

# Assessing the Evaluation Needs of Better Care Funds in Yorkshire and The Humber

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## *Final Report*

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# Contents

<b>Summary .....</b>	<b>i</b>
<b>1. Introduction .....</b>	<b>1</b>
<b>2. Context: The Better Care Fund .....</b>	<b>2</b>
<b>3. Methods.....</b>	<b>3</b>
<b>4. Findings .....</b>	<b>5</b>
<b>5. Conclusions and recommendation .....</b>	<b>13</b>

# Summary

This assessment of evaluation needs in relation to the Better Care Fund (BCF) in the Yorkshire and Humber Region has been carried out by the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) Yorkshire and Humber between April 2015 and January 2016, working in partnership with NHS England and the Yorkshire and Humber Academic Health Science Network.

The BCF aims to support the integration of health and social care services to support improved care and outcomes for vulnerable people. The BCF is governed through Health and Wellbeing Boards (HWBs), which bring together representatives from, variously, NHS, public health, adult social care, children's services and Healthwatch. There are 15 HWBs in the Yorkshire and Humber region encompassing 23 local authorities and 22 Clinical Commissioning Groups (CCGs). Expenditure on individual plans in Yorkshire and the Humber in 2015/16 ranged from £12m to over £240m.

The needs assessment was conducted through structured interviews with 24 individuals, representing 11 of the 15 HWBs in the Yorkshire and Humber region.

## Evaluation of the BCF

None of the areas had in place a comprehensive plan for evaluation at BCF programme level. Individual schemes were being evaluated (or evaluations were planned), with a view gathering evidence to support the re-commissioning, scaling up or rolling-out of services.

Interviewees were not confident that they had a good understanding of the factors that will contribute to the achievement (or otherwise) of BCF targets, or the relationships between reductions in non-elective care and longer term outcomes for local populations.

There was a strong consensus amongst all interviewees that learning from the BCF needs to be located in the context of wider transformational change - regardless of the size, or scope, of individual BCF plans. Interviewees highlighted need to build evidence in relation to the integration of health and social care, prevention and service quality measures.

## Evaluation assets and resources

There is a lack of capacity to undertake evaluation work in the region. Individuals working in local authorities and CCGs have skills and (in some cases) methodological expertise to undertake evaluation work, but this is often not part of their routine work, and BCF evaluation is additional to existing tasks. Interviewees confirmed the absence of resources with the BCF for evaluation and the very limited prospects for allocating additional money to undertake evaluation activity, or support externally commissioned work.

There are examples of scheme evaluations and tools which have been developed for data collection and analysis which interviewees expressed willingness to share within the region. Although local authorities and CCGs are data 'rich', data is often not utilised effectively for

evaluation purposes and data sharing within and across organisations presents significant technical and cultural challenges.

## **Evaluation Needs**

A wide range of evaluation needs were identified. A key concern was ensuring that evaluation supports shared and common understanding across organisations and between service commissioners, planners, providers and users. Variation in approaches to the measurement of inputs and outcomes creates challenges in understanding 'what works'.

Evaluation needs to support real-time learning to inform systems change. The processes of change required to support integration take time to gather momentum and there is a need to identify and capture evidence in relation to short-term indicators of progression toward longer term outcomes.

## **Support mechanisms**

There are existing mechanisms in place to support the implementation of the BCF and integrated care, including a variety of web-based tools and resources. Those interviewed for this assessment were aware of key sites and resources but felt that they lacked the time to navigate a complex infrastructure of support, and commented that it was not always easy to apply generic resources to local contexts. As a consequence, their use was limited.

Interviewees were strongly of the opinion that it would not be feasible to identify substantial additional resources to undertake evaluation work at the level of individual HWBs, although there was some support for the potential for pooling resources at a regional or city-region level to buy-in support to address common issues or problems.

There was strong support amongst interviewees, and from practitioners involved in the project steering group, for peer-led, collaborative support in relation to evaluation of integrated care, potentially delivered through a network or practitioner community and utilising conferences or workshops to provide facilitated opportunities for sharing of evidence and practice. There is potential for such an approach to draw on national tools and resources to address their application within a regional context and to develop agreed regional standards and frameworks for the evaluation of integrated care.

## **Conclusions and recommendation**

The project has confirmed the need to expand the focus of knowledge mobilisation beyond the Better Care Fund to the wider integration of health and social care. There is a very strong appetite within the region for shared learning on this topic and interviewees were candid in their concerns that focusing on the narrow outcomes of BCF plans runs the risk of failing to capture knowledge which can support genuinely transformational change.

Needs ranged from the specific support in relation to data capture and analysis to more generic needs in terms of developing evaluation frameworks, logic models, economic evaluation and return on investment plans linked to transformation pathways.

Learning needs to be facilitated, and peer support and knowledge exchange between academic and practitioner communities would be beneficial. The findings of the needs assessment support the recommendation to develop a knowledge mobilisation and knowledge exchange network for BCF or teams leading on the integration of health and social care services in Yorkshire and the Humber. The network would provide a platform to develop a community of practice for health and social care commissioning teams across the region and promote systematic links into academic partners within CLARHC and the AHSN.

# Introduction

This report presents the findings of an assessment of evaluation needs in relation to the Better Care Fund in the Yorkshire and Humber Region. The needs assessment has been carried out by the Collaboration for Leadership in Applied Health Research and Care (CLARHC) Yorkshire and Humber between April 2015 and January 2016, working in partnership with NHS England and the Yorkshire and Humber Academic Health Science Network (AHSN).

The BCF evaluation needs assessment grew from work undertaken by the CLARHC Yorkshire and Humber supporting CCGs and local authorities to understand the process and impact of integrated care which aims to support independence and prevention. It became clear through this work that although there is much good practice in the region in relation to the evaluation of health and social care interventions there are gaps in the knowledge base which practitioners and commissioners were seeking support with, particularly in relation to capturing the impact of interventions on individuals, health and wellbeing outcomes, and in relation to the financial assessment of programmes. This assessment is a response to that need, and is intended as a first step in developing tools and resources to support health and social care providers in the region to commission and deliver effective integrated care.

The assessment has a number of objectives

- identify the evaluation needs of Better Care Fund (BCF) partnerships in the Yorkshire and Humber region from the perspective of those involved in developing and monitoring the plans
- identify training and capacity building needs in relation to evaluation
- identify the nature and topic of external evaluation expertise requirements of BCF partnerships
- identify the assets of the BCF partnerships with respect to evaluation capacity and skills.

The findings of the assessment are intended to inform the development of architecture for matching expertise with innovation requirements, and building evidence and knowledge mobilisation to support integrated health and social care in the region.

The remainder of this report is set out as follows:

**Section 2** sets the context for the research by outlining the key features of the Better care Fund

**Section 3** outlines the methods used

**Section 4** presents the results of the needs assessment

**Section 5** contains conclusions and a recommendation for a knowledge exchange network in the region.



## Context: The Better Care Fund

In the June 2013 spending round the Government announced the creation of a £3.8 billion Integration Transformation Fund, subsequently referred to as the Better Care Fund (BCF) described as 'a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities'. The BCF aims to support the integration of health and social care services to provide improved care and outcomes for vulnerable people. The BCF is a pooled budget (although it does not represent new or additional resources) which aims to deliver outcomes that benefit both the NHS and local government. As such, the development and implementation of the Fund at the local level requires shared decision making between the NHS and local government.

The BCF is governed through Health and Wellbeing Boards (HWBs), which bring together representatives from, variously, NHS, public health, adult social care, children's services and Healthwatch. These Boards have approved Better Care Fund plans that have been developed jointly by local authorities and NHS organisations, and have pooled an additional £1.5 billion, bringing the overall Fund total to £5.3 billion. Five fast track areas submitted their plans to NHS England for approval in August 2013. The remaining HWBs submitted their plans in February 2014. These BCF plans became operational in April 2014.

Table 2.1 provides a summary of the key features of 150 BCF plans across England (there are 151 Health and Wellbeing Boards, but Cornwall and the Isles of Scilly have a joint plan). There are 1,326 schemes across the 151 HWBs. It demonstrates that, in line with the Fund's aspirations for integration and improving outcomes for vulnerable people, schemes most commonly feature integrated care teams, care at home, intermediate care and reablement services. Schemes which provide support for carers or feature seven day working and assistive technologies are less common. Schemes which address health at care homes are the least common.

**Table 2.1: Features of BCF Schemes (England)**

Feature	Proportion of schemes (%)	Proportion of expenditure (%)
Reablement	35	39
Care at home	34	35
Intermediate care services	33	42
Integrated care teams	41	55
Health at care homes	9	9
Carers support	18	26
7 day working	19	16
Assistive technologies	12	10

Source: NHS England



## Methods

This section provides information on the methodology utilised for the evaluation needs assessment. The assessment has been carried out through a number of phases, outlined in Table 3.1.

**Table 3.1 Evaluation Needs Assessment: Methods and timescale**

Stage	Activity	Action	Timescale
0	Publicity	Ground work and setting the scene. Publicise the intervention via Clinical Commissioning Groups (CCGs) Executive Group, Directors of Adult Social Services, and other relevant groups and meetings.	April/ May 2015
1	Mapping and introduction	Obtain contacts for local authorities and CCGs Prepare a short info sheet or flyer distributed by email and gathering commitment to participate in the assessment Identify key informants from local authorities, public health teams, CCGs and data intelligence teams	July/August 2015
2	Develop needs assessment framework	Work with representatives from local Health and Wellbeing Board areas (Rotherham, Doncaster, Sheffield and North Lincolnshire) to develop the needs assessment tool. Key contacts in these areas form an advisory committee for project.	June/July 2015
3	Undertake needs assessment	Use the developed tool to conduct needs assessment with key informants as identified in mapping and introduction phase. Assessment carried out by telephone interviews.	September/October 2015
4	Results and reporting	Prepare a report. Focus results on: Training needs Collaborative needs and areas for collaboration Assets that might be helpful to share across the BCF community	January 2016
5	Develop architecture for matching needs and expertise	Using the results of the needs assessment as an organizing framework develop proposals for delivering support for evaluating BCF in Yorkshire and Humber.	January 2016 onwards

## The assessment tool

The needs assessment tool was developed by the research team in collaboration with steering group members working in health and social care roles in local authorities and CCGs. The tool was designed to collect data across a number of themes:

- Better care fund plans
- evaluation (in place or planned)
- assets and resources
- evaluation and innovation needs
- support mechanisms

## Informants

Fifteen Health and Wellbeing Boards are included, for the purposes of this assessment, in the Yorkshire and Humber Region: Barnsley, Bradford, Calderdale, Doncaster, East Riding, Kingston upon Hull, Kirklees, Leeds, North East Lincolnshire, North Lincolnshire, North Yorkshire, Rotherham, Sheffield, Wakefield, York. These 15 HWBs encompass 23 local authorities and 22 CCGs.

Informants were identified via initial contact by email with health and social care leaders in the region. A purposive sampling approach was taken. All 15 HWB areas were invited to participate in the assessment by nominating individuals to take part in telephone interviews. Snowballing techniques were used to identify additional interviewees.

Structured interviews were carried out over the telephone with 24 individuals, representing 11 of the 15 HWB areas in the Yorkshire and Humber region. Each interview lasted around 30 minutes. Table 3.2 provides details of the organisational affiliation of informants.

**Table 3.2: Organisational affiliation of informants**

Organisation	Number
Local authority	15
CCG	5
Joint (LA and CCG)	3
Other	1

## Analysis

Notes were taken during the course of the telephone interviews, using a structured and common interview format. The content of notes was analysed to identify common themes and draw out illustrative examples and quotes.

# Findings

The findings of the needs assessment are presented under headings which correlate to the themes contained in the assessment tool:

- Better care fund plans
- evaluation (in place or planned)
- assets and resources
- evaluation and innovation needs
- support mechanisms

## Better Care Fund Plans in Yorkshire and the Humber

Table 4.1 provides summary detail on BCF expenditure for across the 15 HWBs in Yorkshire and the Humber. It illustrates the wide variation in terms of the size of BCF schemes: expenditure ranges from just over £12m in the city of York to £240 million in Sheffield. The plans have an overall expenditure in excess of £626 million and whilst this is small in comparison to overall spending on health and social care in the region it represents a significant investment in the delivery of integrated health and social care services to meet the needs of vulnerable people.

Table 4.2 provides data on the value of anticipated benefits. It suggests that there are anticipated benefits with a value of over £46m arising from reductions in residential admissions and non-elective care, reductions in delayed transfers, and improvements in the effectiveness of reablement.

**Table 4.1 BCF Expenditure Yorkshire and the Humber 2015/16**

	Summary of Total BCF Expenditure £000s							
HWB name	Acute	Mental Health	Community Health	Continuing Care	Primary Care	Social Care	Other	15/16 Total
Barnsley	1,700	0	9,964	0	0	8,271	439	<b>20,374</b>
Bradford	0	0	15,405	0	0	21,940	0	<b>37,345</b>
Calderdale	325	366	7,994	1,091	1,300	3,565	808	<b>15,449</b>
Doncaster	684	3,591	10,883	0	0	9,005	0	<b>24,163</b>
East Riding of Yorkshire	6,901	105	5,881	0	478	7,911	1,203	<b>22,478</b>
Kingston upon Hull, City of	4,776	0	12,802	445	100	12,703	0	<b>30,826</b>
Kirklees	2,453	1,356	2,238	0	2,167	18,164	2,575	<b>28,953</b>
Leeds	2,800	885	8,483	0	2,141	18,019	22,595	<b>54,923</b>
North East Lincolnshire	0	220	916	0	0	3,019	8,673	<b>12,828</b>
North Lincolnshire	1,134	500	1,827	0	80	7,588	1,240	<b>12,369</b>
North Yorkshire	366	1,929	21,174	0	105	22,603	550	<b>46,727</b>
Rotherham	275	445	4,160	616	2,200	13,682	1,938	<b>23,316</b>
Sheffield	56,659	436	22,779	53,561	1,408	108,112	0	<b>242,955</b>
Wakefield	7,662	2,169	13,238	0	0	18,624	0	<b>41,693</b>
York	0	125	3,045	0	0	7,296	1,661	<b>12,127</b>
Total Y&H								<b>626,526</b>

Source: NHS England

**Table 4.2: BCF Yorkshire and the Humber anticipated benefits 2015/16**

	Summary of Benefits £000s					
	Reduction in permanent residential admissions	Increased effectiveness of reablement	Reduction in delayed transfers of care	Reduction in non-elective (general + acute)	Other	15/16 Total
Barnsley	0	0	0	(2,941)	(2,130)	(5,071)
Bradford	0	0	0	(3,363)	0	(3,363)
Calderdale	(302)	(277)	(53)	0	0	(631)
Doncaster	(504)	0	(15)	(498)	0	(1,017)
East Riding of Yorkshire	(234)	0	0	(1,160)	(359)	(1,753)
Kingston Upon Hull, City of	(46)	(27)	0	(1,584)	0	(1,657)
Kirklees	0	0	0	0	0	0
Leeds	(1,570)	0	(2,551)	(4,958)	(99)	(9,178)
North East Lincolnshire	(208)	0	0	(561)	(236)	(1,004)
North Lincolnshire	0	(21)	(102)	(3,846)	(28)	(3,997)
North Yorkshire	(119)	0	(576)	(3,072)	(883)	(4,651)
Rotherham	(22)	0	0	(79)	(294)	(396)
Sheffield	(650)	0	(300)	(3,632)	0	(4,582)
Wakefield	0	0	0	(5,221)	0	(5,221)
York	(263)	0	(729)	(978)	(1,541)	(3,511)
Total Y&H						(46,032)

Source: NHS England

Data outlined in tables 4.1 and 4.2 illustrates the diverse nature of the Better Care Fund in Yorkshire and the Humber in terms the scale of expenditure and anticipated benefits. A first set of questions in the needs assessment tool explored the scale and scope of BCF plans in the region. Responses confirmed this diversity, and the variation in BCF plan structures, aims and objectives cross the region. BCF plans range from those which are primarily focused on the delivery of recurrent services to those which have a substantial element of non-recurrent monies and/or transformative schemes. This diversity means that there is a need to identify common themes and priorities for evaluation in relation to the BCF and to utilise tools and resources which are applicable at a general level and generate learning which is transferable, but which also allow for local variation in terms of schemes and contexts. This is particularly important where HWBs are working across local authority and CCG boundaries:

*We will include evaluation of 35 schemes across 5 CCGs and its difficult to draw out criteria that we can use across all of those..... we do need to work to develop the right tools and criteria for us to use*

## Evaluation of the BCF

None of the areas spoken to had in place a comprehensive plan for evaluation at BCF programme level. In a minority of areas, individual schemes were being evaluated (or evaluations were planned), either internally or through externally commissioned organisations, with a view gathering evidence to support the re-commissioning, de-commissioning, scaling up or rolling-out of services:

*We have agreed that there will be evaluation of local BCF schemes as part of the planning process for 16-17 - the question is would we continue to invest in these schemes?*

The lack of comprehensive plans for evaluation are a reflection of the fact that evaluation is not a programme requirement and in most areas early efforts had focused on agreeing the resources and schemes for inclusion in BCF plans. Interviewees remarked that evaluation has not been a priority in the planning stages of the BCF:

*It feels like early days. We have not had the luxury to properly plan long-term evaluation up to this point*

*There is an in-principle commitment to evaluation of individual schemes but this is not in the plan in any detail. It was not at the forefront of people's thinking*

The lack of focus on evaluation presents a challenge in terms of developing an evidence base across the Better Care Fund. Interviewees were not confident that they had a good understanding of the factors that contribute to the achievement (or otherwise) of BCF targets, or relationships between reductions in non-elective care and longer term outcomes for local populations.

For example, one interviewee commented:

*We need to be able to look across the programme and know what works. It's really difficult at the moment to figure out any kind of information in relation to what's working. We recognise that some work streams need to work differently but there is a lack of overall programme evaluation and a lack of clear direction and strategic vision*

Other interviewees remarked that evaluation needs to identify long term change and support the refocusing of resources toward prevention:

*Schemes are based on scant evidence. The BCF sets challenging targets for reductions in non-elective activity but the risk is that we are missing the point. We need to think about shifting resources. We are in danger of hitting the target and missing the point - for instance, I have been shocked at the frailty of some people who are being reabled*

*It's easy to focus on the numbers coming in to A&E and the immediate issues but we need to understand things that are longer term and would ultimately have more impact. But that's is not where BCF targets are at - the easy wins are not necessarily the people with the greatest needs and reductions in costs don't necessarily result from the things that the BCF is focusing on.*

In addition, there was a strong consensus amongst interviewees that learning from the BCF needs to be located in the context of wider transformational change - regardless of the size, or scope, of BCF plans. This involves building evidence in relation to the integration of health and social care, prevention and service quality measures. A raft of comments from interviewees confirm the importance of this approach:

*BCF is skewed around acute services and acute services are at the end of the chain. We need to do more things upstream. Most areas are under-doctored and doctors see far too many people. We won't get loads more doctors. GPs need to see less people and we need to support people to manage themselves and the whole of our effort should be on reducing dependency.*

*We want to understand what is working and that needs to allow for the fit of BCF in other transformation programmes so that we can build a longer, more sustainable programme of change*

*(The) challenge around BCF is that it is a small part of transformation - much more helpful if evaluation starts to shift to systems change and addresses what system leaders are doing to make a change*

*BCF is a small pot of money - but seen as separate from larger commissioning frameworks. It needs to be about supporting the overall whole.*

*We have had programme support around BCF in place for some time now. We have a shared approach in terms of completing and submitting monthly reports. We have tight governance for that. But we need to start to link BCF with other evaluation needs. There's a whole range of transformational programmes in place - but not necessarily recognition of the links between them*

The need to incorporate evaluation of the BCF into the wider context and to understand whole systems change was emphasised particularly by interviewees in areas considering devolution or where HWBs are engaging with different areas or at a regional level with the acute sector. Interviewees in these areas identified a need to understand the potential for, and impact of, working at economies of scale, but also remarked that devolution and working at wider spatial scales offered opportunities for unblocking barriers in relation to data sharing and governance which have been problematic for many HWBs.

## **Evaluation assets and resources**

A second set of questions in the needs assessment explored assets and resources in place to support evaluation of the BCF. These questions addressed staff and skills, funding, and tools and data. Responses to these questions highlighted lack of capacity and resources to undertake evaluation work. For instance, although in many areas staff within local authorities and CCGs have skills and (in some cases) methodological expertise to undertake evaluation work, this is often not part of their routine work, and BCF evaluation is additional to existing tasks. In addition, interviewees confirmed the absence of resources within the BCF for evaluation and the very limited prospects for allocating additional money to undertake evaluation activity, or support externally commissioned work.

*We have the skills locally - it's about lack of capacity, not capability*

*There is no money allocated in the Fund for evaluation - anything that will happen will be within the system not earmarked for commissioning or we will take someone off the day job to do it - that does make it more difficult to do systematically*

There are examples of scheme evaluations and tools for data collection and analysis which interviewees expressed willingness to share across the region. However, there was also a general recognition that although local authorities and CCGs are data 'rich', this is not always used to best effect for evaluative purposes, and data sharing within and across organisations presents significant challenges.



*There can be issues around the quality and consistency of data capture (across schemes) - service change is not necessarily reflected in the data we get*

## Evaluation Needs

A further set of questions explored evaluation needs. These asked interviewees to reflect on areas where they felt they might benefit from additional methodological or technical expertise, as well as areas where they felt there was a need for additional evidence or knowledge transfer on best practice. A wide range of needs were identified:

- developing relevant KPIs and dashboards across BCF schemes
- scoping programme-wide evaluations - utilising theory of change approaches and mixed methods
- impact evaluation in the context of outcomes-based commissioning/ accountability (OBA) frameworks
- attribution of benefits - avoidance of double counting
- benchmarking and quality assurance
- developing and sharing evaluation tools and resources
- understanding cultural change - how to measure and assess integration; incorporating staff and workforce feedback
- identifying the impact of wider factors and events (including non-medical factors such as socio-economic change and policy reforms) on BCF outcomes
- developing appropriate quality measures (addressing potential contradictions between BCF outcomes and patient views)
- economic evaluation - valuing outcomes, identifying cashable savings and understanding which interventions will lead to cost savings in the longer term
- data sharing and analysis
- future forecasting/ modelling.

A key theme to emerge from responses to these questions was the need for consistency, and ensuring that evaluation supports shared and common understanding across organisations and between service commissioners, planners, providers and users. There was some concern amongst interviewees that variation in approaches to the identification and measurement of outcomes creates challenges in understanding 'what works':

*We need to understand and share what it is that we want to see as an outcome. A lot of what is in the BCF assumes that non-elective admissions are inappropriate but if you asked a patient they might give you a different view. There is some conflict between input/output/quality outcomes which we have not nailed locally*

*Are we all measuring the same thing and in the same way?*

*We don't count all costs and we are not comparing services on a like for like basis - so how will we know if we have saved money in the system? By the same token, if interventions are cost-neutral but everyone is getting better care, surely that is a fantastic outcome?*

A second theme related to the timing of evaluation activities and the need for real-time learning to inform systems change. Problems relating to data flows were identified as a blockage, particularly where multiple systems are being integrated, but it was also recognised that the processes of cultural change required to support integration take time to gather momentum and there is a need to identify and capture evidence in relation to short-

term indicators of progression toward longer term outcomes. Comments from interviewees included

*Timing is a challenge - the biggest challenge has been workforce development and that has been slow in terms of building capability and capacity*

*We need to have real time information and data across health and social care. Data flows need smoothing out - identifying the NHS number helps. People understand data sharing at the patient level but it becomes much more difficult when you need to aggregate and there are still some constraints at a higher level*

*I don't just want to know about some of the longer term public health indicators. Of course we will continue to monitor that and we may see longer term change over time. But what we need to know is about immediate impacts on the system. We are looking for the right measures of change across health and social care and these will include financial indicators and customer satisfaction as well as lifestyle and wellbeing indicators.*

## Support mechanisms

Finally, interviewees were asked to give their views in relation to various mechanisms for providing support for the implementation of the BCF and integrated care, and to consider options for support around evaluation. These included linking practitioners with expertise within the CLARHC, provision of on-line tools and resources (potentially using existing platforms), peer support and commissioning of external support.

Interviewees recognised that there are existing mechanisms in place to support the implementation of the BCF and integrated care, including a variety of web-based tools and resources. Those interviewed for this assessment were aware of key sites and resources but felt that they lacked the time to navigate a complex infrastructure of support, and commented that it was not always easy to apply generic resources to local contexts. As a consequence, their use was limited.

There was no support for the generation of an additional web-based resource, although there was interest in the potential for harnessing existing resources at a regional level:

*Can we just have one site? - regional people or a regional resource. There is a plethora of organisations and sites so don't put more people in.*

In addition, as outlined above, interviewees were strongly of the opinion that it would not be feasible to identify additional resources to undertake evaluation work at the level of individual HWBs, although again there was some support for the potential for pooling resources at a regional or city-region level (within the relevant procurement frameworks) in order to buy-in support to address common issues or problems.

There was strong support amongst interviewees, and from practitioners involved in the project steering group, for peer-led, collaborative support in relation to evaluation of integrated care, potentially delivered through a network or practitioner community and utilising conferences or workshops to provide facilitated opportunities for sharing of evidence and practice.

*Peer support would be useful- participation in professional networks, learning sets and so on would be very useful. We have not done enough of that around BCF but public health colleagues are used to working like that*

*Could we have networking meetings? - maybe 2 or 3 people from each area - perhaps half day supported by experts in the field*

*I would like a facilitated approach - workshops or conferences. It's useful to hear from other people facing the same challenges and to have an opportunity to meet and exchange views with others*

Interviewees suggested that there is potential for such an approach to draw on national tools and resources to address their application within a regional context and to develop agreed regional standards and frameworks for the evaluation of integrated care.

## Conclusions and recommendation

This report has reviewed the findings from an assessment of the evaluation needs of those engaged in the planning, appraisal, commissioning and evaluation of the Better Care Fund in Yorkshire and the Humber. Although the emphasis of the assessment was on the BCF the project has confirmed the need to expand the focus of knowledge mobilisation beyond the Better Care Fund to the wider integration of health and social care of which, in many areas, the BCF is a small part. This is particularly pertinent in the context of ambitions laid out in the November 2015 Spending Review, for health and social care to be integrated across the country by 2020.

The assessment has demonstrated a very strong appetite within the region for shared learning. Although most of those interviewed are confident in the processes in place within their areas for collecting data to populate BCF reporting templates many were candid in their concerns that focusing on the narrow outcomes of BCF plans runs the risk of failing to capture knowledge which can support genuinely transformational change.

The wide range of needs highlighted by interviewees is indicative of the appetite for knowledge exchange in this area. These ranged from the specific needs in relation to data capture and analysis to more generic needs in terms of developing evaluation frameworks, logic models, economic evaluation and return on investment plans linked to transformation pathways.

Whilst some of these needs could be met through existing tools and resources, the majority of those interviewed were not systematically utilising these resources. There were a number of reasons for this, but key challenges included lack of capacity to navigate sites to identify relevant sources of support, and problems translating tools and frameworks in local contexts. This suggests that learning needs to be facilitated, and that peer support and knowledge exchange between academic and practitioner communities would be beneficial.

The findings of the needs assessment lead to a recommendation to develop a knowledge mobilisation and knowledge exchange network for BCF or teams leading on the integration of health and social care services in Yorkshire and the Humber. The network would provide a platform to develop a community of practice for health and social care commissioning teams across the region and promote systematic links into academic partners within CLAHRC and the AHSN. The network would facilitate knowledge exchange in the region in relation to good practice in integrated care, including clinical models, evaluation, learning and public engagement and provide a forum for the development of evaluation and improvement methodologies, and could provide a key mechanism for supporting areas as they move from BCF toward more ambitious and transformative models of integration.