively and were asked to describe these changes briefly.

Twenty-five key informants, the majority of them employed by CCGs or NHS Providers, provided responses. Nearly half of the 25 suggested that Covid-19 had reinforced the need for, and importance of, integrated care and 'joined-up' services or provision. They cited examples of specific services, processes (e.g. hospital discharge and transfer of care), and approaches (working with community and voluntary sectors) that were either currently the focus of local integration-related activity or which they perceived to need greater attention.

> *Covid has really helped our system re-focus on integrated health and care, particularly around hospital discharge and working effectively as MDTs. Plus it's really shone a spotlight in health inequalities.* (KI23, LA, Other Senior Manager)

> *It has only increased the importance of joined up services and the value of the voluntary sector and resilient communities.* (KI24, NHS Provider Director/Assistant Director)

A significant number reported that the pandemic had either highlighted local population health inequalities, or heightened the understanding of the social and other determinants of health, and the need to address them through, for example, targeted services and more equitable access to care, or by tackling inequalities more broadly.

> *More focus on services for vulnerable populations, addressing health inequalities and dealing with the acute impact of COVID on communities such as social isolation, substance misuse, smoking and respiratory disease etc.* (KI44, LA Health or Social Care Professional (non-clinical))

A CCG director/assistant director wrote:

> *Through working closer with the LA, greater understanding of the level of need and diverse populations we are serving across health and social care where we are getting evidence of people who have stopped accessing services during the first wave of COVID. Whilst in the NHS we have always had policies and strategies in working towards reducing variation in access to services, COVID highlights the impact of mental health, social deprivation, disabilities and ethnicity on health and wellbeing to a greater extent.* (KI11, CCG Director/Assistant Director)

Other changes of view included the need for new approaches to care (e.g. strengths-based approaches, increased patient self-management), for co-production across the system, and for a focus on financial balance. An operational manager working for an NHS provider (12) described the value of a 'whole system approach' to service development, citing the benefits of implementing an integrated hub, designed to facilitate hospital discharge, as including the early identification of needs and barriers to care, a reduction in duplication of referrals, the minimisation of failed discharges and timely provision of therapies (e.g. occupational and physiotherapy) in the community post-discharge.

Progress in meeting integration objectives/outcomes

After being asked to report how much progress there had been in meeting eight important objectives/outcomes of integrating health and social care services (see Figure 4.1), informants were asked whether the Covid-19 pandemic had aided or hindered progress in meeting these objectives. As shown in Table 5.1, for three of the objectives, informants were more likely to say that the pandemic had aided progress in:

- Joining-up services (aided 54%; hindered 28%).
- Reducing unplanned admissions (aided 46%; hindered 25%).
- Improving patients/service users' ability to manage own care (aided 46%; hindered 26%).

For the other five objectives, the pandemic was more likely to have hindered progress, for some by considerable margins:

- Improving quality of life for patients/service users (aided 11%; hindered 70%).
- Patients/service users having a greater say in their care (aided 11%; hindered 58%).
- Improving quality of care for patients/service users (aided 21%; hindered 63%).
- Reducing average per patient health and social care costs (aided 7%; hindered 35%; although 42% said they did not know).
- Services becoming more accessible (aided 33%; hindered 49%).

Table 5.1: Whether the Covid-19 pandemic has aided or hindered progress in meeting integration objectives

Objectives/outcomes		Aided progress	Hindered progress	No effect	Don't know
Patients/service users are now able to experience services that are more joined up.	%	54	28	11	7
The quality of care for patients/service users has improved.	%	21	63	7	9
The quality of life for patients/service users has improved.	%	11	70	7	12
Patients/service users are now better able to manage their own care and health.	%	46	26	16	12
Patients/service users now have a greater say in the care they receive.	%	11	58	19	12
Services are now more accessible to patients/service users.	%	33	49	7	11
Unplanned admissions have reduced.	%	46	25	11	19
On average, per patient/service user health and social care costs have decreased.	%	7	35	16	42

Base=57.

Barriers to integration

As mentioned in section 4, informants were shown a list of 16 possible barriers to integrating health and social care services and asked how significant they were in their area. Based on prevailing media commentary and debate about the pandemic's impact on the NHS and care systems, three new potential barriers were added to the 2020 survey which referred specifically to the Covid-19 pandemic:

- The time required to deal with the Covid-19 pandemic.
- Diversion of staff resources in order to deal with the Covid-19 pandemic.
- The financial resources required to deal with the Covid-19 pandemic.

As Table 5.2 shows, the vast majority of key informants identified all three of the barriers concerned with the pandemic as very or fairly significant barriers affecting their local integration activities:

- 80% with respect to the time required to deal with the pandemic.
- 71% for the financial resources required.
- 68% for the diversion of staff resources.

The percentages identifying these Covid-19 issues as significant barriers were higher than for most of the other barriers asked about. The exceptions were: significant financial constraints in the local health and care economy, which was mentioned by 89% of informants; competing demands for time and resources (81%); increased demand for services (75%); and shortages of frontline staff (68%). It is highly likely that some of these other barriers could also have been affected by the pandemic; for example, as shown in Figure 4.2, financial constraints and frontline staff shortages were higher in the 2020 than in the 2019 survey.

Table 5.2: Barriers to integration (2020)

	Very significant	Fairly significant	Not significant	Don't know
	%	%	%	%
Significant financial constraints within the local health and social care economy.	48	41	7	4
Increased demand for existing services.	30	45	17	8
Incompatible IT systems make it difficult to share patient/ service user information	35	31	30	4
Too many competing demands for time or resources reducing the focus on working together.	31	50	17	2
Shortages of frontline staff with the right skills.	32	36	25	8
The different cultures of the partner organisations.	13	53	30	4
Information governance regulations making it difficult to share patient/ service user information.	19	30	47	4
Working out realistic financial savings that could be achieved.	27	37	25	12
Acute services that are not fully engaged with our integrated care programme.	22	30	39	9
Primary Care Networks (PCNs) not aligning with existing integration initiatives.	6	21	64	9
High turnover of managers or other staff.	6	22	64	8
Insufficient leadership of our integrated care programme.	11	22	59	7
GPs not fully committed to our integrated care programme.	6	19	64	11
Time required to deal with Covid-19 pandemic	42	38	17	4
Diversion of staff resources to deal with Covid-19 pandemic	44	24	26	6
Financial resources required to deal with Covid-19 pandemic	33	38	21	8

Bases range between 52 and 54; missings are excluded from the base.

Informants were then asked an open-ended question about any other challenges presented by the Covid-19 pandemic that had affected their local integration activities. Twenty-eight key informants responded to this question. Three-quarters of those who provided an opinion were employed by a CCG or NHS Provider.

Perhaps not surprisingly, given the reported significance of the Covid-19-related barriers to integration described above, one of the most widely reported challenges concerned the demands that the pandemic had placed on local systems or services and their capacity to respond to those demands.

> *The main challenge is the demand that Covid has placed on the system - the staff, the resources, the capacity.* (KI5, CCG Director/Assistant Director)

> *Pent up demand as a result of the pandemic is taking a lot of time and energy for individual organisations to work through - could be an aid to integration if we would work together to resolve.* (KI28, CCG, Director/Assistant Director)

It was suggested by a number of key informants that this was compounded by factors such as inconsistencies in approach across some sectors (e.g. primary care) or between sectors (e.g. health and social care), challenges related to specific settings or services (e.g. care homes, adult social care), and the inability or perceived unwillingness of some services to provide face-to-face patient or service user care:

> *Significant increase in demand for services (approximately a 400% increase) without a comparable increase in staff resources. The unwillingness/refusal of many services to provide face-to-face care or appointments, general practice in particular has been notable by its absence in supporting the delivery of care. Many other health and social care services are not seeing patients/clients or operating at all. Increasing demand on those that are still providing frontline face-to-face care*. (KI12, NHS Provider, Operational manager)

A few informants mentioned the challenges posed to staff wellbeing by Covid-19.

> *Wellbeing of frontline staff, particularly stress-related issues. Some issues re COVID isolation of staff.* (KI36, Other)

Two key informants described what they perceived to be a disconnect between government or national policy and the local situation, with one suggesting that national services around PPE and testing constituted a barrier to local integration and should have been devolved to local areas. Service provision, strategic leadership, ongoing restructuring activities (e.g. vis-a-vis Integrated Care Systems), and operational and future planning were said to have been either 'diverted' or interrupted to deal with Covid-19. A number of informants suggested that Covid-19 had highlighted system level shortcomings (e.g. regarding funding or financial uncertainties) and the lack of joined-up approaches across local organisations or services (e.g. as exemplified by different styles of commissioning and levels of funding comparing health and social care).

> *Significant diversion of focus for limited number of managers to drive operational and strategic changes. Competing demands of recovery, financial restoration and meeting integration objectives.* (KI46, NHS Provider, Director/Assistant Director)

> *Managing the worsening problems of lack of integration at organisational interfaces, which create complexity for patient care through lack of proper integration. New ways of working*

have heightened existing problems at organisational interfaces and thus increase workload, usually in primary care. (KI25, CCG, Health Care Professional (Clinical)

The different styles of commissioning between health and social care can create challenges. (KI11, CCG Director/Assistant Director)

Finally, while the vast majority of key informants, in answering this question, described challenges that Covid-19 had posed to their integration activities, one took a different view, stating:

I think overall integration has been aided by Covid. (KI48, CCG Director/Assistant Director)

Facilitators of integration

The list of 13 potential facilitators of integration (see section 4) did not include any new items specifically to do with the Covid-19 pandemic. However, four new questions were asked which pointed to a number of factors which had aided integration activities as a result of the pandemic.

The first question indicated that the pandemic had led to better day-to-day working relationships between the NHS and local government: nearly three in four informants (n=52) said these relationships were much (33%) or somewhat (40%) better during the pandemic, compared with only 6% who said they had become somewhat worse (and with one in five saying there was no change (19%) or that they did not know (2%)).

Over two-thirds of informants said the pandemic had made it much (37%) or somewhat (31%) easier to secure NHS resources for discharge packages for patients with long-term care needs; only 2% said this had become more difficult as a result of the pandemic, while the remainder said it had made no difference (4%) or that they did not know (27%).

The vast majority of key informants (n=52) also said the pandemic had made it easier to implement changes that their organisation was already thinking about (81%) or that it had prompted new integration initiatives that they planned to keep or further develop (90%).

Informants were also asked an open-ended question about any other ways the Covid-19 pandemic may have facilitated local integration activities. Thirty-seven individuals responded to this question. Again, roughly three-quarters were employed by an NHS Provider organisation or CCG.

While many key informants provided specific examples of how the pandemic had facilitated local integration activities, two overarching themes emerged in the written responses, i.e. ‘increased sharing or willingness to act together’ and ‘accelerated change’. This is perhaps not surprising, given the responses to the pre-coded questions on how Covid-19 may have facilitated integration activities.

Many described closer working and improved co-operation between services and across sectors, evidenced by, for example: sharing and redeploying staff; improved communication, information and patient record sharing; joint problem-solving around Covid-19 related challenges; and an increased willingness to work together collaboratively to plan and deliver patient care and support staff.

Shared responsibility on developing and delivering plans to support both staff and patients. A sense of 'we are all in this together' which broke down previous barriers and challenges. A willingness to find solutions. (KI11, CCG Director/Assistant Director)

Very marked improvement in willingness to collaborate in a wide variety of ways. I have been wittering about lack of co-operation and trust between the different elements of the system since 2007 - particularly in the provision of Care at Home and the commissioning thereof and I have noticed a very marked improvement in the speed and willingness to co-operate - particularly between Adult Social Care and the other NHS organisations. (KI17, Other)

Virtual working re consultations and triage, digital solutions, sharing of staff resources, shared agreement of system priorities. (KI47, CCG Director/Assistant Director)

Several commented specifically on perceived closer and/or better working relationships between strategic and operational levels within the local health and care system, between commissioners and service providers, and between acute and community or primary care sectors. The impacts of the perceived increased willingness to collaborate across teams and sectors were said to have been beneficial to both patients and staff, and had resulted, for example, in the streamlining of referral and discharge processes for patients. A couple of key informants also reported either that closer relationships with the Voluntary and Community Sector (VCS) had become a mechanism for integrating care or that the mobilisation of local communities had helped to ease pressures on the NHS.

All aspects of the local health and social care system have been improved particularly by providers and commissioners working even more closely together and by building upon the MDT's that had already been developed over the past 2 years. (KI36, Other)

The discharge process has exponentially improved by having a collaborative joined up approach. The introduction of a single referral form has reduced the amount of required documentation and eliminated duplicated referrals. In basing staff from community teams in the acute hospital, patients can be referred directly to the appropriate community. (KI12, NHS Provider, Operational Manager)

Much closer working with the VCS – i.e. aligning their workforce to our Integrated Teams PCN footprints rapidly became a mechanism for integrating care at a local level. (KI26, NHS Provider, Director/Assistant Director)

Many of those who responded to this question also reported that changes which had been planned before the pandemic, including to services, processes and practices, had been accelerated by Covid-19, while other local changes occasioned as a result of the pandemic were said to have happened at speed. A significant number described the accelerated implementation of digital and technological innovations in order to improve information sharing, support remote working by professionals, and facilitate virtual delivery of care to patients, for example, in the absence of face-to-face appointments. A few informants noted that digital solutions and remote working made it easier for staff to attend meetings or for timely information exchange and care delivery planning to take place across organisations (e.g. NHS and social care).

We were already planning remote patient monitoring (telehealth) but Covid has provided impetus to implement it at scale (thanks to NHSx). (KI8, NHS Provider, Other Senior Manager)

IT transformation happened at a pace no-one could have predicted. The national crisis focused minds and did enable resources to be diverted to tech solutions, but also for clinicians to embrace the urgent need to change their care delivery models. (KI18, NHS Provider, Health Care Professional (Clinical))

Massive acceleration of use of digital health services…remote working - could better get people round the table for meetings virtually, easier for busy GPs to be involved etc. (KI23, LA, Other Senior Manager)

Several key informants reported that the pandemic had either led to the introduction of new integrated services (e.g. a frailty service), teams (e.g. to facilitate discharge) or care pathways (e.g. related to referrals and points of access), or to the development or modification of existing ones, to beneficial effect. Finally, a small number reported either that the pandemic, in combination with other factors, had resulted in *reduced* health and social care integration activity, or that they did not know whether it had facilitated any integration activities.

Other impacts of the Covid-19 pandemic on integration activities
The survey also asked open-ended questions about the impacts of the pandemic on:

- Strategic relationships between local health and social care services.
- Operational relationships between local health and social care services.
- The day-to-day work of local health and social care integrated, community-based MDTs.

Key informants were then asked what they thought the impacts the pandemic might have over the next 12 months for these same three aspects of integration.

<u>Strategic relationships between local health and social care services: perceived impact to date</u>
Roughly 70% of those who responded to this question were employed by an NHS Provider organization or CCG. Regardless of their employing organization, however, the majority of the 42 key informants who described the impact of the pandemic on strategic relationships between health and care services did so in positive terms, reporting that relationships had improved or been strengthened. Although the question was posed specifically about relationships between health and social care services, responses sometimes referred to relationships between different NHS sectors as well as between the NHS and social care. The need to work together to solve problems during the Covid crisis was said, among other things, to have resulted in stronger local leadership, improved communication, greater trust and understanding between organisations, and the sense of a common purpose.

Strengthened relationships - genuine trust through a shared sense of urgency / common purpose. (KI26, NHS Provider, Director/Assistant Director)

Closer working between LAs and NHS organisations, put in place a Chief Executive Group to unblock key issues which met daily at the height of the pandemic and has now been more formally established as part of our system governance. Has helped to build relationships and understanding between partners. (KI33, LA, Director/Assistant Director)

Good integrated strategic relationships. Ability to work through complex service reconfiguration problems and to stand together to achieve the change in the face of objection. Development of governance structures to drive integrated working and collaboration through working as a team. Local authority membership and mental health partners embedded within leadership team. Strengthening GP voice, but beginning to develop a balanced leadership team that describes the whole system and works together. (KI25, CCG, Healthcare Professional (Clinical))

Additionally, a number suggested that relationships had also improved at middle management and frontline levels, and between the statutory and voluntary or community sectors.

Strengthened relationships with Councils, PCNs and voluntary sector and brought acute providers better together. (KI24, NHS Provider, Director/Assistant Director)

Relationships are much improved particularly at the middle management level and in the frontline delivery of services. Staff have developed and maintained positive and effective working relationships that have enhanced the provision and delivery of care across the health and social care spectrum. (KI12, NHS Provider, Operational Manager)

However, a small number of key informants reported that, while local strategic relationships had always been good or had been strengthened due to the challenges posed by Covid-19, the pandemic had also served to highlight issues such as resourcing levels, and a few expressed a concern that gains made at a strategic level might dissipate over time (see next section). A couple highlighted difficulties caused by disparities in funding for health and social care, while cultural differences between organisations and silo-related behaviours were still perceived to exist in some parts of the local system, albeit that strategic relationships had been strengthened as a consequence of the pandemic.

In [place name] we have good relationships and so will work through things. However, the national disproportionate funding between health and care makes it really hard to deliver real change and also means more effort is needed to try and minimise negative impact. (KI39, NHS Provider, Local Integration Transformation Lead/Co-ordinator)

Supported good relationships while money flowed to do the work we all agreed needed doing but we are starting to see drawing back as money is being restricted. (KI29, CCG Director/ Assistant Director)

Finally, a couple reported that strategic level work on integration had had to take a back seat in the face of dealing with the immediate impacts of the pandemic.

Strategic relationships between local health and social care services: anticipated impact of the pandemic in the next twelve months

Many of the 38 informants, almost three-quarters of whom were employed by an NHS Provider or CCG, who expressed an opinion described factors which, in conjunction with the pandemic, they predicted might lead to closer strategic relationships and further integration activities or, alternatively, factors which could create impediments to closer strategic relationships. Some of these factors (e.g. patient needs, resources and funding) were said to have the potential to create both opportunities and challenges.

A substantial number of those who responded to this question, regardless of which of the four employer organisation categories to which they belonged, expressed optimism that strategic relationships would remain strong or strengthen further. Some of these speculated that issues such as the ongoing need to provide effective care for patients with complex problems, the pent-up demand for treatment of non-Covid-19-related illnesses, some populations having been disproportionately affected by the pandemic, and the observed increase in mental health issues would continue to drive local strategic collaboration and integration activities. Local structural re-organisation related to ICSs, PCNs and CCGs was also mentioned as having potential for positive impacts on relationships and integration activities in the face of Covid-19.

There will continue to be increased focus on those individuals with greatest risk and complexity and this is driving improved care and integrated solutions. (KI4, NHS provider-healthcare professional (clinical))

Continue to strengthen with the caveat of adequate funding for health and social care. Giving ICSs a firmer statutory footing and changes to local government will support with this. (KI33, LA, Director/Assistant Director)

However, others expressed the view that pent-up demand and the impacts of the pandemic on patients and staff, as well as the need to maintain a focus on Covid-19 rather than, for example, on prevention-related activities, might challenge future relationships and/or progress. A couple suggested that the apparent focus on acute services might be to the detriment of strategic relationships, to other non-hospital sectors and to investment in local integration activity.

I suspect that they will become strained as both LAs and CCGs have dramatically slowed down facilitating discharge of patients who need a package of care leading to significant bed pressures already! (KI35, NHS Provider, Chief Executive/Accountable Officer)

The risk is more focus on acute capacity rather than community capability due to delays in access/diagnostics etc. There is a risk that the uncertainty of the financial regime means that investments cannot be made in prevention/over focus on acute flow. (KI22, NHS Provider, Health Professional (Clinical))

Furthermore, and as noted above, some informants who suggested that relationships would continue to strengthen at the same time expressed a concern, also voiced by others, that funding and other resource-related issues, might, in the next twelve months, put a strain even on strong strategic relationships, deter further collaboration, or lead to retreat into organisational silos. Again, a few highlighted disparities in funding between different parts of the NHS, between the NHS and social care, or the lack of funding for social care, as issues which could challenge relationships.

The focus on collaboration to resolve problems will continue. The financial impact of recession may make this more difficult if individual organisations need to resort to protecting their own statutory duties. (KI45, CCG, Director/Assistant Director)

Depends on the financial context and framework - tight financial controls makes organisation[s] retreat into their own organisational interests not those of patients. (KI29, CCG, Director/Assistant Director)

It will make it harder for people to look above the parapet and implement transformation actions that are required particularly around place-based service delivery. Resources continue to be prioritised for acute settings and prevention is ignored. (KI16, Other, Chief Executive/Accountable Officer)

However, it was also suggested that the next twelve months might also hold opportunities if local funding was distributed more effectively:

From the perspective of my organisation it hastened the need for a review of current resources and plans going forward. Services that are often under-resourced but still provide effective care and value for money are likely to see an increase in financial and staff resources to further develop and expand the existing scope. This is the hope and aspiration anyway. (KI12, NHS Provider, Operational Manager)

Operational relationships between local health and social care services: impacts of the pandemic to date

The majority of the 36 key informants who responded to the open-ended question about any impacts that the pandemic had had on operational relationships between local health and care services reported that such relationships had improved, been strengthened, or developed in new, positive directions as frontline and other staff from different organisations worked together to respond to, and resolve, challenges created by the pandemic. While roughly 40% of those who responded were in the 'NHS Provider' category, and a further 30% were employed by CCGs, informants from all employer organisation categories expressed positive views about working relationships.

The pandemic was said to have led, for example, to improved partnership and team working across organisations, reduced barriers between services, better use of resources, speedier decision-making and more holistic approaches to patient care.

> *Strengthened. We were in a good place, but we've had to continue down the road at further pace, and head into new areas that we've been working on.* (KI5, CCG, Director/Assistant Director)

> *More collaborative working partnerships particularly between NHS provider and social care, as well as with acute settings.* (KI27, LA, Director/Assistant Director)

> *Very much improved relationships which has startled and pleased many long-term professionals who had more or less given up expecting the barriers to come down. Most of the professionals I deal with have remarked on their surprise at the speed and the extent of changes in the way they interact with other agencies and the voluntary sector.* (KI17, Other)

> *Much more pragmatic decision-making and empowerment given to operational managers to "do the right thing".* (KI26, NHS Provider, Director/Assistant Director)

However, a couple of informants reported that the requirement for some professionals to work from home had created some local challenges:

> *Lack of visibility (in co-located teams) of social workers (who were all told to work from home) has led to a breakdown in relationships within clinical areas.* (KI22, NHS Provider, Health Care Professional (Clinical))

Furthermore, a few suggested that improved operational relationships were not necessarily universal across their local patches, due, for example, to individual challenges such as contractual arrangements or local strategies being out of synch with frontline activities, because of challenges associated with specific services, or because once the initial crisis was over, pre-existing institutional and cultural barriers and resource constraints were perceived to be re-emerging.

> *Some areas have embraced new relationships and in others there still remain barriers. Whilst you can work well together on a 'frontline' basis, it can quickly break down unless the policy and strategy is jointly committed to all the way up the line. It's not been easy in some instances and the contractual platform which underpins services has not yet caught up with the integrated strategy and vision.* (KI11, CCG, Director/Assistant Director)

> *Initially, operational relationships improved as the crisis unfolded, people had to work together to deal with immediate needs. But as things settled down, usual institutional*

barriers arose around resources and priorities. (KI16, Other, Chief Executive/Accountable Officer)

Improvement in working together in certain areas (e.g. care homes work in the borough). Integrated discharge hub locally not working that well and this is causing strains between local acute trust / community provider (who "owns" the hub) and local authority. (KI30, NHS Provider, Health Care Professional (Clinical))

Operational relationships between local health and social care services: anticipated impact of the pandemic in the next twelve months

As noted above, the first wave of the pandemic was perceived to have had a number of positive impacts on operational relationships between health and social care organisations. Asked about the impacts that the pandemic might have on these relationships in the next twelve months, 32 key informants, over 70% of whom were employed by CCGs or NHS provider organisations, responded. Over a third of the 32 , representing between them all four types of employer organisations, voiced positive aspirations for the future. However, concerns were also expressed about challenges that the next 12 months might bring. Two overarching themes concerned the 'future focus' of their operational activities, and those factors that were said to be likely to have an impact on operational relationships.

Key informants indicated that they believed or hoped that the next twelve months held operational-level opportunities to continue improving and deepening relationships between services and/or building on new ways of working, or on services implemented or developed in response to Covid-19, notwithstanding potential challenges ahead.

Improved services, better resources and the building upon new ways of working that have [been] extremely successful. (KI12, NHS Provider, Operational Manager)

Hopefully the streamlined approach to decisions will stick! Less aware of future impacts but hopefully we will continue to see more examples of health and care working closely together for a clearly defined outcome. (KI23, LA, Other Senior Manager)

Beyond the obvious pressure of winter, covid and catching up on delayed planned operations, tired staff who have had a difficult year, I don't think there will be any material negative impact. Should we end up with significant staff shortages across the sector, that will have an impact on our ability to deliver but shouldn't impact negatively on relationships. (KI51, LA, Director/Assistant Director)

Notably, one LA Director/Assistant Director expressed concerns about the future of social care:

Pace of change has been rapid and this is likely to continue. Need to manage potential risks of social care being subsumed by health agenda. Financial challenges on the sector will be significant. (KI27, LA, Director/ Assistant Director)

In terms of 'future focus', key informants described a perceived need, as already alluded to above, to focus at an operational level on new ways of working, and building on service developments, as well as on developing new staff roles or skills, coping with the build-up of demand created by Covid-19, caring for high-risk patient groups, and educating patients about the use of technology and self-management.

I think it is likely that we will see much wider use of MDT-based problem-solving and a broadening of approaches to the use of common skills - that is, less dependence on traditional role-descriptions and a wider acceptance of generic approaches to initial assessments and reports. (KI17, Other)

Need to look at how we can continue to develop the services we have (discharge hub / joint frailty clinic) in light of the pandemic and also the changes from NHSE about same day emergency care (could improve this greatly but likely to be many stressors too. (KI30, NHS Provider, Health Care Professional (Clinical)).

…more technology may be required and staff roles changing to manage the increasing demand on services that have had to reduce their footfall in order to implement NHSE guidance. We also need to think about how we support the general public better in the increasing use of technology to access care/self-care - particularly in areas of deprivation and high ethnicity. (KI11, CCG, Director/Assistant Director)

As illustrated by the quotes above, many also referred to a range of inter-related factors or combined factors, the majority of them challenges, which might negatively affect operational progress in the next twelve months. The most widely reported concerns had to do with financial resources and capacity, followed by staff fatigue and burnout.

There may be some fighting over resources. (KI13, NHS Provider, Programme Manager)

Battle fatigue in some of our operational managers who worked tirelessly for months and now have to content (sic) with complex restoration, winter, the potential return of CIPs and new targets etc. (KI26, NHS Provider, Director/Assistant Director)

As reported above, working remotely was sometimes cited as an existing challenge and a couple suggested that the inability of staff to meet face-to-face might continue to pose challenges to operational level working relationships during the next twelve months, although one health care professional working for an NHS Provider noted that remote working also had potential for enhancing such relationships:

Staff will continue not to have the chance to develop new trusting relationships face-to-face and so this may slow down integrated working. However, with the use of video conferencing this could also be enhanced. (KI4, NHS Provider, Health Care Professional (Clinical)).

Health and social care integrated, community based multi-disciplinary teams (MDTs): impacts of the pandemic to date

Community-based MDTs are one of the most widely reported health and social care integration initiatives undertaken by the Pioneer sites (Erens et al 2019a). Key informants were therefore asked about the impacts, if any, of the pandemic on their local health and social care integrated, community based MDTs. Virtually all of the 37 key informants, almost three-quarters of whom were employed by CCGs or NHS Provider organisations, who answered this question reported that Covid-19 had affected some aspects of MDTs' operation, including various professions' and organisations' participation in the MDT, workload or patient care. Key informants reported both positive and negative impacts of Covid-19 on MDTs, with some reporting that the pandemic had simultaneously resulted in gains and losses in terms of their day-to-day working.

A significant number indicated that their MDTs had continued to operate effectively since the start of the pandemic, or that the pandemic had accelerated their development, led to improved ways of

working, broader participation by a range of professionals and organisations, or increased the scope of their work through collaboration with other sectors.

> *These teams were already well established and have continued to work effectively and to manage more complex patients. The work with care/nursing homes has been strengthened*. (KI45, CCG, Director/Assistant Director)

> *Significant pressure to support a higher caseload of vulnerable and frail patients. However we have started new projects with voluntary sector support, as an example, working alongside community response teams to enhance the current support offer.* (KI47, CCG, Director/Assistant Director)

> *Reviewing and developing further neighbourhood-based working with social care, mental health and community-based provider.* (KI27, LA, Director/Assistant Director)

However, the pandemic was also said by some to have led to an increased workload for MDT staff with resulting implications for staff wellbeing. A few reported that aspects of patient or service user care (e.g. face-to-face assessment) had been hindered by the pandemic, or that integration with other services (e.g. mental health) had been adversely affected.

> *I believe there has been a significant increase in the hours worked and the pressure of workload experienced by community MDT staff and in primary care.* (KI17, Other)

> *Significantly increased workload, an increase of some 400%, it has become very clear that much of what has been achieved has been through the goodwill of dedicated frontline staff under difficult circumstances.* (KI12, NHS Provider, Operational Manager)

> *Lack of home visiting from teams giving less insight into patients' home situations and social links.* (KI34, NHS Provider, Health Care Professional (Clinical))

Almost one-third of the key informants who responded to this question mentioned that their MDTs had moved either fully or partially online, or were in the process of doing so. Perceived benefits of this approach to day-to-day MDT working were said to include improved efficiency, a broader range of professionals being able to participate in meetings, and improved relationships and communication.

> *Virtual meetings are less time consuming and therefore happen more often, with more participants so new relationships are building. More patient voices being heard through more frequent and better attended forums now held virtually.* (KI40, NHS Provider, Director/Assistant Director)

> *Improved use of digital technology has meant that we are in a position to better plan partnership meetings - integrated team meetings etc irrespective of whether staff can get into the office or not. It has enhanced the ability to develop our local care partnerships because GPs etc have been able to more easily get to meetings, and people who work city-wide can get to more meetings in a day than they could if they had to travel and be physically present.* (KI51, LA, Director/Assistant Director)

However, several key informants were less positive about MDTs having to work remotely, and suggested that working in this way had had a number of downsides, particularly where the more

informal aspects of MDT meetings were concerned, such as those related to relationship building between professionals and the perceived benefits of informal, face-to-face information exchange.

> *Whilst technology has proved helpful, we have lost the pre- and post-meeting chat/gossip which results in more meetings that aren't necessary.* (KI42, Other, Chief Executive/ Accountable Officer)

> *There are benefits from moving more to digital, home working etc, but the human, softer side has been impacted. This can make it harder for the day-to-day teams in terms of relationships etc.* (KI39, NHS Provider, Local Integration Transformation Lead / co-ordinator)

<u>Health and social care integrated, community based multi-disciplinary teams (MDTs): likely impacts of the pandemic over the next twelve months</u>

Over three-quarters of those who responded when asked about the likely impact of the pandemic on community-based MDTs in the next twelve months worked for a CCG or NHS provider. Roughly half of the 31 who responded described the direction of travel as one of building, or capitalising, on the work that MDTs were currently doing in the face of the pandemic in order to further develop their teams, including in terms of broadening the scope of their remits, staff roles, and collaborations or partnerships. Individual key informants suggested that their teams might build on aspects of the care they were providing to specific patient groups or care sectors, or increase their focus on population health issues.

> *Hope it will accelerate the next steps of joint working and shared teams.* (KI47, CCG, Director/Assistant Director)

> *Further development and particularly focus on integration with primary care teams and mental health and learning disability community teams.* (KI2, LA, Director/Assistant Director)

> *I think it is likely that pressures on the system will increase and I expect that will accelerate and widen the scope of the use of MDT teams in community services and a blurring of traditional demarcations between different role types. I believe this is likely to broaden the roles of some staff, leading to more reliance on their judgement and this in turn leading to a greater level of job satisfaction.* (KI17, Other)

A couple suggested that teams might need to 'rebuild' or refresh the way they worked.

> *We are refreshing the way we work…we are no longer physically co-located in some cases due to the need to comply with organisational Covid secure requirements (many of the buildings that we shared are small and result in staff either working from home or in more area based offices) - this could have resulted in a fracture in relationships - it has meant that we are adjusting the way we work, senior operational managers are looking at how to reframe 'team meetings' and 'case meetings' and 'MDT meetings' in the light of new practice and I think will arrive a good place.* (KI51, LA, Director/Assistant Director)

Most of the responses evidenced some optimism about the development of MDTs over the next twelve months in spite of the pandemic. However, a number of individual concerns were expressed about the potential impacts of Covid-19 on the day-to-day working of MDTs during this period. These included fears about: the availability of adequate funding for MDTs in the face of the demands being placed on them; Covid-19 slowing progress towards integration; difficulties engaging specific organisations/sectors; the impact of expanded PCN teams on MDTs; and potential risks to patients when they were not being seen in person by health or care staff.

> *Difficulty with home visiting, may not spot those most at risk, demonstrates the need for an integrated population health management system and integrated care record.* (KI6, CCG, Programme Manager)

> *I think the teams are struggling operationally to build relationships with PCN's due to reduced capacity of primary care and see a workforce being built in primary care through DES which duplicates or competes with integrated community teams which we are seeking to avoid.* (KI46, NHS Provider, Director/Assistant Director)

<u>Additional comments about how the Covid-19 pandemic has helped or hindered local integration activities in the past few months</u>

Finally, key informants were asked whether they wanted to make any additional comments about how the pandemic had helped or hindered their local integration activities in the previous few months. Twelve key informants, most of whom worked for NHS providers, responded. Half of these reported that Covid-19 had facilitated integration activities by leading to an increase in collaborative working relationships and partnerships across services and sectors.

> *"Don't waste the crisis" is a truism that proves its worth again. There has been a really significant shift in positive collaboration between agencies and this is much overdue .... but should be welcomed and the momentum sustained to bring about fundamental changes in the way the whole system functions.* (KI17, Other)

> *COVID-19 has shown the potential to respond to social and medical need as a system and this improved patient care and outcomes.* (KI10, NHS Provider, Integration Transformation Lead / Co-ordinator)

A couple of others suggested that it had resulted in new and beneficial ways of working, to a greater focus on the needs of specific patient groups (e.g. those with mental health problems), or to the introduction of new initiatives.

> *The pandemic has helped us to put in place some initiatives we have been trying to implement for years as necessity has reduced some of the barriers to adoption. Examples include virtual triage and virtual appointments, greater skill mix in primary care of the none GP workforce.* (KI47, CCG, Director/Assistant Director)

However, the pandemic was also reported to have made it more difficult to move funding to the community sector, and to have led to delays in the planning and implementation of integration-related activities.

> *The introduction of block contracts, with associated reduction of activity and change in the way care has been delivered, has made it more difficult to shift funding out of the acute sector to the community.* (KI4, NHS Provider, Health Care Professional (Clinical))

6. Conclusions

The fifth key informant survey was carried out in autumn 2020, seven years after the start of the Wave 1 Pioneers and nearly six years since the Wave 2 Pioneers were established. The survey was carried out six to seven months after the first national lockdown had begun on 23rd March, and eight to nine months after the first Covid-19 case had been diagnosed in England.

This report provides only a brief description of general trends (e.g. in progress) over the five surveys; further analysis of all the key informant surveys will be combined with findings from other parts of our evaluation of the Pioneer programme for publication in future reports and journal articles.

The emphasis of this report is to look at key informants' perceptions of the impact of the Covid-19 pandemic on local health and social care integration activities.

The main findings from the survey include:

- As would be expected, the Covid-19 pandemic had a profound impact on both the individuals and organisations involved in the planning, management and delivery of integrated health and social care initiatives.
- Two-thirds of the key informants who responded to the survey said their own role had changed as a result of the pandemic, typically leading to the individual taking on additional strategic and/or operational roles and responsibilities.
- In terms of the organisation and provision of integrated health and care services, the pandemic was said to have presented opportunities or had a **positive impact** both on local integration objectives and progress towards increased integration:
    - It reinforced the importance of providing 'joined-up' services (such as hospital discharge and transfer of care) and approaches (including working more closely with the community and voluntary sector).
    - It highlighted the importance of tackling health inequalities in the local population.
    - The pandemic emphasised the need for new approaches to care (such as increased patient self-management and valuing a 'whole system' approach to service development).
    - The need to work together to solve problems created by the pandemic was said to have strengthened both *strategic and operational relationships* between local health and social care services, such as: improved communication and trust between organisations and between the statutory and community and voluntary sectors; improved team working across organisations; better use of resources; and reduced barriers between services.
    - The pandemic was felt to have progressed a number of key objectives that integrating services aim to achieve including: joining up health and social care services; reducing unplanned admissions; and helping patients/ service users to better manage their own care.
    - Not only did the pandemic speed-up, or make easier, the implementation of changes that were already in the planning stage, it also prompted new integration initiatives that local organisations now planned to keep.
    - Specifically in relation to MDTs, the pandemic was viewed by some key informants as accelerating their development, leading to improved ways of working, and collaboration with a wider range of organisations/ sectors.
- In contrast to the positive impacts identified, key informants also described a number of challenges or **negative impacts** on the integration of health and social care services arising from the pandemic:

- Most notably, the pandemic generated considerable pressures on health and care managerial and clinical staff and services, which required significant extra staff time and financial resources to deal with, as well as an awareness of pent-up demand that would need to be dealt with once the pandemic retreated.
    - The pandemic was said to have highlighted concerns about funding and a financially uncertain future
    - The increased workload for staff (particularly, but not exclusively, those on the frontline) increased stress and reduced wellbeing.
    - Another negative impact was reducing the capacity to plan (including for integrating services) in order to deal with the immediate demands arising from the pandemic.
    - The requirement for non-frontline staff to work from home during lockdown was said to have led to the breakdown of some working relationships, while remote working (for example, of MDT meetings) also resulted in a reduction of informal, but still important, opportunities for face-to-face relationship building and information exchange.
    - The inability of staff to visit patients' homes during lockdown resulted in less insight into patients' home situations and social connections.
    - The pandemic was felt to have hindered progress in several key objectives that integrating services aims to achieve, including: improving quality of life and quality of care for patients/service users; giving patients/service users a greater say in their care; making services more accessible; and reducing average health and social care costs.
- The survey was carried out in the relatively early stages of the pandemic, and key informants may well have given different responses had the survey taken place after dealing with the pandemic for a year or more. With this in mind, we asked key informants to predict how they thought the pandemic might influence strategic and operational relationships between health and social care services/organisations over the next 12 months.
    - Some key informants thought the ongoing pandemic would continue to have a positive impact in terms of driving local collaborations and integration activities, and to continue the deepening of working relationships, partnership working, etc that had already begun.
    - But several challenges over the next year were also mentioned. Key informants suggested that a continued focus on the pandemic could lead to strains in relationships between different parts of the NHS as well as between health and social care services, and make it more difficult to plan and provide resources for integration activities. Financial uncertainties were mentioned as having the potential to challenge future relationships. In the extreme, it was mentioned that the pandemic could even deter further collaboration and lead to a return to previous organisational silos. Several also felt that some of the improvements that had arisen due to the pandemic (e.g. in working relationships) would prove to be short-lived. A continuation of high workloads and remote working could reduce the opportunities of developing new trusting relationships.

The majority of those of those who responded to the open-ended questions described themselves as working for NHS Providers or CCGs. However, there were still LA and 'Other' key informants who responded to each of these questions, and, although fewer in number, their opinions are represented in the main themes which emerged in the responses. As can be seen from the quotes included, key informants provided quite detailed information and perspectives, leading us to assume that the Covid-19 pandemic and its local impacts had had a profound effect on those working on health and social care integration during the summer of 2020.

Previous reports from the evaluation of the Integrated Care Pioneers (Erens et al 2015) suggested that the Pioneers had not found a solution to a so-called 'integration paradox'. This refers to the situation whereby, within an increasingly adverse environment of increased demand and fewer financial resources, the need for integration becomes more pressing in order to improve quality of care and patient/service user outcomes while achieving cost savings. These same demand and cost pressures, however, also increase incentives to defend the historic distribution of resources and roles between organisations, leading to a retreat into more 'siloed' ways of working, thereby making it increasingly difficult to bring about integrated services.

Results from the 2020 key informant survey, however, appear to suggest that an extreme jolt to the system such as that triggered by the Covid-19 pandemic has led to a number of developments that promote the integration of health and social care services. The pandemic increased demand on the system and on staff to an extent never before experienced by the NHS. While it is true that financial resources were also significantly increased during the pandemic, the additional funding provided to health and social care was used to cope with the huge increase in demand arising from the pandemic, particularly at the acute level to meet the large number of Covid-19 patients entering the hospital system every day, and there was no 'surplus' funding to assist local areas with integration activities. Despite this increased pressure on resources, our key informants identified a number of positive impacts of the pandemic on integrated ways of working, such as highlighting the importance of integrated services, valuing a 'whole system' approach, developing new ways of team working, improving communication, and strengthening strategic and operational relationships across services and organisations.

While the perceived improved local relationships and integrated ways of working reported by key informants is undoubtedly related to the fact that health and social care organisations/services had to pull together to battle the specific impacts of, and challenges created by, Covid-19, the developments over this period may provide a solid base on which to further progress sustainable integrated services. Considerable optimism was expressed by some key informants about the future of local integration. Whether, in actuality, local NHS and social care services are able to maintain the integration-related gains already made remains to be seen. There are extensive challenges on the horizon: e.g. the pandemic has continued well into 2021 and, despite the successful vaccine rollout in England, will undoubtedly create enormous challenges reaching well beyond the end of this year, the persistent high levels of demand, growing waiting lists for health services, very high staff workloads, along with reported staff burn-out, ceaseless financial pressures, and the significant financial disparities between health and social care. Without centrally coordinated planning, it is possible that integration initiatives will continue in some areas, but regress in others, with perhaps an even starker incarnation of the 'integration paradox'. Support from national policy-makers – e.g. in the form of continuing financial and other assistance for the development of local integrated care systems and primary care networks, but perhaps even more importantly by providing sufficient financial resources which are distributed equitably across health and social care – will be important to enable the continued development of sustainable integrated services.

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Appendix: Pioneer key informant survey 2020 questionnaire

Pioneer key informant survey 2020

Q1 Browser Meta Info

Q2
Health & Social Care Integration in the Context of the Coronavirus Pandemic: Key Informant Survey 2020

This is the fifth and final 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 2021) being 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.

This survey asks about all integrated health and social care activities in your local area, but this year we have also included **questions on how the Covid-19 pandemic is affecting ongoing local integration activities**. This year's survey provides a unique opportunity for you to contribute directly to the national evidence base by feeding back your experience of how the pandemic has facilitated or hindered the progress of integration activities in your 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 surveys have been presented to NHS England and the Department of Health and Social Care and are available on the PIRU website (www.piru.ac.uk).

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 **10-15 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 As a result of the Covid-19 pandemic, did your role change this year, or did you take on new or additional responsibilities?

- ❍ No (1)
- ❍ Yes (please type in) (2) ____

Q6 How long have you been in your current post? *Please type in years and months*.

	Type in number
Years (1)	
Months (2)	

Q7 And how long have you been working in this local area? *Please type in years and months.*

	Type in number
Years (1)	
Months (2)	

Q8

Progress

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)

Q9 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.*

____

Q10 Has the Covid-19 pandemic changed your views of what objectives or outcomes are most important for integrating health and social care services in your area?

- ❍ No (1)
- ❍ Yes (please type in how this has changed your views) (2) ____

Q11 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. (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)	❍	❍	❍	❍

Q12 How has the Covid-19 pandemic affected progress in...

	Aided progress (1)	Hindered progress (2)	No effect on 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. (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)	❍	❍	❍	❍

Q13 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. (11)	❍	❍	❍	❍
Increased demand for existing services. (12)	❍	❍	❍	❍
Primary Care Networks (PCNs) not aligning with existing integration initiatives. (13)	❍	❍	❍	❍
The time required to deal with the Covid-19 pandemic. (14)	❍	❍	❍	❍
Diversion of staff resources in order to deal with the Covid-19 pandemic. (15)	❍	❍	❍	❍
The financial resources required to deal with the Covid-19 pandemic. (16)	❍	❍	❍	❍

Q14 *Please type in* any other **challenges** presented by the Covid-19 pandemic that have affected your local integrated health and social care activities.

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Q15 **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. (13)	❍	❍	❍	❍	❍
Developing local plans to become an Integrated Care System. (10)	❍	❍	❍	❍	❍
Planning the local Primary Care Networks (PCNs). (1)	❍	❍	❍	❍	❍

Q16 Did the Covid-19 pandemic make day-to-day working relationships between the NHS and local government better or worse?

- ❍ Much better (1)
- ❍ Somewhat better (2)
- ❍ No change (3)
- ❍ Somewhat worse (4)
- ❍ Much worse (5)
- ❍ Don't know (6)

Q17 Did the Covid-19 pandemic make it easier or more difficult to secure NHS resources to fund discharge packages for patients with long-term care needs?

- ❍ Much easier (1)
- ❍ Somewhat easier (2)
- ❍ More difficult (3)
- ❍ It made no difference (4)
- ❍ Don't know (5)

Q18 Did the Covid-19 pandemic...

	Yes (1)	No (2)	Don't know / not applicable (3)
Make it easier to implement changes that your organisation was already thinking about? (1)	❍	❍	❍
Prompt new initiatives in integration that you plan to keep or further develop? (2)	❍	❍	❍

Q19 *Please type in* any other ways the Covid-19 pandemic may have **facilitated** your local integrated health and social care integration activities, such as shared patient/service user records, telehealth, etc.

____

____

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Q20 The final questions ask you to describe the impacts, if any, of the Covid-19 pandemic on local health and social care integration activities.

Firstly, what impacts, if any, has the pandemic had on **strategic relationships** between local health and social care services?
*Please type in any impacts **to date.***

____

____

____

Q21

Strategic relationships

*Next, please type in any impacts you think the pandemic may have over the **next 12 months**.*

____

____

____

Q22 Secondly, what impacts, if any, has the pandemic had on **operational relationships** between local health and social care services?

P*lease type in any impacts **to date.***

____

____

____

Q23

Operational relationships

*Next, please type in any impacts you think the pandemic may have over the **next 12 months**.*

____

____

____

____

Q24 Lastly, what impacts, if any, has the pandemic had on the day-to-day work of your local health and social care integrated, community-based, multi-disciplinary teams?

Ple*ase type in any impacts **to date**.*

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Q25

Health and social care community-based multi-disciplinary teams

*Next, please type in any impacts you think the pandemic may have over the **next 12 months**.*

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Q26 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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Q27 *Finally, have you any other* comments you would like to make about how the Covid-19 pandemic has helped or hindered your local integration activities in the past few months? *Please type in*

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