Supporting integrated care in practice: Perceptions of a national support programme for the development of New Care Models in England

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Abstract

Purpose: This paper investigates the perceptions of key informants on a national support programme for the development of New Care Models in England (2015/16 to 2017/18). It focuses on the perceived facilitators and barriers affecting the development and implementation of the New Care Models programme and offers some insight into the role of national level support in enabling local integration initiatives.

Design/methodology/approach: A set of 29 interviews were carried out with a variety of respondents at the national level (including current and past programme leads, strategic account managers, advisors to the programme and external regulators) between October 2017 and March 2018, and analysed thematically.

Findings: A set of facilitative elements of the programme were identified: the development of relationships and alliances, strong local and national leadership, the availability of expert knowledge and skills, and additional funding. Challenges to success included perceived expectations from the national Vanguard programme, oversight and performance monitoring, engagement with regulators, data availability and quality, as well as timetables and timescales. Crucially, the facilitators and challenges were found to interact in dynamic and complex ways, which resulted in significant tensions and ambiguities within the support programme.

Originality/value: The paper demonstrates that analysis of facilitators and challenges with respect to the national support of implementation of integrated care initiatives should move beyond the focus on separate influencing factors and address the tensions that the complex interplay among these factors create.

Keywords: integrated care, vanguards, new care models.

Background

In common with health services across the world, the National Health Service (NHS) in England has, in recent years, seen an increasing focus on policies designed to integrate care between health sectors and between health and social care. The Five Year Forward View (FYFV) (NHS England, 2014) set out an overall vision for NHS reform, based around the creation of a number of 'New Care Models' (NCM) which would seek to break down barriers between care sectors, and provide integrated care to populations, suggesting that NHS England (NHSE) would: 'design a model to help pump-prime and 'fast track' a cross-section of the new care models' (NHS England, 2014, p.26). Following an application process, pilot sites were chosen and designated as 'Vanguards'. Three types of New Care Models (NCM) were established: multispecialty community providers (MCPs), based around local primary, community and social care services; primary and acute care systems (PACS), bringing together hospitals with the full range of local community service providers; and extended care in care homes (ECH), which sought to improve services in care homes via better integration with other local services. A further two models – acute care collaboratives (ACCs) and urgent and emergency care networks (UECs) were also developed as part of the Vanguard programme, but were largely based around hospitals, and less engaged with the support programme. In July 2015 further guidance was issued that set out an explicit goal for the Vanguard programme to develop approaches which could be subsequently rolled out more widely (NHSE, 2015).

In addition to receiving additional funding, Vanguards were assisted by an NHSE New Care Models support programme, which was extensive and included: a designated lead for each model; topic-specific support around common issues such as information management, contract models, accountability; local account managers; and regional and national events. The programme was also organised around 10 enabling areas/support workstreams, which helped facilitate developments at the local, cohort (MCP, PACs, ECH, UEC and ACCs) and national levels. The workstreams centered around (1) designing new care models, (2) evaluation and metrics, (3) integrated commissioning and provision, (4) new operating model, (5) governance, accountability and provider regulation, (6) empowering patients and communities, (7) harnessing technology, (8) workforce redesign, (9) local leadership and delivery, and (10) communications and engagement (NHSE, 2015). The NHSE team also consulted national regulators in the development of the NCM programme.

This paper reports part of a wider national evaluation of the New Care Models Vanguard programme (2017-2021) funded by the NIHR Policy Research Programme, that aims to investigate the effects of the Vanguard programme on the NHS, including its local organisations, wider partnerships and service users. The evaluation focuses on three of the new care model types: MCPs, PACS and EHCs. This paper

draws from our Interim report of the National Evaluation of the NCM programme (Checkland *et al.,* 2019, in press) and reports the initial findings relating to the experiences and perceptions of key national informants associated with the NCM support programme. These findings offer some insight into the role of national level support in enabling local integration initiatives.

First, some overall perceptions of the programme's achievements are presented. The paper then looks thematically across the programme, and provides descriptions of approaches and programme elements identified as facilitative. It explores how relationships were built, the nature of leadership, the availability of expertise, and the impact of additional funding. Continuing with the cross-thematic analysis, factors seen to be challenging are then outlined, including expectations from the NCM programme, oversight and performance monitoring, engagement with regulators, data availability and quality, and timetables and timescales. These findings are then discussed and conclusions drawn.

Design and Methods

For this aspect of the programme evaluation, an exploratory qualitative approach was adopted. Between October 2017 and March 2018, 29 interviews were carried out with a variety of respondents at the national level, using either face-to-face or telephone interviewing. Respondents included current and past employees of NHSE including programme leads, strategic account managers, as well as advisors to the programme, and people involved with Arm's Length Bodies (e.g. regulators). See Table 1 below.

Table 1. Respondents

Respondent type	Numbers interviewed
NHSE employees (current / past)	19
Advisors	7
Arm's Length Bodies	3

Separate interview topic guides were developed for each group of respondents. For the National Vanguard support team (including those leading the programme and its different elements, advisors and those providing support to the programme), the approach was relatively unstructured in order to elicit narratives from respondents, which helped understand the development of the programme over

time, along with their assessment of the value of each of the elements and any adjustments that have been made over the life of the Vanguard programme.

Interviews were recorded and transcribed verbatim, followed by coding using NVivo11 software and a thematic analysis with an inductive approach (Braun and Clarke, 2006). Throughout this report examples of direct quotes from respondents are used. To preserve anonymity, each respondent was given a unique ID number. Ethics approval for this evaluation was obtained from the University of Manchester (Approval Number: 2017-2113-3253).

Findings

Overall Perceptions of the programme's achievements

Senior staff involved in and associated with the Vanguard programme were asked to describe the goals of the NCM support programme and their perceptions of how far these had been achieved. In general, national-level informants were very positive about the programme, in particular the local energy and enthusiasm generated by the initial bottom up and developmental approach:

> *In terms of the progress of the sites, I have been overwhelmed by the commitment of the teams who are working on the programme, and the commitment to making their local systems work. I think it's been fantastic, and anyone who's worked on it, it's been a joy to do, a joy to see, 'cause you don't often get the opportunity to do this, and see that. [ID002]*

This sense of excitement and energy was repeatedly identified as a key outcome by staff at all levels within the programme, particularly those closest to Vanguard sites. The approach, based upon empowering local teams to develop in their own way, was lauded as being different to previous change programmes:

> *I love the way it just feels different from what we've done before and actually potentially quite transformational. […] I've seen real changes in people's attitude towards the care sector and people's relationships and behaviours, and that's amazing, and I'm seeing new leaders emerging. [ID007]*

However, a distinction was made between the perceived success in generating enthusiasm for change in the Vanguard sites, and the more limited progress towards developing a set of defined care models which could be replicated elsewhere. Thus, in the early stages of the programme, focus on what made up the elements of a care model was overshadowed by both the desire to generate a broad local coalition to support change and by the need to provide generic support around such things as information governance, change management and contracts. It was argued that, towards the latter stages of the programme, the emphasis had shifted:

> *And I think we probably, in the beginning, oversold this as being a New Care Models programme. It was about new care models, because it was about how to support them, how to support and enable their delivery […] And I think over time, the balance began to redress itself. In other words, we began to ask questions of the Vanguards, saying: 'what is it that you're doing that's working […] What are those common elements across different MCPs or different PACS or whatever?' [ID018]*

It was acknowledged that designing a more concrete and specific care model was easier in the ECHs than it was in the more broadly focused MCPs or PACS, with the six ECHs regarded as a more coherent group:

> *So the lead for the ECHs has really fostered a very tightly knit community of them and it feels like they had a very clear goal. I think they had six evidence-based practices that everybody seems to agree were the right thing to do, and then they focused on upping everyone's game to do the six of them in concert rather than just bits and bobs. So that has felt culturally quite distinct from the other two. [ID013]*

Approaches and programme elements identified as facilitating

Cutting across the main elements of the NCM support programme, there were some common features, mechanisms and ways of working which contributed towards the perceptions of success and helped in achieving the programme's goals and supporting its operation.

The following cross-cutting facilitators are described: (a) the development of relationships and alliances, incorporating learning and feedback; (b) strong local and national leadership; (c) the availability of expert knowledge and skills (within and outside the programme), and (d) additional funding.

a) The development of relationships and alliances

One of the key roles of the NCM support programme was said to be the brokering and support of relationships within and between the different 'layers' of the system. This included within Vanguard sites, between Vanguards and their wider health economy, between Vanguards of different types and between Vanguards and those developing broader integrated care policy.

This helped build trust, gain a shared understanding of the programme and its goals, share emerging learning, and support communication. It was also argued that the rapidly changing policy context required these trusting relationships in order to accommodate changes in local, national and regional policy.

Account Managers were seen as having a particularly important role in relationship brokering across many levels. Their role was described as including: 'critical friend'; bridging between local and national teams; brokering relationships (described by one respondent as acting like 'a dating agency'); and 'filling gaps'. They were thus required to get to know their local sites well, and at the same time have a clear understanding of both local and national systems and structures:

> *When that's previously been evaluated, the account management support has been rated very highly by Vanguards. You know, they say they quickly develop a one-to-one relationship with them, they meet them on a regular basis, they are that kind of jam in the sandwich, if you like, between the Vanguard and the support that's available to them, helping them to direct to the most appropriate place [ID021]*

Multiple mechanisms were employed to broker and sustain developing relationships. Many of these encouraged the sharing of 'success' stories. The development of communities of practice was one such mechanism. The scale and scope of community of practice activities varied and each model was separate from the others. The ECHs developed a particularly close-knit community of practice by virtue of their small number, and similarities in their design and range of interventions. The face-to-face meetings were regarded as very helpful. In the MCPs for example:

We have communities of practice across each of the care models, and they meet regularly. [In the MCPs] we used to talk about what difference had they made to patients, every time we met, and it was really good, because it really focused them on the care model. [ID002]

In the spirit of open learning, Vanguards were encouraged to visit one another. However, this quickly became unmanageable to those seen as most successful or high profile as they could become over-burdened with requests. As a result, open days were arranged instead.

In addition to the Vanguard open days, regional and national events were organised. Some of these were facilitated by external organisations, for example the Kings Fund and the Nuffield Trust:

We held a Vanguard event and so did the North […] where we brought all the Midlands and East Vanguards together and invited a wide range of stakeholders to come and hear what the Vanguards had been doing. That was geographical […] don't think the London and South have done that, but the North and the Midlands and East have [ID021]

Whilst multiple modes of communication were used and valued (such as webinars, tweets, newsletters, and emails), face-to-face meetings had a special role in developing trust and relationships at all levels.

b) Local and national leadership

Leadership was seen as important at the policy level, the NCM support level and at the implementation level within the Vanguard sites. Having a clear driving force at national level with strong support was seen as important, although this element somewhat faded during the last six months of the programme, as those in NHSE supporting the programme started to move into other roles:

[A]nd the way that was managed from a leadership sense, the idea was that you'd then have senior people in the leadership team who are responsible for owning those [models, enablers] as well. [ID007]

Many respondents emphasised the particularity associated with leadership – exactly who is in a leadership role matters, as this shaped both how they were seen and how they reacted to circumstances. Thus, it was seen as important that many of those at the top of the national programme had worked at the NHS frontline, and were seen as understanding the relevant issues.

Strong local leadership for the Vanguards was also seen as important, from the initial proposal, making change, learning and seeing the Vanguard develop to continue after the support programme ended. This was well-recognised in advance by the support programme.

In addition to local political leadership it was also argued that successful Vanguards required a strong management structure, including individuals able to lead the difficult day to day work of supporting change:

> *Some of them had stronger [Project Management Officers] than others and therefore somebody central driving it. I guess with any sustained innovation, if the senior leadership of the organisation's committed to it, it will happen and some will have been stronger committed than others. [ID023]*

c) *Availability and sharing of expert knowledge and skills*

The availability of expert knowledge and expertise from within and outside the programme was seen as a facilitator. Seconding people into the programme with expert knowledge and establishing an advisory group were seen as positive:

> *I would say that having some really expert people working on the contracts and nitty-gritty side of things […] team has really moved that agenda on. [ID014]*

In addition to having access to individuals and groups with expertise, the FutureNHS online Collaboration platform was intended to be a live resource. This platform aimed to bring together evidence, and foster an open approach to sharing local experiences. Whilst it was valued, some found it difficult to use, as access was wide with over 5,000 users and information was not always well organised. It included case studies of the sites, evaluations and learning resources. There seemed again to be an emphasis on sharing successes, and some attempt to learn more general lessons:

But the idea is, therefore, to not just have a kind of series, you know, this Vanguard did this and this Vanguard did this, but actually to have […] the collected view of the MCPs about how you should best do risk stratification, for example. [ID008]

A robust evaluation programme was widely acknowledged as having been very helpful for the programme overall, both in terms of supporting Vanguards in understanding 'what works' (or doesn't work) and in providing external credibility for the programme. Experts brought in, such as the Information Analytics Unit, were regarded as independent at both the national and local levels, and this was seen as important:

So I personally think it is a big advantage to have someone who is respected and independent, and has no vested interest in finding these things effective or not. And I think you add the analytical skills, so when you're saying about control groups, […] I think they are much stronger study designs than NHS England would produce themselves. [ID029]

d) Additional funding

The Vanguard programme was perceived to be well-resourced, both in terms of the direct funding Vanguards received and the funding available to assist both the support and evaluation programmes. Any assessment of 'what works' had to take account of this, as many of the elements described above required funding, whether that be to organise events, free up staff time or run evaluative activity. In addition to cash funding for the support programme, there was also funding in kind locally such as the secondment of staff to support different elements:

I can give you the exact numbers but, you know, if I went back to my desk, but we're talking in the order of 120 people on the [national] team. And an overall budget of about eight million [ID006]

Respondents perceived the evaluation as equally well-resourced:

I got a sense that actually people were surprised at how much money was being spent on evaluation. From my perspective as somebody who has been involved in these types of things in the past, I'm delighted that they did invest properly in doing a proper evaluation, a multidisciplinary, robust independent evaluation. [ID013]

Funding to each individual Vanguard was not without strings, with each Vanguard required to meet specific conditions which were monitored over time:

> *Each Vanguard has funding conditions* […] *For example, that they demonstrate spread and replication, that they help us create products for spread and replication, that they, importantly, deliver the whole of the published care model by the end of the calendar year, which is a key one* […] *We measure them against those, with a quarterly assurance process, where we check in with the Vanguards on a formal basis to determine where they are against all of those funding conditions. [ID021]*

Factors found to be challenging

A set of features, mechanisms and ways of working that hindered the programme and its operation were identified. This section focuses on the following commonly identified challenges: (a) expectations from the Vanguard programme; (b) oversight and performance monitoring; (c) engagement with regulators; (d) data availability and quality (evidence base); and (e) timetables and timescales.

a) *Expectations from the NCM Vanguard programme*

As a flagship national programme provided with significant additional funding, the Vanguard programme was, by necessity, ambitious. As a result, many of the assumptions underpinning both local and national plans were probably over optimistic, given that the programme as a whole only lasted three years (National Audit Office, 2018, p. 36). Generating sustainable local change in complex organisations takes time, and it may have been unrealistic to expect Vanguards to have had a significant impact in such a short time:

> *[W]hen the programme was set up, there was an awful lot of rhetoric around, we will break down the barriers, you don't need permission to do things, we will be able to do things, and this was political rhetoric as opposed to programme rhetoric, around the whole concept of, actually giving these guys autonomy, to do things and break the rules. So, we set up, I think, a significant expectation about what could be done. [ID002]*

These high levels of expectation exerted pressure on Vanguards, which may in itself have militated against robust learning, especially learning from things that did not work so well. The expectation that Vanguards would contribute 'good news stories' that would be disseminated and displayed on the NHSE website added to this pressure.

b) Oversight and performance monitoring

The programme required processes to be put in place to demonstrate how funding would be used and how it would generate value. The core of this process was the logic model and value proposition that every Vanguard had to produce at the outset, but many at the local level did not have the expertise to do this. Support for logic modelling was initially contracted out by NHSE to organisations that support commissioning (Commissioning Support Units); they in turn contracted some aspects of it out to management consultants, as the timescales were so short. The process was therefore quite variable. Many saw the logic models as a tool to help focus the development of the Vanguard in their first year, rather than as live documents over the lifetime of the programme or as tools to underpin evaluation. For many sites, this meant that logic models were not used as intended to monitor inputs and outcomes over the lifetime of the Vanguard:

> *Do I think Vanguards themselves have the ability to create logic models, certainly when*
> *we spoke to the Vanguards during the site visits, most that we spoke to were not aware*
> *of logic models, which is why we decided it is something that we needed to commission.*
> *[ID015]*

Over time the monitoring of Vanguards was stepped up, with funding for the final year of the programme linked to performance against a small number of nationally determined metrics. Whilst the Account Manager role was intended to be supportive and developmental, in some cases they were perceived as taking on a more performance management role over time with the Vanguards. This potentially led to tensions around their role within the overall programme and to distrust between types of actors in the system:

> *We have come under increasing pressure during the course of the programme to operate*
> *a bit more like performance managers and that has been to some extent challenging.*
> *[ID003]*

c) Data availability and quality

Both the operation of the Vanguards and the evaluation programme required timely access to available data and data sharing between different organisations. Both of these proved difficult, in large part because of issues associated with information governance:

> *The information governance, and that was very challenging, because we perceived, or people perceived that there are a number of blocks in the system around sharing records [ID002]*

This was an area in which it had been hoped that standard national solutions could be developed to support local organisations who wished to share data and patient records. However, this proved difficult, and different Vanguards developed different solutions, based around local organisations' interpretations of data sharing rules and legislation.

There were also issues with data availability for the various evaluation elements, including the intended 'rapid cycle' evaluation carried out by the Improvement Analytics Unit (IAU):

> *I'm not sure we would say that we're providing rapid feedback quite yet. Certainly, the first two, it took a lot longer than we were hoping to get the data downloads. [ID029]*

d) Engagement with regulators

Engagement with regulators was not always straightforward for the Vanguards, despite the involvement of organisations such as the Care Quality Commission (CQC – the main regulatory body for England) and NHS Improvement (NHSI) in the FYFV. Engagement of Vanguards with the various regulators was facilitated by NHSE via the account managers, with discussions of emerging issues such as how to regulate organisations striving to work in an integrated way. CQC has issued reports which look at the extent and effectiveness of cross-organisational collaboration within health economies. (CQC, 2016, 2018). However, rather than moving to an approach which inspects groups of organisations working together, CQC is inspecting health economies as a collective as well as inspecting the individual organisations. This is, perhaps, unsurprising, given that the legislation governing regulation and inspection remains unchanged:

> *At the moment, because they're all registered separately we would still interact with them as an individual provider. That means that we need to inspect them and we need to publish*

individual reports. But as far as possible, we're trying to coordinate that and if we want to, if it makes sense, we are able to also use different powers to publish a report on how the Vanguard is working together as a whole. [ID020]

However, the engagement of CQC with the Vanguard programme was valued. The CQC, in particular, worked closely with the Vanguards from the start and their support was appreciated:

I'd say one of the best partners we had on the Vanguard programme was the Care Quality Commission. We were very in tune with them and they were very close to us on making sure that, as the models were developed, that they could understand what the new regulatory needs would be. [ID009]

But the process had been difficult, requiring flexibility. This regulator pointed out that the variability within the Vanguard programme had made it difficult to design a 'one size fits all' system:

When we first started to think about this…[we thought that] we currently regulate an organisation that looks like Type A and the NHS and the health and care system is shifting towards something that will look like Type B and therefore we need to update our model to regulate Type B […] The way that we've come about it is how do we make our approach to regulation flexible and agile enough to respond to all the different kind of ways that an organisation might construct itself in its care delivery, rather than, this is how we'll regulate a new model. [ID008]

d) Timetables and timescales

The Vanguard programme was established at a very rapid pace, with the programme starting within a few months of the initial submission of expressions of interest. This meant that those providing support and those in local Vanguards were required to work very quickly to get things up and running. In addition, whilst the programme was initially established as a three year programme, funding was allocated in an annual cycle, leading to uncertainty:

If you look across all types of ACOs [Accountable Care Organisations], change has actually taken greater than five years to happen. So, I am not sure a three year funding cycle is where we should have been, and what we should have perhaps thought about is […] fewer

> *Vanguards. Five year experiments with a view to then working out what the next five years looks like. [ID010]*

Local evaluations also had to be procured rapidly; with in some cases no experience of such procurement, and national support programme streams found that they were working to very tight timescales:

> *I found that within my own workstreams […] that it's very easy to say I'm going to do this, this and this. Then actually trying to procure that, whether that's a difficulty in terms of recruiting people to deliver it, or difficulty in getting someone else to provide it, or difficulty finding somewhere to hold an event… we completely misjudged that. [ID009]*

By the third year of the programme, there was perceived pressure to demonstrate improvements, with the final year's funding conditional upon improvements in a narrow range of national metrics. Respondents argued that the programme needed to 'hold its nerve', with benefits more likely to accrue over a longer time period:

> *So I can see real tangible changes […] I think there is still that unrealistic expectation from the very top of the shop, and I mean DH and, you know, government, where they expect it, oh, they've learnt it, you go and do it. Well, no, you have to take people with you to make the real change and for it to be sustainable, and you cannot rush that. [ID022]*

Respondents felt that the expected pace of fully adopting new initiatives, as well as their scale and spread, was often unrealistic.

Discussion

In this paper, the perceptions of those involved in the NCM support programme have been explored. We describe what support was provided, highlighting the elements perceived as having either supported or inhibited development and success across the support workstreams and different programme elements. The findings indicate a familiar set of facilitating factors frequently noted with respect to integrated care initiatives in many contexts. For example, leadership, relationships,

communication, and adequate funding have been previously captured as integral to policy imperatives for health and organisational development worldwide (Kodner and Spreeuwenberg, 2002; de Stampa *et al.,* 2010; Gottlieb, 2013; Goodwin 2013; Leichsenring et al 2013; Glasby and Dickinson, 2014). Over recent decades there have been numerous examples of international integrated care models focusing on the needs of community-dwelling older people, that have sought to embed these factors and tackle the implementation challenges they bring with varying degrees of success (WHO, 2016). Examples of the most cited include the Canadian PRISMA model (Program of Research to Integrate the Services for the Maintenance of Autonomy) (MacAdam, 2015), the Basque Country integrated care model (Urtaran-Laresgoiti *et al.*, 2018), the Buurtzorg model originating in the Netherlands (Monsen and deBlok, 2013), and the population based Kaiser Permanente in the USA (Pines *et al.*, 2015). Looking across the models, it would appear that there are a set of components and delivery strategies that are associated with successful integrated care models (WHO, 2016) including the characteristics highlighted by our research. Added to this are a number of well-known elements such as self-management support, developing a multiprofessional working culture, adopting evidence-based clinical pathways and protocols, aligning incentives, and investing in supporting information technologies. It was of interest that, aside from monitoring and auditing requirements, published evidence of any higher level support provided for programmes of this nature (as for the New Care Models) was difficult to extract. Such a finding does not suggest that this was not in place.

It is noteable however that these examples are not only the most cited but are also among the most established, with clear operational pathways and evidence-based outcomes. While this may come as no surprise, this suggests a connection with what ultimately can be viewed as a model of integrated care and is in contrast to the New Care Models that the Vanguards aspired to be. While both share implementation characteristics, the obvious differentiation from the Vanguards is that the international examples were developed over lengthy periods of time. This is arguably a key factor for sustainability and scaling, where the pressure to achieve implementation and outcomes success 'at pace', or within an overambitious timescale, was not evident in the international examples. PRISMA features for example are now embedded in the regional health strategy, which is becoming the normal system of care for frail older people in Quebec, but this has taken nearly two decades to become established (MacAdam, 2015). The Buurtzorg model, with its emphasis on neighbourhood nurse-led care, has become an international brand from its inception in 2006, and has scaled across the globe, but this has taken 13 years https://www.buurtzorg.com/. Further implications of the pace of change in relation to the Vanguards is elaborated on later.

With a focus now on the UK context and with reference to specific programmes of integrated care in England, Ling *et al.* (2012) reported the importance of the facilitating factors during 'Integrated Care Pilots' – an earlier initiative to integrate primary and secondary care provision in England (DH, 2009) as well as early evaluation findings from a more recent initiative – Integrated Care Pioneers (https://www.england.nhs.uk/new-care-models/integrated-care-pioneers/). With this latter initiative, there has also been considerable focus on the Pioneer 'learning community', and like the Vanguards, it consists of both face-to-face and virtual meetings of area-based groups to drive health and care improvements at local levels, and disseminate lessons learnt across the country. That such communities of practice have been encouraged in these initiatives is not surprising; it could be argued that the convoluted nature of integrated care implementation in particular necessitates the sharing of experiences, and with the New Care Model's ambition of rapid scale and spread, the adoption of this strategy for the Vanguards makes sense. Such a view is shared internationally; authors note for example that these communities have proven capable of solving healthcare professionals' integrated care information and communication problems by generating the kind of tacit knowledge that emerges from interactions among colleagues (Gabbay and le May, 2004; Soubhi *et al.,* 2010). However, there is still little evidence to show whether the use of communities of practice actually leads to improved efficiency in the integration across primary and hospital care services (Ranmuthugala *et al.,* 2010), but this should not override the importance of information sharing and relationship building that these fora encourage (Soubi *et al*., 2010).

Returning now to a reflection on our results, it must be observed that, with respect to our facilitating factors, they were not merely happenstance or contextual backdrop; the Vanguard Support Programme actively sought to ensure these factors were in place, enabling Vanguard success. So on the face of it, the fact that the support programme seemed to adopt and embed an evidence-based approach from the onset instils a sense of credibility in their execution. For example, the Vanguard NCM programme provided a very good level of extra funding across all programme elements – supporting workstreams, model leadership, evaluation and facilitation – which could be seen as being unique in comparison to other similar and overlapping programmes, notably the Integrated Care Pioneers. Similarly, our findings demonstrate that the Vanguard support programme actively engaged in creating opportunities to bolster relationships and communication, especially in cases with no pre-existing relationships (e.g. between national and local leadership). There were robust and multi-modal methods of communication across the Vanguards, between the Vanguards and the national support

team, and with the public. A significant element of the programme was the facilitation of relationships at multiple levels, in which account managers played a key role.

Use of account managers has been successfully employed in previous integrated care initiatives (e.g. 'managed clinical networks' in Scotland; Woods, 2001). In relation to existing literature (Birkinshaw *et al.,* 2000), account managers in the Vanguard NCM programme have been identified as 'boundary spanners', linking local Vanguard networks with the national team and maintaining these 'vertical ties' (Goodwin *et al.,* 2004). Reflections from interviewees demonstrated that the Vanguard programme had a clear, overt understanding of the way facilitating factors (e.g. introducing account management roles, dissemination methods) operated and capitalised on them.

However, it is overly simplistic to regard elements of the programme as either facilitators or barriers. The role of account managers, for example, was not perceived as straightforwardly positive by our respondents. In some cases, the account managers and stream leaders were seen as taking on a performance management role over time with the Vanguards, exerting pressure and adopting a punitive approach (e.g. advising that future funding may no longer be available). While Vanguards that were regarded as succeeding by the national team experienced a more positive influence of account managers (building and helping maintain crucial links between the local and the national teams), the same role was experienced more negatively in those cases where national expectations did not match local achievement. Instead of being guided by a distinct set of facilitators and barriers, the Vanguard programme was characterised by tensions between them. While the programme capitalised on existing knowledge on the importance of strong leadership and relationship building by appointing account managers, organisational processes around oversight and performance monitoring by the account managers had a detrimental effect on local-national relationships. Also towards the end of the programme, the roles were dissolved as people moved to other positions, to the detriment of sustainability.

Another example of a tension between facilitators and barriers is evident in interviewee reflections on the evaluation of the Vanguard performance. The impartial nature of the national elements of the evaluation (including the data dashboards and the expertise of IAU) were felt to be helpful, as was the rigorous approach to assessing outcomes. However, this impartial and rigorous approach to evaluation was somewhat in contrast to the active approach taken by the national support team to generating case studies and 'good news' about the Vanguards for dissemination, based on a small set of 'headline' metrics. The purpose of this activity was to generate and maintain local enthusiasm, in

keeping with the 'bottom up' approach to development, as well as to provide evidence of progress to ensure continuing national support for the programme and wider dissemination of the approach. Nonetheless, despite the purpose of generating 'good news', putting pressure on Vanguards to rapidly produce success stories was in direct contrast with the national programme's aims of impartial and rigorous evaluation.

In addition to this and returning to the pace of change, the speed at which the NCM Vanguard programme was set up had a number of knock on effects that emerged over its course. During the first year, there was a tension between the push to get the Vanguards up and running, coming from senior leaders, and the difficulties of formulating a cohesive plan of what and how the programme was going to run from the new and emerging team. The rapidity of development also led to issues of sequencing where parts of the programme did not necessarily develop in the intended order and/or certain aspects of the programme being prioritised during the early stages, whilst others were delayed until a later date. For example, necessary guidance about the different care models was not published until the programme was underway. This led to considerable delays in the rolling out of initiatives within the Vanguards and getting the tangible results so desired. Given that there are enduring problems at a local level regarding implementation, as noted by previous integrated care programme evaluations (Ling *et al.,* 2012; Erens *et al.,* 2017), it is no surprise, as Erens *et al.,* point out, that this all results in considerable impediments to progress at the scale and pace originally hoped for. This highlights not only the need for improved knowledge transfer across programmes to create a more realistic expectation of integrated care development and growth, but also determined and timely action at the programme level to establish more credible timescales and pace of change.

While our sample was drawn from a range of different senior players and we ensured a diverse sample associated with the NCM support programme, it inevitably cannot be complete and there may have been valuable perspectives absent. However there appeared to be adequate data saturation within the analysis, with the recurrence of themes evident. Overall, our findings demonstrate that facilitators and barriers are not boundaried or separate from one another. The way these factors influenced the success of the Vanguard NCM programme involves complex interactions, which result in significant tensions and ambiguities. It is therefore paramount that discussions on ways to support planning and implementation of integrated care initiatives move beyond ascertaining separate influencing factors (e.g. relationships, leadership and funding; Ling *et al.,* 2012), but also acknowledge the tensions these create.

Conclusion

The Vanguard NCM support programme was successful in developing and setting up a wide-ranging set of pilot initiatives testing approaches to integrated care, the components of which have synergies with other integrated care models worldwide. The programme was explicitly bottom-up in its approach, and this supported the development of significant local enthusiasm and engagement. This was undoubtedly also helped by additional funding, both direct and indirect via the support programme. In terms of learning which may be relevant to other national change programmes, it is clear that a well-funded national support programme has the potential to play a significant role. Our study suggests that, whilst national funders often see managerial spending as less important than funding spent on front line services, having strong managerial and technical support is crucial if local front line services are to make the significant changes required to tackle ongoing demographic challenges. However, a number of tensions was also present. For example, a focus on sharing perceived 'good news' about the programme was helpful in maintaining enthusiasm and engagement, but may have also been problematic in limiting the extent to which the programme as a whole enabled learning from things which had gone less well, as these were less likely to be shared or examined. Providing a relationship function through account managers was perceived as initially helpful, but could not be sustained in a positive way as it adapted to the need to drive better outcomes and moved in the latter part of the programme to other policy developments. Future initiatives would, therefore, benefit from acknowledging – and where possible addressing - the tensions between competing aims and support strategies.

Moving beyond the Vanguard programme, the NHS Long Term Plan (https://www.england.nhs.uk/long-term-plan/) explicitly references the perceived 'success' of the Vanguard programme, and suggests that the lessons learned will be rolled out via Integrated Care Systems. The early findings from our study and those of the Integrated Care Pioneers (Erens *et al.,* 2017) suggest that this will not necessarily be straightforward, especially with respect to tensions relating to the pace of change. In particular, our study highlights the time consuming hard work required to integrate care across organisational boundaries, and the need for protected time as well as a strong support function if local organisations are going to be able to build the relationships they need to work more closely together. The next phase of this study explores in more depth how Vanguards are moving forward in this new landscape.

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