

# Putting integrated care into practice: the North West London experience

*Research summary*

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## Acknowledgements

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The Whole Systems Integrated Care (WSIC) programme in North West London is a bold initiative that builds on prior developments such as integrated care and community budgets pilots. It seeks to improve quality of care for a population of over two million people. The WSIC programme is the largest of the 14 integrated care pioneers launched by the Coalition Government in 2013 to remove barriers to integrated care and enable it to be extended 'at scale and pace'.

The Nuffield Trust and the London School of Economics and Political Science were commissioned to evaluate the WSIC programme's early stages from February 2014 to late April 2015, independently assessing the initial processes and progress to date. The evaluation was formative in nature, providing feedback and challenge as part of the WSIC programme's commitment to adaptive learning. Here we present a summary of our findings.

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### Key points

- The WSIC programme is ambitious and well resourced through funding from the pooled budgets of the North West London Collaboration of Clinical Commissioning Groups. As a result, it has been able to make significant investments in co-design and planning, before developing pilot schemes, known as 'early adopters'.
- The initial co-design phase was completed roughly within the planned timescale, and its outputs have supported the early adopter phase. However, the programme was more than a year behind schedule when our evaluation ended and had yet to deliver significant service change. As elsewhere, design and planning were characterised by energy and pace, but progress slowed as implementation began.
- National barriers that have slowed progress include difficulties obtaining data-sharing agreements, and clarifying and establishing the necessary information governance arrangements; separate payment systems and governance structures between sectors; and organisational fragmentation. Such barriers cannot be fully removed without the national action promised but yet to be sufficiently fulfilled.
- Locally the programme has had to strike a balance between a number of factors, including collective leadership and local autonomy; integrated commissioning and integrated provision; and NHS leadership and local authority engagement. This has been achieved with varying degrees of success at different points in the process.
- The WSIC programme was seen to be approaching a 'tipping point' when our fieldwork ended in late April 2015. Changes in the programme's leadership around that time had created concerns about the weakening of its strategic management capacity.
- The WSIC programme has been led by NHS commissioners and has tended to reflect their agendas and interests. This focus may reflect a deliberate assessment of where the greatest benefits are to be secured for service users in the current financial climate over the short term.

- Nevertheless, the WSIC programme should consider whether it has given sufficient priority to achieving its broader ambition of preventing ill health and promoting wellbeing. Both the NHS and local authorities should pay greater attention to the potential for a wider local government role in support of the WSIC programme. This approach would require a governance framework capable of engaging with local government as a whole, as well as with the community, third sector and other agencies
- The extent of lay partner involvement in designing, planning and governing the WSIC programme has been a defining feature of its approach, and provided an additional source of challenge to established practices. However, if timescales slip further, there could be risk that these patients, service users and carers may become frustrated and question the purpose of their involvement.
- While the programme wisely avoided setting early output targets, the systematic monitoring of service use, patient and user experience, and overall cost-effectiveness is now required in order to begin to demonstrate delivery of person-centred outcomes and value for money.
- As accountable care partnerships begin to form, transparent and robust governance and accountability arrangements will be required to accompany them. This will have implications for the roles and responsibilities of commissioners that still need to be clarified locally and nationally.
- The ambitious nature of the programme has enabled a whole health economy approach, but has added complexity in terms of governance and management processes. This evaluation identifies lessons about the need to balance central and local support and resources, and to ensure that the complexities of a pan-North West London approach do not outweigh its advantages.
- The role of the programme team and the value of products such as the toolkit were strongly endorsed in our early adopter survey, although the programme was also criticised in some of our interviews for its overly structured programme management approach.
- The costs of the programme to date are not insignificant: £24.9m over the three years 2013/14 to 2015/16, of which £7.9m was spent during the first two years on management consultancy to provide specialist expertise and support. Unsurprisingly in the current financial climate, the evaluation reported findings that questioned the value of such levels of investment in both management consultancy, and the programme team, as well as evidence that their support had been positively appreciated. It is likely that the programme will need to account more explicitly for the cost-effectiveness of its current and past spending, especially in the absence of evidence, to date, that it has secured significant levels of service change on the ground.
- The WSIC programme has sought to maintain an inclusive, learning style, incorporating formative evaluation, lessons learned from the earlier North West London integrated care pilots, international experience and external advice. This commitment to adaptive learning is reflected in its current governance review and should enable it both to reflect on the lessons of this evaluation and address the significant strategic challenges it continues to face.



To find out more about the WSIC programme and our evaluation, see the full research report: [www.nuffieldtrust.org.uk/publications/integrated-care-north-west-london-experience](http://www.nuffieldtrust.org.uk/publications/integrated-care-north-west-london-experience)

For more information on the WSIC programme, go to: <http://integration.healthiernorthwestlondon.nhs.uk/>

## Background

Delivering more integrated care has been a concern of English health policy since the Hospital and Community Care Plans of 1962 and 1963. More recent initiatives have included the development of care trusts, managed clinical networks, integrated care pilots, the integrated care pioneers in 2013 and the new care models programme as part of the Five Year Forward View in 2015 (NHS England and others, 2014).

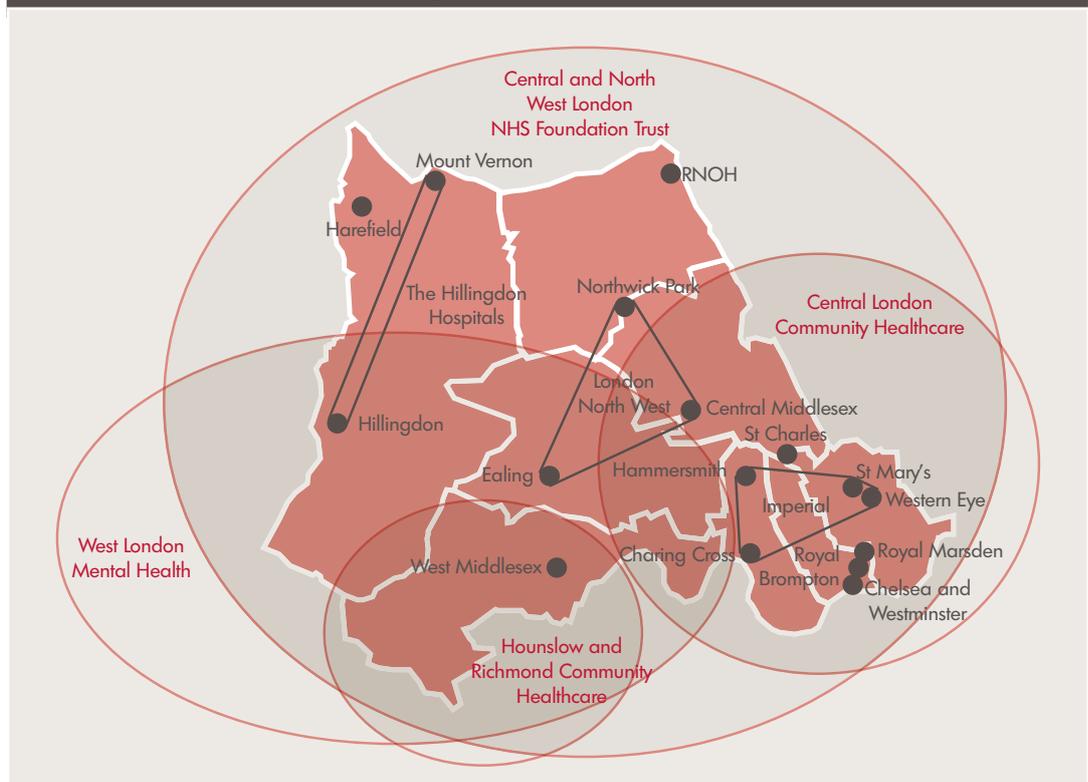
The Whole Systems Integrated Care (WSIC) programme in North West London is the largest of the integrated care pioneers – 14 areas of England chosen to pilot different ways of delivering better joined-up care.<sup>1</sup>

The WSIC programme builds on prior initiatives in North West London, such as integrated care pilots and community budgets work, seeking to improve the quality of care for local people and to support them in leading independent lives.

The area covered by the WSIC programme has a population of over two million people, with significant variations in deprivation and population health status.

The commissioner and provider landscape in North West London is complex. Commissioners include eight clinical commissioning groups (CCGs), eight local authorities and the NHS England North West London local area team. Among other collaborative financial arrangements, the eight CCGs have pooled their 2.5 per cent transformation budgets to pay for the WSIC programme and related change initiatives.

Figure 1: Map of the North West London provider landscape covering acute trusts, and mental health and community services



1 For details of the pioneer programme, see: [www.england.nhs.uk/2013/11/01/interg-care-pioneers/](http://www.england.nhs.uk/2013/11/01/interg-care-pioneers/)

NHS providers include nine acute and specialist hospital trusts, four mental health and/or community trusts and over 400 GP practices. The provider landscape has recently been subject to large-scale reconfiguration through a local transformation programme called *Shaping a Healthier Future*.

### Development of the WSIC programme

The vision of the WSIC programme is ‘to improve the quality of care for individuals, carers and families, and to empower and support people to maintain independence and to lead full lives as active participants in their communities’ (WSIC Integrated Care Toolkit, 2014).

The programme was designed in two phases, with the first phase focused on co-designing the WSIC programme (October 2013 until late February 2014) and the second on implementing a set of early adopter schemes – local pilots of integrated care, intended to test out the wider principles and aims of the WSIC programme in a practical manner (from March 2014) prior to implementing these across North West London as a whole.

The co-design phase was organised and run by the WSIC programme team, with considerable consultancy support. This team was part of a wider Strategy and Transformation team, which provided development and implementation support to other transformation programmes in North West London in addition to the WSIC programme.

The co-design phase brought together health and social care organisations, as well as patients, service users and carers, from across North West London into working groups to develop solutions to common challenges to the design and delivery of integrated care. The idea was that solutions generated by these groups would be piloted locally by the early adopters, which could experiment with new ways of working and models of care. The co-design phase culminated in the launch of the WSIC Integrated Care Toolkit in May 2014, which provided an overall framework for the design, development and implementation of the early adopter schemes.

Details of the nine early adopters are set out in Table 1. The full research report that accompanies this summary (which can be accessed [here](#)) contains further information about the early adopter selection process, as well as detailed case studies of some of the schemes.

Table 1: Key features of the nine WSIC early adopters

Early adopter	Population group(s)	Size of population group(s)	Model of care	Piloting new model of care by end of April 2015*
<b>Brent</b>	≥65 with one or more LTCs	~11,000	MDTs, self-management, care plan	
<b>Central London/ Westminster</b>	<75 with LTCs ≥75 with LTCs ≥75 mostly healthy	59,938 (4,582 + 44,828 + 10,527)	MDTs, self-management, new care-coordinator role, better GP access	
<b>Hammersmith and Fulham</b>	≥65 with LTCs ≥65 mostly healthy	Awaiting latest information	Virtual Ward, MDTs, self-management, care plan	
<b>Ealing</b>	≥75 with LTCs	11,978	MDTs, self-management, care coordinator, GP at heart of model	✓
<b>Harrow</b>	≥65 with LTCs	36,478	Virtual ward to pre-empt deteriorations or crises self-management. The above supported by enhanced primary care provision.	
<b>Hillingdon</b>	≥65 with LTCs such as COPD, PVD, diabetes, stroke, dementia, mobility issues or social isolation	11,358	GPs as hub, care coordinator, care plan, overall team for care at home	✓
<b>Hounslow</b>	<75 with LTCs ≥75 with LTCs Adults and elderly with organic brain disorders	58,391 (47,687 + 9,865 + 839)	MDTs, self-management, care coordinator and plan, GP at heart of model	
<b>People with long-term mental health needs – two early adopters</b>	West London CCG	3,400	Community Living Well – addressing bio-psycho-social needs of individuals building on community assets	
	Brentford & Isleworth locality (Hounslow)	580	Wellbeing Network – using wellbeing mapping to agree goals and support recovery	
<b>West London</b>	≥75 with LTCs ≥75 mostly healthy	11,000	Single provider model, two integrated GP hubs	

\* Our collection of data finished at the end of April 2015. However, we sought updates on this table in June 2015, which revealed that some components of an additional three early adopters had begun to be implemented (Hounslow, West London and Harrow).

CCG, clinical commissioning group; COPD, chronic obstructive pulmonary disease; LTC, long-term condition; MDT, multi-disciplinary team; PVD, peripheral vascular disease

## Evaluation

The Nuffield Trust and the London School of Economics and Political Science were commissioned by Imperial College Health Partners (ICHP) and funded by ICHP and the North West London Collaboration of CCGs to evaluate the development and implementation of the initial design and piloting phases of the WSIC programme from February 2014 to late April 2015.

The evaluation sought to provide independent assessment of the way in which the WSIC programme was designed; its involvement of local stakeholders in the processes of design; the development and early implementation of the early adopter schemes; and the extent to which the WSIC programme appeared to be on track towards its objectives. We were not commissioned to assess the cost-effectiveness of setting up or operating the WSIC programme.

The methods used in the evaluation comprised documentary analysis, meeting observations, interviews, workshops, a focus group, and surveys of early adopter steering committee members and GP practices across North West London.

These activities took place between early February 2014 and late April 2015. In total, we conducted 73 hour-long interviews, face to face or by telephone. Interviewees included managers and professional staff from the acute sector; CCGs; community and mental health services; local authorities; lay partners; third sector representatives; and frontline staff. We also observed approximately 120 hours of meetings at the pan-North West London and local early adopter levels.

Further details of the methods can be found in the accompanying research report, which can be accessed [here](#).

## Findings

### Defining the scope of the programme and interpreting the vision

The WSIC programme set out its ambitions in terms of better health and care outcomes for people in North West London, to be secured by supporting them to remain independent for as long as possible and lead full lives as active participants in their communities. Care out of hospital is to become the first point of call. This vision was widely recognised by those we interviewed for this evaluation as being person-centred, transformational and ambitious.

As the programme evolved, however, there seemed to be some confusion about how the programme aligned with the wider strategic health and social care plans in North West London. There was also perceived to be a lack of clarity about how the plethora of central government initiatives joined up at the North West London level, as well as concern about the associated risk of change fatigue. Those we spoke to often identified the need to produce a single narrative for change.

The terminology of ‘whole systems’ suggests that WSIC sought to offer a comprehensive approach to integration in which the re-configuration of hospital services and development of different population-based models and approaches would be systematically aligned. Such an approach is reflected in the vision and principles of the programme. In practice, however, WSIC has primarily focused to date on services operating at the boundary between the hospital and community.

The WSIC programme has been led primarily by NHS commissioners and its direct costs have exclusively been funded by them. Local authority financial, and consequentially capacity, constraints have seriously limited their ability to engage fully in the programme. The predominance of NHS leaders within the programme’s structures has been a major contributor to its focus on immediate health service concerns at the expense of prevention and wellbeing. This move away from the wider place-based approach contained in the WSIC programme’s pioneer bid raises a question about how the programme has sought to balance responses to short- and medium-term health and social care pressures, against initiatives to address determinants of health and wellbeing that may have more limited pay-back in the short term.

The programme has been characterised by strong and effective leadership, and our survey of early adopter steering committees found that the programme was viewed as having clear leadership, management and governance structures.<sup>2</sup> Our interviewees also commented positively on the influence and credibility of key senior figures involved in the WSIC programme. Changes to the leadership of the programme near the end of the evaluation period, however, were seen to have weakened the programme’s strategic management capacity and had become a cause for concern.

### Co-design and the challenges of lay involvement

The initial phase of co-design was run at a pan-North West London level and was highly inclusive in its philosophy. One important aim of this phase was to allow a balance to be struck between a push from the top for standardisation and consistency, and a pull from the bottom for local ownership. In particular, the WSIC programme team was keen for the integrated care programme to be seen as a joint piece of work between themselves and

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<sup>2</sup> Find out about this survey and the results at:

the rest of the local health and care system, and not something that was imposed on local organisations and teams in a traditional NHS top-down way.

The involvement of lay partners – patients, service users and carers – in the WSIC programme has been a striking aspect of its inclusive approach, with significant time, attention, resource and support being provided to it. Indeed, this element of the co-design phase appeared to be one of the programme's defining characteristics. This has been highly valued by those working within the WSIC programme, but how far it has enabled wider involvement of communities beyond the individual lay partners themselves is yet to be seen.

Our interviews revealed that there were initial doubts among providers, NHS commissioners and some members of the programme team about extensive lay partner involvement. However, such doubts were reported to have been largely replaced by enthusiasm at the end of the co-design phase. Particular value was seen in how lay partners had provided an additional and different source of challenge to clinicians, managers and others. Indeed, we observed lay members making important contributions to the discussion in a range of meetings at the pan-North West London and local levels. Some respondents to our survey of early adopter steering committees also described the lay partners as providing a valuable source of challenge to established practice and having an important role in raising awareness of the programme in the community.

While the extent of lay engagement is impressive, at the end of our evaluation we observed and were told of some frustration among lay partners about the slow pace of change. This suggests that, if timescales slip further, there is a risk that lay partners could become disillusioned with the programme and the purpose of their involvement.

There was a consensus that the programme would have benefited from bringing in the third sector more strongly during the co-design phase, although our research suggests that this gap may now have been partially addressed by some of the early adopters in the subsequent implementation phase, indicating that the local level may be the more appropriate (or, rather, more natural) level of engagement for NHS organisations with third sector providers.

Our research also revealed a relative absence in the co-design phase of frontline staff, including social workers and community nurses. It also painted a picture of a core group of GPs who were highly committed to the WSIC programme, but also of a wider group of GPs who felt a general sense of detachment. In our survey of early adopter steering committees, fewer than half of the survey participants felt that GPs had been extremely or very involved in the design of their early adopter – a figure which fell to around 30 per cent when our respondents were asked about the involvement of wider primary care. Similarly, in our survey of GP practices in North West London, 50 per cent of GPs who completed the survey said that they had not been that involved or were not involved at all in the WSIC programme and/or its early adopter projects. More positively, three quarters of GP respondents said that they had heard about the programme, although the depth of this knowledge was not explored.

If a core focus of the WSIC programme remains that of putting GPs at the centre of coordinating care, it will be crucial to ensure that the wider community of GPs in North West London understand and feel committed to the WSIC programme and the early adopter schemes; recognise how their own practice will need to change to enable roll-out of new integrated care services; and feel that support is available to them to make such changes.

Interviewees from all sectors raised concerns about whether the engagement of social services could be sustained under current financial constraints.

Lastly, while acute providers were clearly involved in the co-design phase in terms of attendance at WSIC programme workshops, some of our interviewees questioned whether attendance in this case constituted true engagement. Others commented that acute providers lacked ownership of the programme, had been 'passive' or might display greater interest if they could take on the role of prime contractor in provider networks.

### The early adopter schemes

A central feature of the WSIC programme was a set of early adopters to test out features of the WSIC vision. A comparison of the original 25 expressions of interest and the final nine early adopter models of care reveals that the former were relatively diverse in the populations they had chosen as their focus, while the latter were broadly similar in this regard. At the time our research report was written in June 2015, eight of the nine early adopters had chosen people over the age of 65 or 75 with one or more long-term conditions as one of their population groups. Only two of the early adopters had chosen the mostly healthy elderly as one of their target groups, and none had focused on mostly healthy, non-elderly adults, with implications for the wider wellbeing agenda described in greater detail below.

The early adopters described the programme team as being very supportive, particularly in relation to the materials produced and in helping them think about and plan to address difficult issues. Three quarters of respondents to our early adopter steering committee survey felt that the WSIC Integrated Care Toolkit had been helpful in the design of their early adopter scheme. However, concerns were raised about the overall cost and utility of both the co-design process and the toolkit, with questions raised about whether these represented good value for money.

This evaluation was not commissioned to conduct cost-effectiveness studies of any aspect of the WSIC programme and is not in a position to provide an assessment of the actual or potential value for money secured by investment in the programme, including its support from management consultancy. The WSIC programme is funded as part of the North West London Financial Strategy (2014/15 to 2018/19), which is a collaboration between the eight North West London CCGs and has been used to support large-scale transformational programmes across the sector. The costs of the WSIC programme are not insignificant: £24.9m over the three years 2013/14 to 2015/16, of which £7.9m was spent during the first two years on management consultancy to provide specialist expertise and support. Further details of this expenditure are provided in Box 1.

As we have noted above, the evaluation found evidence of both appreciation for the role of management consultants and the programme team, alongside scepticism about the value that had been derived from such costly investment. In the current financial climate, it is likely that the programme will be asked to account more explicitly for the cost-effectiveness of its current and past spending, especially in the absence of evidence that it has, to date, secured significant levels of service change on the ground.

**Box 1: North West London Financial Strategy**

“The North West London Financial Strategy (2014/15 to 2018/19) is a collaboration between the eight North West London CCGs and has been used to support large-scale transformational programmes across the sector. Resources are pooled to enable the strategy to support three clear objectives, the first of which includes covering the design, planning and implementation costs of large-scale change (‘transformation’) programmes across North West London, including the WSIC programme.

In 2013/14, strategy funding for the WSIC programme amounted to £6.4m, which was split between pan-North West London support and implementation (£3.7m), and direct CCG funding for local support (£2.7m). In 2014/15, strategy funding for the WSIC programme amounted to £8.5m, again split between pan-North West London support and implementation (£5.5m), and direct CCG funding for local support (£3.0m). At the end of this study, 2015/16 strategy funding consisted of £10m, with a greater proportion allocated to direct CCG funding (£6.75m) compared with pan-North West London support (£3.25m) – to reflect the shift towards local ownership and direction of resource.

The majority of the pan-North West London resource each year was allocated to bringing a wide range of specific, specialist expertise to bear on the barriers to integration (£3.5m in 2013/14 and £4.4m in 2014/15), as well as a comprehensive programme of co-design incorporating the input of over 200 representatives (staff and service users) from across health and social care, resulting in the North West London Toolkit. The technical expertise has included input on:

- supporting the early adopters through initial intensive work to develop new models of care and the development of a step-by-step handbook
- building informatics capability, including a range of tools and system developments, and the information governance approach and infrastructure required to support it
- designing a new approach to funding health and social care based on a capitated methodology
- developing legal guidance and template contracts to support new provider models and ways of commissioning to support integration
- the design and delivery of an organisational development programme and an extensive programme of co-design across the North West London system
- ensuring that national and international best practice is brought to bear on the North West London model.”

The results of this work are available at:

**<http://integration.healthiernorthwestlondon.nhs.uk/>**

[Publicly available information provided by the North West London Collaboration of CCGs]

### Finding a balance between local autonomy and central programme support

The WSIC programme team recognised the need for an approach to change that was sensitive to local organisations' autonomy and felt different from what had been perceived as the somewhat top-down style of working in North West London, including the earlier integrated care pilots. Nevertheless, an ongoing theme of our evaluation was the tension between (a) having a large, well-resourced and highly-structured programme management approach to facilitate standardisation and consistency, as well as provide financial and operational support to the early adopters, and (b) the need to ensure local innovation and ownership of the programme by providing the early adopters with sufficient autonomy.

Our research suggests that while the people leading the early adopters valued the leadership, energy and resource of the programme team, they were yet to be fully satisfied that the team was providing them with the support needed as they entered into the implementation phase of the programme. Perhaps most fundamentally, questions remained at the end of the evaluation about which functions were best fulfilled collectively at the North West London level on behalf of the CCGs and boroughs, and which were more effectively located at the local level.

The review of WSIC programme governance arrangements initiated by the programme executive group in May 2015 will need to weigh these factors carefully as it seeks to achieve a balance appropriate to the current stage of implementation and the demands of the external environment. If arrangements for integrated commissioning and service delivery, such as local integrated provider models, are to be progressively introduced, clear and robust accountability arrangements will be required to accompany them. Jupp (2015) has helpfully begun to explore such issues in the context of the continuing policy commitment to integrated care, particularly in light of the Five Year Forward View (NHS England and others, 2014).

### A limited interpretation of 'inclusivity'

Inclusivity has been a central element of the way in which the WSIC programme works and its approach to change. At the time our evaluation ended, however, engagement had almost exclusively been limited to the NHS, lay partners and a small number of third sector organisations and adult social care participants. The last of these did not always find it easy to engage fully because of the various pressures facing local government.

Importantly, there is little evidence that the WSIC programme had engaged sufficiently with the wider range of stakeholders, especially in local government and the community, whose involvement was identified in the national call for pioneer applications as necessary to address the social and economic determinants of health. Housing and public health are two critical examples. In practice, therefore, the scope of engagement has tended to reflect the requirements of vertical integration within the NHS, as well as horizontal integration with social care where this has had a necessary role in supporting the medical models adopted locally.

This focus on primary care and vertical integration within the NHS may reflect a deliberate assessment of where the greatest benefits are to be secured for service users in the current financial climate, at least over the short term. The issue for consideration is whether the NHS, which has provided most of the leadership and resource for the WSIC programme, has defaulted into a way of working that is unlikely to secure the wider wellbeing goals implied by the local and national pioneer visions. However, we

recognise local stakeholders might argue that the national priority given to reducing avoidable admissions in 2015/16 and extending integration 'at scale and pace' by 2018 provides little space for taking a longer-term view.

If the WSIC programme is to achieve its original aim of preventing ill health and promoting wellbeing, as well as providing person-centred care, it will require a governance framework capable of engaging more fully with local government as a whole and not just with adult social care. This framework will also need to enable engagement with the community and voluntary sectors, and other agencies such as those in employment, housing and benefits services. At the time our evaluation ended, the programme did not appear to have taken full advantage of the potential contribution of local government beyond that of adult social care's role in facilitating discharge and helping avoid unnecessary admissions or re-admissions.

Many of the responsibilities of local government are related to the social and economic determinants of health, and it is arguably more experienced than the NHS in public engagement, including public involvement in service re-design. In addition, while Health and Wellbeing Boards are at differing stages in their evolution, the local partners in North West London may not have sufficiently considered how far these could develop a stronger contribution to systems leadership.

It is also unclear how far all the early adopters have explored the opportunities for integrating case management systems and their 'back office' infrastructures across the NHS and local government. There may also be a risk that strengthening the central coordinating role of GPs through additional care coordinator and care navigator posts will duplicate functions, leading to poor use of resources or services that are more difficult to coordinate. While these functions may well need to be expanded, it is important to do this within the bigger picture of the care journeys undertaken by, for example, older people throughout their life course. More specifically, this risk arises from the initial focus on models of care for the frailest older people, rather than the population as a whole. The establishment of separate social care and NHS infrastructures for managing personal budgets would similarly risk the duplication of administrative and professional resources.

Lastly, while our interviewees appreciated the inclusive philosophy of the WSIC programme, we also identified concerns about the centralised facilitation of this involvement. Our evidence identified perceptions that this tended to be characterised too much by a linear process of structured programme management (for example, through weekly and fortnightly meetings and reports) and too little by softer but equally necessary processes of 'winning hearts and minds' at all levels in the system, especially the frontline. At the same time, our interviews showed a broadly based perception that the programme began to operate in a less centralised and top-down way as early adopter implementation began. It is the case that the rate of progress slowed thereafter, but our evidence does not allow us to make a causal connection.

#### **Unintended consequences have proved important**

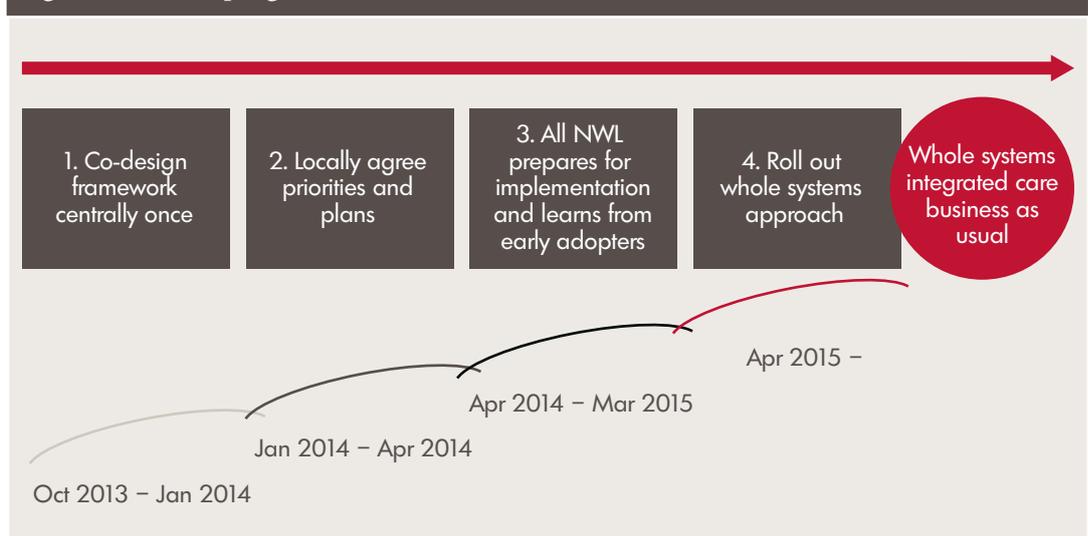
An important observation from this research has been the role of unintended consequences within an integrated care programme of the scale of North West London. While taking a structured approach to programme management can help drive things forward, it risks focusing attention too much on the milestones within the project plan and not taking full account of unforeseen changes along the way.

An example of this was the way in which a number of health and care organisations in Central North West London came together as part of the local Better Care Fund plan to bid successfully to run a new Community Independence Service aimed at supporting frail and vulnerable people in their own homes, with Imperial College Healthcare NHS Trust as the lead provider. We were told of how this bid could not have been mounted without the prior collaborative working enabled by the WSIC programme. However, the details of how the Community Independence Service would interact with the early adopters in these central boroughs of North West London were unclear at the end of our evaluation.

### Barriers to moving from design to implementation

In the North West London pioneer bid, submitted in June 2013, the project timetable envisaged early adopters being ready to pilot their new models of care with shadow budgets from January 2014. This starting date was subsequently shifted to April 2014, as seen in a later WSIC programme timetable given in Figure 2. Slower than expected progress, however, meant that this was moved back again, to April 2015.

Figure 2: WSIC programme timetable (from December 2013)



Since being formally designated as early adopters in March 2014, these local schemes have moved at different paces. Some of this was expected, and, indeed, was encouraged by the WSIC programme's philosophy of allowing local innovation to solve local problems. However, it is striking that while some areas were beginning to pilot new models of care by late April 2015, others were a long way off and did not have a clear idea of when they would be ready to pilot a new service. Overall, the early adopter programme was then running some 15 months behind schedule, with few service changes having yet to begin operating.

The early energy and pace for the design and planning phase of large-scale change in health care, followed by struggles and delays with implementation and roll out of new services, is something that is well documented in the research literature (Best and others, 2012; Bardsley and others, 2013). In addition, there is a well-evidenced tendency for integration initiatives to focus on joint structures and processes, without necessarily producing better outcomes (Cameron and Lart, 2003; Wistow, 2011). The Department of Health's call for pioneer bids recognised the continuing influence of

local and national barriers to better coordinated care (Department of Health, 2013; National Collaboration for Integrated Care and Support, 2013), and offered to remove them. The interim report from the evaluation of the pioneer programme (Erens and others, 2015) found that national barriers were generally limiting progress, including those associated with information sharing and information governance, payment systems, funding levels and the tension between sustaining acute sector provision while potentially reducing its provider role.

North West London is not unique, therefore, in experiencing difficulties in moving from design to delivery. It is significant that some of the foundation stones for the WSIC model of care developed through the co-design phase included mechanisms such as accountable care partnerships, integrated commissioning, capitated budgets and information sharing. None of these are arrangements that are readily facilitated by mainstream governance frameworks in the NHS or local government. It is consequently unsurprising that each has provided a sticking point or source of delay in the various early adopter schemes. This being said, at the time our evaluation ended, the national agenda was showing signs of becoming more aligned with that of North West London (through, for example, the Vanguard and devolution programmes), and it is to be hoped that the national offer to remove barriers will now begin to be fulfilled more effectively.

However, there are also issues that the WSIC programme and local leaders should be able to address. For example, the programme still appears to be struggling to find the optimum balance between a number of factors such as: collective leadership and local autonomy; integrated commissioning and integrated provision; NHS leadership and local authority engagement; and locally appropriate variation and acceptability, and programme-wide consistency and standardisation. Managing such tensions is integral to a programme such as this, and requires a form of management ('systems leadership') that has been likened to 'being comfortable with chaos' (Timmins, 2015). As the same source points out, NHS leaders have relatively little training or experience in managing systems as opposed to organisations. Yet doing so is a style of working that is becoming increasingly relevant as public sector managers recognise the complexity of addressing the needs of an ageing population or reducing health inequalities. The ability to work through hierarchies must be complemented by skills in working across organisations and through networks to achieve better outcomes for people and places in a cost-effective way.

One of the WSIC programme's leaders was a participant in Timmins' work and, in its Change Academy, the programme potentially has a resource that could improve systems leadership skills across all of its partner organisations at the many levels where these will be essential. This in-house learning resource was still being designed when our data collection finished. Its programme was intended to include a range of activities for senior managers and clinicians, such as a 12-month leadership skills development course, masterclasses on specific topics (for example, service improvement or behavioural change), and support on how to access and use the materials in the toolkit and toolbox.

One of the most critical challenges facing the WSIC programme is how it can sustain energy for, and commitment to, change, and provide necessary support at the local borough and CCG level. The programme was at a 'tipping' point at the time our data collection ended in late April 2015. It now needs to move quickly into actual

service change for local people, to demonstrate that the significant investment of time and money has been worthwhile. Greater clarity is needed about the sort of flexible and tailored support to be offered to individual early adopters, and for how long this will be available.

In our formative feedback, we have recommended that the programme undertake a root cause analysis of the slow progress and delays in implementation. The WSIC programme is beginning to address this issue through a review of its governance arrangements – something which, in turn, should reflect the scope of the programme's vision.

### **The importance of information sharing and data**

International evidence on the development of integrated care consistently highlights that information sharing via individual electronic care records is a vital prerequisite for well-coordinated care (Shaw and others, 2011; Lonsdale and others, 2015). Our evaluation of the WSIC programme has revealed, once again, that information sharing can be a barrier to progress, as witnessed for example by the time taken to secure agreements for sharing data or to ensure interoperability between proprietary systems. This finding was also common among the national integrated care pioneers (Erens and others, 2015).

## Lessons learned

We have identified a number of lessons that we recommend the programme should consider as part of its next steps. These lessons may also be of value to other areas as they design and implement their own approaches to integrated care.

### With a large integrated care programme, there are both economies and diseconomies of scale

A large-scale integrated care programme such as WSIC offers benefits in terms of enabling a whole health economy approach and pooling CCG resources for management and developmental support. The scale does, however, create additional complexity in terms of accountabilities, governance and management processes, with inevitable tensions arising from having a central strategy and support team alongside local initiatives.

### NHS management has a tendency to dominate within integrated health and social care

Given the national and relatively centralised nature of NHS policy and management, and the constraints and lack of capacity in local government, it is not surprising that integrated care programmes have a tendency to feel somewhat dominated by NHS and health service concerns. In North West London, this has meant that more wellbeing-focused aims have at times felt secondary to putting in place services for people with complex health and care needs.

### It is better to promise short and deliver long

Perhaps the most striking lesson from the WSIC programme is the wisdom of avoiding the temptation to promise early changes to emergency hospital activity and costs as a result of developing a programme of integrated care – something which has almost always resulted in frustration and disappointment (Bardsley and others, 2013). With the WSIC programme, the programme team elected to have an initial period of planning and design, during which the evaluation focused on assessing the process of stakeholder engagement, and early progress in establishing new services.

### The balance of central and local support and resource needs constant adjustment

In any health and care development programme, constant attention will need to be given to the balance of support and resource at ‘head office’ or in a central programme team, and that which is allocated to localities or pilots. Formative evaluation support can be helpful here, as can the development of regular, open and honest reflective workshops involving all parties.

### A focus on involvement and relationships will take you only so far

There is a strong tendency for integrated care initiatives to invest heavily in co-design, planning and engagement work that is intended to foster stronger relationships across organisations, professions and the boundaries that so often lead to fragmented care. The experience in the WSIC programme, in common with wider research evidence, is that it is challenging to move from co-design and engagement to service change and implementation. Alongside involvement, there needs to be parallel investment of time and resource in transactional issues such as contracts, data and IT, and the development of new work processes, focusing on the main parties to be affected and putting in place arrangements to arbitrate between them as tough issues emerge relating to workforce, funding and service change.

### **Lay involvement can be a powerful but uncomfortable tool**

There has been extensive lay partner involvement in designing, planning and governing the WSIC programme. This was impressive, and came to be welcomed by a wide range of stakeholders. In particular, it was reported to have provided an additional and different source of challenge to clinicians, managers and others. There are, however, unanswered questions about how far the lay partners involved in the programme can most effectively become anchored in wider community networks within each of the local areas, and how the relationship between these partners and local managers might be tested if the implementation of integrated care continues to fall behind schedule.

### **Information and data really do matter**

In common with other UK and international programmes of integrated care, the WSIC programme team has found that issues of data sharing, governance and IT have caused delays to the overall programme of service change. A commonly agreed need to share data for the purposes of improved care coordination so often runs into difficulty when the practicalities of interoperable systems, data-sharing agreements, and professional or organisational culture come into play. These and other barriers, including payment systems, governance structures and organisational fragmentation, cannot be fully removed without national action, such as that promised (but not yet delivered) when the national pioneer programme was announced.

### **Local government has more than adult social care to offer**

Social care has an essential role in supporting the day-to-day delivery of health services. It is also part of wider local government structures, and councils possess expertise, infrastructures and leadership responsibilities that could greatly assist the transformation of local whole systems. Both the NHS and local authorities should consider whether that potential is sufficiently recognised and exploited in the context of integrated care.

### **Formative feedback**

Commissioning a formative evaluation is part of a reflective and learning style in policy development and implementation. It is particularly appropriate in situations of complexity, characterised by multiple stakeholders and difficulties in establishing the causal relationships between activities and outcomes. It requires evaluators to be confident in their relationships with their commissioners, and the latter to be prepared to receive messages that are potentially uncomfortable or inconvenient. It also requires time and structure: formative feedback is not a corridor conversation. In addition, since evaluators cannot evaluate their own impact, it requires open dialogue between evaluators and commissioners to learn about this impact and the consequences of the formative approach.

## Conclusion

The WSIC programme in North West London is large in scale, ambitious and well resourced when compared with other national integrated care programmes (Erens and others, 2015). The scope and scale of the programme are reflected in the extent and sophistication of its management and developmental resources. It has also been remarkable in its commitment to involving many local people and organisations, and seeking regular critique of its approach, progress and prospects. The commissioning of this study as an early formative evaluation providing feedback and challenge is itself evidence of such openness and readiness to learn.

The initial co-design phase attracted enthusiasm and succeeded in producing outputs roughly to time and, perhaps more importantly, in both extending working relationships between different actors and demonstrating the value of involvement of lay partners. Implementing the early adopter schemes proved much more difficult, and timescales slipped considerably. As the WSIC programme seeks to move from design to delivery at scale, it will be vital for the programme executive and its constituent members to identify the reasons for this delay and address those that are within local control.

An important juncture has been reached, as changes occur to the leadership of the programme, the NHS England Five Year Forward View (NHS England and others, 2014) becomes a central feature of NHS planning, and the WSIC programme is held accountable for its use of resources and progress to date. Within the wider context of constrained public finances and the forthcoming Comprehensive Spending Review in November 2015, the requirement to demonstrate the value derived from the significant investment made in the WSIC programme reinforces the need to put more specific targets in place around service utilisation, patient and user experience, and overall cost-effectiveness.

The WSIC experience reveals valuable lessons for other policy-makers and practitioners leading integrated care schemes, namely in the challenges it has had in moving from planning and design to implementation of integrated care, and how it has sought to address these. As the programme moves forward, it is important that its leaders – the eight CCGs, seven boroughs and their organisational partners – sustain and build on the early adopter pilots and translate their experience into delivering sustainable service change across North West London. They will need to avoid what so often happens in the NHS: that not enough time is provided to bring about the changes needed to local services before the policy and management focus moves onto a new initiative.

The story of integrated care initiatives is one of great expectations often not met. Ambitions typically run ahead of the changes that occur on the ground. The early energy and pace that goes into the design and planning phases of large-scale change, as we have seen from this study of North West London, is often followed by struggles and delays with implementation. Policy-makers must set realistic expectations, provide sustained and tailored support, and allow time for clinicians and managers to deliver changes to the ways in which patients are cared for. Alongside this, there is a need for careful and robust monitoring of progress over the longer term, feeding into local governance and accountability arrangements, so that investment and implementation deliver the transformational changes promised at the outset.

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