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CONFERENCE ABSTRACT

Why Implementing Integrated Care is so much harder than designing it: experience in North West London. England

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Introduction: Delivering more integrated care has long been a priority in England. Both care quality and cost effectiveness have been seen to require effective collaboration between local government and the NHS. Despite repeated national programmes and some localised progress, success has never been universalised. The recent Coalition Government launched several initiatives to enable integrated care to 'become the standard model for everyone with health and care needs' (Hunt and Lamb 2013).

Among these initiatives was the establishment of 'integration pioneers' in the 'most ambitious and visionary areas' to 'help to get the ball rolling' and share 'every lesson learned'. In return, central government promised support to remove national barriers to integration. The Whole Systems Integrated Care (WSIC) programme in North West London (NWL) was the largest pioneer in terms of population (2.4million) and partners (31 agencies). This paper reports on an initial evaluation conducted by its authors between January 2014 and May 2015.

Theory/Methods: A primarily qualitative evaluation with a strong formative element was commissioned to provide ongoing feedback and independent assessments of:

- How WSIC was designed;

- Stakeholder involvement;

- Early implementation of pilot schemes;

- How far WSIC appeared on track to meet its objectives.

Data were collected through documentary analysis, non-participant observation, 73 interviews, workshops, a focus group, and two web-based surveys.

The interviews and focus group were recorded, transcribed and analysed using NVivo. Emerging findings were fed back in round table sessions to help structure reflections on progress.

Results:

- WSIC built on lessons identified by an earlier evaluation in NWL (Curry et al 2013). It was ambitious and well resourced from funds pooled by the eight CCGs: £14.9m over the first two

years of which most (£7.9m) was spent on management consultancy to address barriers to integration and lead a co-design.

- A programme team developed a timetabled process for integrated care to become 'business as usual' from April 2015. A key principle was to save time and resources by addressing problems once rather than in each of eight local areas.

- The initial co-design phase was completed largely on time. However, the programme was more than a year behind schedule when our evaluation ended and had yet to deliver significant service change. Only two of eight early adopter projects had begun operations by April 2015.

- By late April 2015, the WSIC programme was seen to be approaching a 'tipping point'. Changes in the programme's leadership created concerns about its strategic management capacity and the need to demonstrate its ability to deliver change was considered increasingly urgent.

Discussion:

- A complex mix of enablers and barriers with local and national origins was considered responsible for the relative success of the design stage and the much slower progress subsequently. Co-design, inclusivity (especially of lay partners), an openness to learning, a clear, timetabled route map, together with roles of the programme management team and its resources were seen as valuable enablers.

- However, the transition from planning to implementation and roll out of Early Adopters proved more difficult than anticipated. While some of the barriers could be addressed locally, others ultimately required action by central government. Among the former, the programme struggled to find the balance between, for example: collective leadership and local autonomy; integrated commissioning and integrated provision; NHS leadership and local authority engagement; local variation and programme-wide consistency; investment in design and support for ongoing implementation and change.

- Managing such tensions is integral to such a programme and requires capabilities in systems leadership. NHS leaders have relatively little training or experience in managing systems as opposed to organisations.(Timmins, 2015).

- National barriers slowing progress included difficulties in: securing data-sharing and information governance; developing payment and accountability systems aligned with integrated care objectives; enabling local government to be more equal partners especially when their finances were cut more heavily than the NHS; maintaining acute provider viability while reducing hospital admissions; balancing completion and collaboration.

- Many of these barriers were identified before the Pioneer initiative but, despite the national commitment to remove them, little progress has yet been made.

Conclusion: The distinction between local and national barriers and facilitators is an analytical one. In practice, they are interdependent. The NWL case shows the importance of developing effective local systems leadership capabilities within a national framework structured to support such leadership. It also highlights the need to ensure integration barriers are removed

during the design stage and that the transition from design to delivery is planned and supported.

Keywords: whole systems; co-design; implementation; national barriers; systems leadership