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National evaluation of the Vanguard new care models programme

Interim report: understanding the national support programme

March 2019

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Executive summary

Introduction and background

The Five Year Forward View (FYFV) (NHS England 2014a) described a vision for the future development of the NHS focussing upon new ways of working to improve care delivery rather than upon structures, and aimed to break down barriers between different organisations and care sectors. It was proposed that a number of 'Vanguard' sites would be established to test potential new ways of providing services and five types of New Care Model (NCM) were proposed: Primary and Acute Care Systems (PACs); Multispeciality Community Providers (MCPs); Enhanced Health in Care Homes (ECHs) Urgent and Emergency Care (UEC); Acute Care Collaboratives (ACCs). This report focuses largely on PACs, MCPs and ECHs, as these three types of Vanguard were established to address broadly similar issues, in particular extending care outside hospitals.

In order to support the implementation of and learning from these Vanguards, an extensive support programme was established, led by NHS England. This support included an evaluation programme, of which this study forms part. Commissioned by the NIHR Policy Research Programme, the study aims to investigate the effects of the Vanguard programme on the NHS, including its local organisations, wider partnerships and service users. There are three over-arching objectives:

- Determine the extent to which the Vanguard programme has resulted in the implementation of new models of service delivery in England;
- Identify factors that support or inhibit that implementation at the local (micro), meso (local health economy) and macro (national-level support and evaluation programmes, national regulatory context) levels;
- Ascertain the impact of the programme on relevant outcomes, including economic assessment of costs and cost-effectiveness.

Study aims, objectives and research questions

To meet the above objectives, the study addresses the following research questions:

- RQ1: To what extent are the new care models being successfully implemented? Are there commonalities in factors that may enable or inhibit local programme implementation?
- RQ2: How do Vanguards interact with other policy initiatives such as Integration Care Pioneers and Sustainability and Transformation Plans?
- RQ3: How are Vanguards responding to support from NHS England within their local operations, and how has this influenced Vanguard activity?
- RQ4: What does a comparative outcomes analysis tell us about costs and cost-effectiveness?
- RQ 5: What do the findings tell us about this approach to programme implementation?

This Interim Report focuses upon the macro level, exploring in depth the operation of the national support programme, in order to examine how it has worked, the enabling and inhibiting factors and any wider lessons for future policy implementation.

Theoretical framework

We identify three areas of academic literature relevant to the study:

- Models of policy development;
- Policy implementation;
- Piloting as a policy approach.

We have used Matland's (1995) classification of policy programmes to help aid the identification of appropriate approaches to implementation. He summarises both top down and bottom up models

of policy implementation and suggests a number of possible definitions of ‘implementation success’. He suggests that adjudicating between these different definitions depends upon an understanding of the goals of those developing policy, and that therefore approaches to implementation should be different depending upon the characteristics of the policies concerned. His resulting model classifies policies along two axes: the degree of conflict, and the degree of ambiguity. *Conflict*, as envisaged by Matland, refers to policy goals or means to achieving policy goals which are, in some way, incommensurate or incompatible. ‘Conflict’ does not necessarily mean conflict in its colloquial sense of overt opposition or political wrangles. *Ambiguity* refers to how far goals are clear.

In addition, we characterise Vanguard as forms of policy pilot¹ and use Ettelt et al’s (2014) definition of the purposes underlying policy piloting to explore the programme. These include:

- Piloting for experimentation
- Piloting for early implementation
- Piloting for demonstration
- Piloting for learning

Methods

In this report we address the following research questions:

- How has the national support and evaluation programme operated, and which aspects are perceived to have been particularly helpful or problematic?
- What type of pilot are Vanguard, and how do they fit with established typologies of policy implementation?
- What can we learn from this about approaches to policy programme implementation?

The project is being conducted in phases (work packages (WP)), with an initial scoping phase undertaken to understand different types of Vanguard, the support programme in greater depth and the developing national context. The second phase (running alongside) involved synthesising the findings from local evaluations. The third phase will consist of primary data collection using case study methods to explore in depth the experiences (qualitative) of a sample of Vanguard and outcomes (quantitative) between areas with and without Vanguard sites. A final phase will synthesise the findings. This report focuses upon phase 1.

Work package 1 methods

WP1a: establishing Vanguard scope and activities and preparation for study - This WP started the process of synthesising this information, and initiated the development of a database which has provided a dynamic resource for the study.

WP1b: understanding the national context (macro level)

Between October 2017 and March 2018 we carried out 29 national level interviews with a variety of respondents at the national level, leads, consisting of current and past NHSE employees (n=19), advisors (n=7) and Arms Length Bodies (n=3.) In addition, in spring 2018 we collaborated with the National Audit Office (2018) in carrying out a survey of Vanguard leads.

Findings

¹ Although the word ‘pilot’ is not formally used to describe Vanguard, their set up, declared purpose and implementation meets the characteristics usually associated with pilots, including identifying ‘early adopters’, testing out approaches and establishing ways to capture learning to inform future implementation

From our interview accounts we built an overarching narrative of how the programme was developed and operated, identifying the different elements such as enabling streams, logic modelling and evaluation. We then considered what has worked well (facilitators) and not so well (obstacles) across the support programme. Finally we conducted an in-depth analysis (using Matland's (1995) framework) highlighting cross-cutting themes identified in the data gathered.

Programme goals

Using published policy documents we identified the following goals as underlying the programme:

- To test out approaches to integrating care across organisational boundaries;
- To test out approaches to implementing these new ways of working, including overcoming relevant barriers and exploring ways of supporting innovative activity;
- To use the learning derived from the development of the models to develop replicable care design frameworks and 'standard approaches and products' which could then be adopted by other areas;
- To use the learning from the implementation of the models to develop common approaches to implementation that could themselves be spread alongside the developed models.

In Matland's (1995) terms the programme was *high in ambiguity* – the proposed 'models of care' were not specified in detail – and *low in conflict*, in that the programme is presented as being the settled view of all of the relevant NHS organisations, with a clear road towards the development of defined models of care.

Careful reading of the policy documents suggests that the Vanguard programme was conceived of as a pilot supporting *early implementation* (as evidenced by the intention to establish Vanguards in areas which have 'already made good progress') and for *learning*, with an explicit intention that the Vanguard sites would test out approaches to change, which would then be spread more widely.

Considering the development of the programme over time, we highlight an initial intention for there to be subsequent waves of Vanguards, which was quickly superseded by the announcement of STPs and ACOs (later renamed Integrated Care Systems, ICS), which were positioned as 'scaling up' New Care Models to cover larger populations. By spring 2017 NHSE documents were making claims as to the success of the programme against a small number of metrics (emergency admission growth in particular). In 2016 'frameworks' for MCPs, PACS and ECHs were published. These are generally non-specific and process-dominated, although that for ECH is somewhat more specific. Intended standard business models and organisational forms have not been developed (National Audit office 2018 p32).

The support programme

Vanguards have been supported by an implementation programme consisting of the following elements (NHS England 2015d):

- Designated national lead for each model
- Support to develop logic models describing the local scheme
- 10 support streams, covering: model design; evaluation and metrics; integrated commissioning and provision; governance, accountability and provider regulation; empowering patients and communities; harnessing technology; workforce redesign; local leadership and delivery; and communications and engagement
- Local account managers
- A variety of learning and networking events and opportunities

It is difficult to establish clearly the exact costs of the NCM programme. Direct funding to the 50 Vanguards, the NHSE NCM team, evaluations (national and local) and funding from the Vanguards

themselves, set against savings being generated would ideally be included. The recent NAO report (2018) suggests approximately £329m direct investment between 2015 and 2018 with an additional £60m on the Vanguard NCM programme, support and monitoring (including national and local evaluation and staff costs). However, support costs are approximate, as there is no clear accounting for the time of staff seconded from other roles in NHSE to support the programme.

The evaluation programme

The programme was underpinned by an extensive evaluation programme, consisting of the following elements:

- Individual Vanguard evaluations, including locally commissioned evaluations and a quarterly 'dashboard' setting out performance against a number of headline metrics compared with baseline and with non-Vanguard sites
- Outcomes from the whole cohort of MCP and PACs Vanguards were compared with counterfactuals, using statistical techniques to establish whether or not any changes seen were statistically significant.
- Some individual interventions were subject to evaluation
- Interventions common across a number of Vanguards were subject to thematic studies in order to understand how different contexts affected these
- Independent national evaluation (our study)

In addition, an Improvement Analytics Unit was set up in partnership with the Health Foundation in order to provide advanced analytics support to NHSE. As of March 2019, the Unit has produced 4 detailed analyses of individual Vanguard performance. Others are reportedly still under way.

Enabling and inhibiting factors

We found some common features, mechanisms and ways of working which helped in achieving the programme's goals and supporting its operation. These included:

- The development of relationships and alliances, incorporating learning and feedback, with local Account managers particularly valued;
- Robust and multi-modal means of communication;
- Strong local and national leadership;
- Availability of expert knowledge and skills (within and outside the programme);
- Flexibility within the programme, with the support team endeavouring to react to the needs of local sites;
- Good level of funding (across the programme elements).

We also identified a set of features, mechanisms and ways of working that were problematic. These included:

- Over-optimistic expectations from the national programme;
- Oversight and performance monitoring, with a narrowing over the course of the programme to focus upon a narrow range of metrics which did not necessarily reflect the aims of some Vanguards;
- Difficulties associated with the continuation of existing national processes for regulation and oversight which may not be flexible enough to accommodate local innovations;
- The availability of high quality data and information, and issues with data sharing between organisations
- Short timescales and a requirement for rapid progress, with guidance not always keeping pace with programme developments.

Assessment of programme success

Those we interviewed praised the support programme for being genuinely ‘bottom up’ and facilitative, with the generation of significant local engagement and enthusiasm frequently remarked upon. However, senior managers acknowledged that the aspiration to generate replicable ‘models’ of care which could straightforwardly be ‘spread’ more widely was not achieved. At the time of writing, no contracts have been let to new forms of provider organisation based upon new care models.

The impartial nature of the national elements of the evaluation (including the data dashboards and the IAU) were felt to be helpful, as was the rigorous approach to assessing outcomes. 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 Vanguard for dissemination. 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.

Cross-cutting themes

In addition to the specific issues relevant to the different aspects of the support programme, we also found a number of issues arising across the interviews:

- Being a pilot: licence to do things differently? Those involved valued the ‘bottom up’ and facilitative nature of the programme, whilst identifying a degree of tension between this approach and the increasing focus upon a narrow range of performance metrics
- Temporality, sequencing and timing: the programme was both ‘long term’ and ‘too short’, with a very real tension between a narrative that emphasised long term and meaningful ‘bottom up’ change and one which required the demonstration of results within a timetable, which satisfied the political needs associated with the programme. The rapid pace at which the programme was initiated meant that there was limited opportunity for the Vanguard to explore and take account of the existing evidence base underpinning proposed interventions.
- The nature of data and evidence: we identified a tension between a desire to promulgate local stories of success in order to encourage the spread of innovation, and the more cautious approach embodied in the evaluation programme, which was designed to carefully analyse outcomes against counter-factuals
- Legacy, scale and spread: we found some lack of clarity over what the appropriate relationship might or should be between an MCP or a PACS and an ICS covering a wider geographical area. The question identified by one of our interviewees as to whether the wider roll out of new models of care should mean replication of successful local initiatives (as implied by the initial programme goal of developing ‘products’ and frameworks to support wider roll out) or scaling up of successful initiatives to cover wider populations remains unanswered.

These tensions are inherent in the programme which was seen as both long and short, bottom up whilst meeting narrowly defined top down goals, and capable of both scaling up and spreading out. In addition, many of the elements of the programme were found to have multiple purposes. For example, local evaluations were intended to support local learning and feedback, and provide formative evidence for sites, but also provide context for the findings coming out of the broader analysis of data. The programme itself also appeared to have had multiple purposes. Piloting for demonstration, implementation and learning are all visible in the initial design and set up of the programme, whilst the evaluation team took an approach which constructed Vanguard as experiments which may or may not deliver better outcomes. This highlights the inherent contradiction in the programme between an underlying assumption that the new care models *would be* beneficial (evidenced by the initial intention to have waves of Vanguard and by the requirement

for STPs to demonstrate that that were going to roll out MCPs, PACS and ECHs) and the commitment to robust evaluation designed to explore in depth *whether or not* new care models delivered better outcomes. This contradiction is made more acute by the narrowing of national focus on outcomes down to a small number of measures of hospital use, as it is possible that *Vanguards* may have been delivering service improvements not captured by these metrics.

Discussion and conclusions

We have explored the elements of the national support programme, and highlighted the aspects of this regarded as important by those involved. The programme was seen as successful in developing local enthusiasm and drive for change, but the intended ‘products’ and ‘replicable frameworks’ to support wider roll out were not developed. The importance of facilitating and maintaining relationships was clear, with a particular emphasis on face to face meetings and on trusted individuals capable of bringing people together across boundaries. The generation of energy and enthusiasm was seen as vital, and was facilitated by the widespread dissemination of perceived successes. At the same time, the pace of the programme was an issue, as was the perceived pressure to perform and demonstrate success as quickly as possible against a narrow range of metrics. The evaluation programme overall was praised as rigorous and professional (National Audit Office 2018). The investment in evaluation seen with the *Vanguard* programme has potentially had a beneficial impact on the general approach to evaluation in the NHS, building local expertise in commissioning evaluations and supporting the development at national level of the Improvement Analytics Unit. The focus by the national evaluation team on establishing whether or not headline improvements in metrics are statistically significant is also important.

We suggest that the programme was conceived of and presented as a programme high in ambiguity – with an explicit commitment to allowing bottom up development of the new models of care, with minimal pre-specification of what these should look like - and low in conflict. However, in practice, it appears that the over-arching goal of allowing bottom up development of new care models was, in practice, incompatible with the goal of producing tangible/clearly defined ‘products’ and frameworks which could be rolled out more widely. Whilst there was little political conflict surrounding the programme, there was, at least over this relatively short timescale, a degree of incompatibility between the bottom up, low specificity approach which saw generating local buy in and enthusiasm as paramount, and the clearly stated intention of creating defined frameworks which could be spread.

We suggest that, as pilots, *Vanguards* could be said to be designed to fulfil three of the ‘purposes’ - implementation, demonstration and learning – as set out by Ettelt et al (2014), whilst the evaluation programme also embodied an approach based upon experimentation. This is potentially problematic, as each of the four purposes carries with it different underlying assumptions about what is known about the value of the pilot intervention, and implies different approaches to their wider roll out. Whilst many policy programmes embody a variety of different purposes in this way, the *Vanguard* programme is unusual in the extent to which resources were invested in supporting these potentially incompatible purposes. Thus, if *Vanguards* are seen as early adopters, then subsequent waves should follow quickly, as was initially attended. If, on the other hand, *Vanguards* were pilots for learning, then a longer timescale, with the associated architecture of learning events would be appropriate. ‘Experimental’ pilots, as suggested by the investment in an extensive evaluation programme, do not assume the superiority of the intervention, and require time to assess whether and how far new approaches are beneficial, before deciding whether or not to roll them out more widely. These tensions are particularly acute in a programme which set off with no established ‘model’ of intervention.

Published documents and public statements by senior NHSE officials highlight the importance of the programme in demonstrating that the NHS could implement and manage change. It could therefore be argued that the NCM Vanguard was a pilot with the additional purpose of ‘performing’ for an external audience – in this case, demonstrating to HM Treasury that the NHS would use any additional investment wisely and that such investment would finance a change programme which would improve performance. This may also, in part at least, explain the strong emphasis in the programme on collecting and disseminating ‘good news stories’ of successful change, and the relative generosity of funding available both for investment and to support implementation.

Lessons for policy

The nature of the NCM Vanguard programme required the generation of enthusiasm for change at local levels and across multiple organisational and sector boundaries. Our study suggests a number of lessons for future policy implementation, as well as some issues which require following up at local level in order to understand in more depth how they were experienced. The following seem to have been important:

- **Active approaches to relationship building**, with local account manager support and opportunities for face to face meetings;
- **A permissive approach to change**, which encouraged local areas to develop their own approaches within a broad framework of support;
- **Celebration of small successes** to encourage ongoing engagement;
- **Access to expertise** and the opportunity to engage at national level with regulatory bodies to solve problems.

However, other issues were not always helpful such as:

- **Data availability** and sharing issues;
- The **rapid pace** of the programme overall;
- Undertaking **multiple local evaluations** was an expensive and time-consuming approach, which requires further assessment .

Significant investment was allocated to **the evaluation programme**, which was praised as rigorous and professional (National Audit Office 2018). The focus by the national evaluation team on establishing whether or not headline improvements in metrics are **statistically significant** is also important, and it is to be hoped that future innovations are subject to a similarly rigorous approach, although this may generate conflict with an approach designed to facilitate engagement by celebrating early successes. The provision of **additional resources as direct payments to local areas** as well as underpinning extensive support and evaluation programmes was important, and this will be explored further in our ongoing study.

In relation to policy implementation design, when implementing a programme in which the desired outcomes are unclear, a more **cautious approach**, with an **initial assessment of relevant evidence relating to proposed interventions**, and subsequent **careful assessment of how far particular service interventions have been beneficial in what ways** might be more likely to **yield products which could support wider roll out** as outputs. However, this approach would not be compatible with the desire to rapidly demonstrate progress.

In terms of future policy making and planning we suggest that the **multiple purposes** underpinning the NCM Vanguard programme **may have been problematic**. For example, there is a tension between the need for ‘good news’ from a programme and the need to really understand in depth whether and how particular changes to services are actually beneficial.

We have highlighted the **lack of clarity** over how the NCM Vanguard programme **was intended to be disseminated and spread** and shown a **tension between approaches to ‘scaling up’ and ‘spreading**

out'. It may be useful for those involved with the NCM Vanguard support and evaluation programme to work closely with the team now responsible for supporting developing ICSs, with the explicit intention of considering whether and how the different local NCM Vanguard service models might best be implemented over a wider population.

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Abbreviations

ACC	Acute Care Collaborative
ACO	Accountable Care Organisation
ALB	Arms' Length Body
ACS	Accountable Care System
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CSU	Commissioning Support Unit
ECH	Enhanced Care Home
EoI	Expression of Interest
FYFV	Five Year Forward View
HMRC	HM Revenue and Customs
ICS	Integrated Care System
MCP	Multidisciplinary Community Provider
NAO	National Audit Office
NCM	New Care Model
NHSE	NHS England
NHSI	NHS Improvement
NIHR HS&DR	National Institute for Health Research Health Services and Delivery Research
PACS	Primary and Acute Care System
PHE	Public Health England
SSAM	Senior Strategic Account Manager
STP	Strategic Transformation Plan / Partnership
TDA	Trust Development Authority
UEC	Urgent and Emergency Care network
WP	Work Package

1 Chapter 1: Introduction to the policy context and theoretical framework

1.1 Introduction

The Vanguard new care models programme was established following the publication of the Five Year Forward View (FYFV) (NHS England, 2014a). Bringing together all of the principal Arm's Length Bodies with responsibility for aspects of the NHS, the FYFV set out a vision for the future development of the NHS which focused upon new ways of working to improve care delivery rather than upon structures, and which aimed to break down barriers between different organisations and care sectors (see box 1).

Box 1: Extract from Five Year Forward View

The traditional divide between primary care, community services, and hospitals - largely unaltered since the birth of the NHS - is increasingly a barrier to the personalised and coordinated health services patients need. And just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three.

Over the next five years and beyond the NHS will increasingly need to dissolve these traditional boundaries. Long term conditions are now a central task of the NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care. As a result there is now quite wide consensus on the direction we will be taking.

- *Increasingly we need to manage systems – networks of care – not just organisations.*
- *Out-of-hospital care needs to become a much larger part of what the NHS does.*
- *Services need to be integrated around the patient. For example a patient with cancer needs their mental health and social care coordinated around them. Patients with mental illness need their physical health addressed at the same time.*
- *We should learn much faster from the best examples, not just from within the UK but internationally.*
- *And as we introduce them, we need to evaluate new care models to establish which produce the best experience for patients and the best value for money. (NHS England, 2014a p16)*

To achieve this vision, it was proposed that a number of 'Vanguard' sites would be established to test potential new ways of providing services. A number of types of New Care Model (NCM) were proposed, and these were eventually narrowed down to five types: Primary and Acute Care Systems; Multispeciality Community Providers; Care Homes; Urgent and Emergency Care; Acute Care Collaboratives. In order to support the implementation of and learning from the Vanguards, an extensive support programme was established, led by NHS England. This support included an evaluation programme, of which this study forms part. Commissioned by the NIHR Policy Research Programme, the aim of this study is to investigate the effects of the Vanguard programme on the NHS, including its local organisations, wider partnerships and service users. There are three overarching objectives:

- Determine the extent to which the Vanguard programme has resulted in the implementation of new models of service delivery in England

- Identify factors that support or inhibit that implementation at the local (micro), meso (local health economy) and macro (national-level support and evaluation programmes, national regulatory context) levels
- Ascertain the impact of the programme on relevant outcomes, including economic assessment of costs and cost-effectiveness

To meet these objectives, the study is addressing the following research questions:

RQ1: To what extent are the new care models being successfully implemented? Are there commonalities in factors that may enable or inhibit local programme implementation?

RQ2: How do Vanguard interact with other policy initiatives such as Integrated Care Pioneers and Sustainability and Transformation Plans?

RQ3: How are Vanguard responding to support from NHS England within their local operations, and how has this influenced Vanguard activity?

RQ4: What does a comparative outcomes analysis tell us about costs and cost-effectiveness?

RQ 5: What do the findings tell us about this approach to programme implementation?

This Interim Report focuses upon the macro level, exploring in depth the operation of the national support programme, in order to examine how it has worked, the enabling and inhibiting factors and any wider lessons for future policy implementation. Our specific sub-questions for this report are:

- How has the national support and evaluation programme operated, and which aspects have been particularly helpful or problematic?
- What type of pilot are Vanguard, and how do they fit with established typologies of policy implementation?
- What can we learn from this about approaches to policy programme implementation?

This report is divided into 7 chapters. An initial introduction briefly sets out the policy context relating to the Vanguard. This is followed by a discussion of relevant policy literatures, setting out the theoretical framework which underpins the study. We then describe our methods, before describing the elements of the support programme and its intended objectives and operation. Based upon interviews with managers involved in the support programme, we then explore the operation of the programme, highlighting what was perceived to go well and what was problematic, and testing the elements of the programme against what is known from the wider literature. We then explore across our interviews, drawing out wider issues relevant to policy implementation, and a final discussion explores the ambitions of the programme and considers the lessons for future.

1.2 Policy background: types of Vanguard

The Vanguard set out to design, test and deliver a variety of scalable and replicable New Care Models (NCM) for the whole of England, with the expectation that success would be replicated elsewhere. The Guidance stated that:

Right from the start of the programme, we have built in the principle of national replicability and spread to the design of what all Vanguard deliver locally. The success of the programme and the value delivered for the taxpayer will not be defined by successful local delivery in the Vanguard systems, but the extent to which they have made it easy to spread learning across the NHS and social care.(NHS England, 2014b p6)

In addition, the FYFV backed “diverse solutions and local leadership” and at the national level developments were to take place to facilitate the developing policy environment and support Vanguard teams.

Five so-called ‘new care models’ were proposed (see Table 1): primary and acute care systems (PACS); multispecialty community providers (MCPs); enhanced health in care homes (ECH); urgent and emergency care networks (UECs); and acute care collaboratives (ACCs). In January 2015 (NHS England, 2014b) local areas (individual organisations or partnerships) put together proposals for new schemes and ways of working and 50 were designated as Vanguards across England. These received additional funding with which to test out these new models of providing integrated care. They were backed by a national support programme, run by NHS England and designed to facilitate the development and spread of NCMs within and beyond the Vanguards.

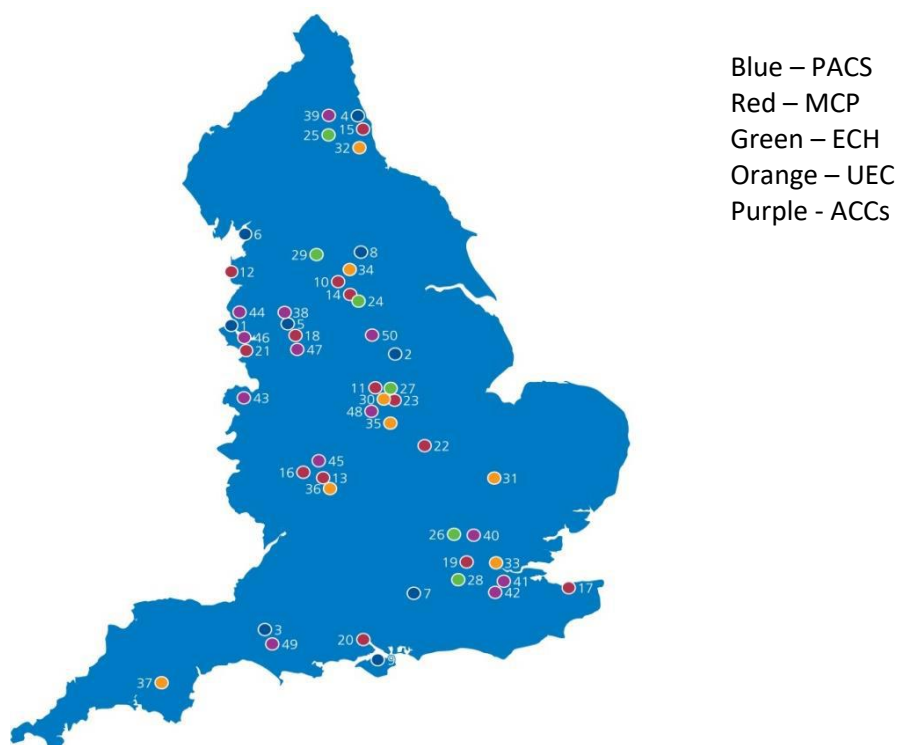
At the outset there was an intention for successive cohorts of NCM Vanguards to be developed (NHS England, 2014b p10). The support programme was to be co-developed rapidly with the initial sites. It was to “blend the provision of technical expertise with peer learning, and removal of barriers to change”.

Between January and September 2015, 50 Vanguards, of 5 different types were selected and funded across England (see Figure 1). Their start dates varied and there are different numbers of each model as shown in Table 1 below. They are geographically spread around England. For a full list refer to <https://www.england.nhs.uk/new-care-models/Vanguards/about-Vanguards/> and Appendix 1.

Table 1: Types of Vanguard

Vanguard Type	Date	Number	Description
Primary and acute care systems (PACS)	March 2015	9	Joining up GP, hospital, community and mental health services to improve the physical, mental, social health and wellbeing of the local population. Population-based care model based on the GP registered list.
Multispecialty community providers (MCPs)	March 2015	14	Moving specialist care out of hospitals into the community. Working to develop population based health and social care. Population-based care model based on the GP registered list.
Enhanced health in care homes (ECH)	March 2015	6	Offering older people better, joined up health, care and rehabilitation services. Care homes working closely with the NHS, Local authorities, the voluntary sector, carers and families to optimize health of their residents.
Urgent and emergency care networks (UECs)	July 2015	8	New approaches to improve the coordination of services and reduce pressure on A&E departments
Acute care collaboratives (ACCs).	Sept 2015	13	Linking local hospitals together to improve their clinical and financial viability, reducing variation in care and efficiency

Figure 1: distribution of Vanguards in England



PACs and MCPs differ in scope and scale. Both include primary, community, mental health and social care, but a PACS also includes most hospital services. As a result, a PACS offers the potential to transform an entire hospital business model, across inpatient, outpatient, medical and surgical pathways. A PACS may also be larger than an MCP, serving the population of its local hospital as a minimum (NHS England, 2016a).

The MCPs and PACS however are trying to achieve the same thing, focussing on a population based care model, and although led by different organisations and covering a slightly different range of services they are very similar in operation and the distinction between the two has become less relevant. ECHs appear to be seen as the most successful identifiable group (by our interviewees), having been less well supported at the outset, and the acute care developments are seen as very different to the MCPs, PACS and ECHs. There is also an acute medical model programme which has links to Vanguards. Each care model type had a designated lead (some of whom changed over time e.g. acute care) champion from NHS England (NHSE).

In 2016 care model frameworks were developed and published (NHSE) for PACs (<https://www.england.nhs.uk/wp-content/uploads/2016/09/pacs-framework.pdf>), MCPs (<https://www.england.nhs.uk/wp-content/uploads/2016/07/mcp-care-model-frmwrk.pdf>) and ECHs (<https://www.england.nhs.uk/wp-content/uploads/2016/09/ehch-framework-v2.pdf>). These were intended to illustrate the care models and their associated business models.

UECs were never fully embedded into the programme and were only formally part of the programme for one year. The idea came directly from the Keogh report (Keogh, 2013) and the model

was a set of interventions that had already been established but were to be implemented more quickly than the rest of the country. It was not experimental in the same way as the other models. The mandate for change was driven by NHSE and the reorganisation of urgent and emergency care services became part of the core remit of NHSE. This model was moved over to a different national director, and was no longer managed by the NCM team. It therefore became disconnected from the programme as a whole. ACCs were very diverse in nature and this model also tended to be separate from others in the NCM programme. These Vanguard units had some quite specific support requirements around governance and regulation, and were less focused on whole population health care design. They were driven by the acute sector, and received less national support. Their role and remit was to address clinical and financial sustainability and reduce variation in cost and quality.

This report therefore focuses largely upon the support and evaluation associated with MCPs, PACS and ECHs. However, those we interviewed were also engaged with aspects of the ACC and UEC programmes, and many of the issues we raise here are relevant in these areas, in particular availability of data, and the need for relationship building activities.

1.3 Policy development and implementation

There are three areas of academic literature relevant to the study. These include:

- Models of policy development;
- Policy implementation;
- Piloting as a policy approach.

1.3.1 Policy development

Traditional models of the policy-making process envisage a rational approach to policy making, in which identification of a problem is followed by an analysis of potential alternatives, evaluation of the pros and cons of each potential solution, implementation of the preferred policy option, and evaluation of the outcomes of the policy (Parsons, 1995 p77). It has long been recognised that this represents an idealised version of the process, with scholars highlighting issues such as: media and other influences on what appears to be a problem requiring policy attention (Downs, 1972); the role of think tanks in defining problems and suggesting solutions (Stone, 2013); the role of epistemic communities of experts in influencing policy approaches (Haas, 2009); policy transfer across countries and jurisdictions (Evans and Davies, 1999); and the existence of policy 'sub-systems', within which interest coalitions, ideas and policy actors interact in complex and changing ways (Sabatier and Weible, 2014). Kingdon (1993, 1995) argues that three 'streams' interact in the policy process: the problem stream, in which issues vie for political attention; the policy stream, in which ideas and potential policy solutions are discussed and advocated; and the political stream, which determines what resources exist and can be mobilised. Policy gets made, according to Kingdon, when these three streams line up and a 'policy window' opens.

It is beyond the scope of this report to explore any of these models of policy making in any detail. However, a number of issues arise out of this broad literature that are of relevance to the development of the Vanguard programme:

- The role of coalitions of interest groups in defining both problems and potential solutions
- The importance of feedback loops occurring at every stage, with both formal and informal knowledge and experience feeding back to influence ongoing policy development as well as approaches to implementation
- The complexities associated with policy transfer from other jurisdictions, given the variability of local contexts
- The requirement for political attention and resources for policy to be both made and implemented, and the influence of the wider political context on policy development and implementation

The context within which the Vanguard NCM programme was developed is therefore important. As set out in Box 1 (p13), the Five Year Forward View highlights a growing consensus around the problems facing both health and social care, driven by an aging population and underpinned by a climate of limited resources. In the face of these challenges, it is argued that the over-arching policy goal should be to 'break down barriers' between different care sectors, refocusing care around the needs of individuals. Furthermore, it is argued that 'policy transfer' from other jurisdictions should be actively sought, and that policy implementation should be accompanied by an explicit commitment to evaluation, with establishment of feedback loops to support implementation and adjust policy over time. In terms of political context and resources, the establishment of NHS England as an Arm's Length Body under the Health and Social Care Act 2012 may have offered a political opportunity. The analysis provided in the Five Year Forward View, including the potential for increased efficiency arising out of new ways of providing more integrated care, convinced HM Treasury to support the programme, with the allocation of £2.2 billion 'transformation funding', £389 million of which was used to support the establishment of the Vanguard NCMs (National Audit Office p17). In Chapter 4 (p41) we set out in more detail how these aspirations were embodied within the programme, and how the available financial and other resources were applied to support implementation.

1.3.2 Policy implementation

This section draws upon a recent review of the literature relating to policy implementation undertaken by Hudson, Hunter and Peckham as part of a study of the implementation of the Care Act.

Traditionally, policy implementation was seen as a stage in the process subsequent to the formulation of policy ideas (Parsons, 1995 p77). However, the importance of linkage between policy making and its implementation was clearly set out by Pressman and Widalsky (1979) in their seminal study exploring why policy initiatives often fail at the implementation stage. In particular, they highlight the importance of 'decision points' at which agreement must be obtained locally to support implementation. Consideration of the implementation 'problem' in the literature has tended to focus upon two alternative approaches: top down models, by which implementation is said to require a 'good chain of command and a capacity for co-ordination and control' (Parsons, 1995 p465); and bottom up approaches which emphasise the role of local micro-level actors in supporting – or thwarting – policy implementation (Parsons, 1995 p468). Thus, Hogwood and Gunn (1984), for example, identify 10 'conditions' for perfect policy implementation, suggesting that top down policy implementation should seek to address these in advance. Elmore (1979) coined the term 'backward mapping', suggesting that effective policy implementation requires initial identification of the local conditions which would be required were a particular policy to be successfully implemented, with the focus of implementation being upon how best to engineer the policy to accommodate these. Lipsky (1980) focuses on local discretion, highlighting the fact that ground-level public-facing public servants with some degree of discretion over their work may not only determine whether and how policy is implemented, but the sum of their individual decisions may enact a policy which is quite different from that intended. Barret and Fudge (1982) reject the dichotomy between top down and bottom up approaches, arguing that there is a continuum between policy and action, with local experience of policy implementation feeding back to influence not only the approach taken to implementation, but often also the policy itself, with policy incrementally reformulated to support implementation. Saussman et al argue:

In healthcare policy implementation insufficient attention has been paid to how knowledge from practice is routinely incorporated into the overall policy process, with a need to integrate both a 'top-down' and 'bottom-up' understanding of policy implementation (Ferlie et al, 2009). In addition, there is a gap in research on policy

design in terms of how the structural features of a policy's design influence implementation and in turn (re)shape policy content (Howlett et al, 2014).(Sausman et al., 2016 p564)

A further area of increasing interest is the concept of 'policy failure', with analysts increasingly interested in using the failure of policies to understand the policy process in more depth. Hudson et al identify four categories of explanation for policy failure:

- overly optimistic expectations;
- implementation in dispersed governance;
- inadequate collaborative policymaking;
- the vagaries of the political cycle.

Optimistic expectations have been identified as an issue hampering policy implementation in many countries (OECD, 2015). Hudson et al identify a number of factors which may contribute to over-optimism: underestimation of the complexity of both programmes and contexts; inadequate evidence base; over-optimism about the probability of aligning stakeholders' interests; strategic misrepresentation by individuals and groups keen to secure investment; and incentives which act to entrench a short-term view, with those responsible for policies often not in post when they come to fruition. Contexts in which levels below central government have power and authority may make implementation more difficult, with the need for collaborative policymaking, including interaction between micro, meso and macro levels of policy formulation and implementation, identified as necessary in these more pluralistic contexts (Ansell et al., 2017). Finally, the short length of political terms of office have been identified as problematic, with the architects of policies often not there to be held to account for their impacts (Ansell et al., 2017). This generates incentives for new appointees to have new programmes under their command, rather than inheriting responsibility for the effects of previous policies.

Matland (1995) summarises both top down and bottom up models of policy implementation, and argues that:

While top-downers have a strong desire to present prescriptive advice, bottom-uppers have placed more emphasis on describing what factors have caused difficulty in reaching stated goals.(ibid p149)

He goes on to consider what 'implementation success' actually means, suggesting a number of possible definitions:

....agencies comply with the directives of the statutes; agencies are held accountable for reaching specific indicators of success; goals of the statute are achieved; local goals are achieved; or there is an improvement in the political climate around the program.(ibid p154)

He suggests that adjudicating between these different definitions of success depends upon an understanding of the goals of those developing policy, and the extent to which these are based upon explicit expressions of values, underpinned by democratic legitimacy. This suggests that approaches to implementation should be different, depending upon the characteristics of the policies concerned. His resulting model classifies policies along two axes: the degree of conflict, and the degree of ambiguity. *Conflict* refers both to conflict between goals, and conflict in the means of meeting goals. Most programmes carry within them multiple goals, and so this dimension refers to how far either goals are incompatible with one another – ie if you achieve one goal you can't achieve another – or how far the means of meeting those goals are incompatible. For example, there may be a shared

overall policy goal of reducing the prison population, but those of different political persuasions, or those with different professional viewpoints might regard the best way of meeting that goal differently. It is important to be clear here that 'conflict' does not necessarily mean conflict as in its colloquial sense of overt opposition or political wrangles. Conflict, as envisaged by Matland, refers to policy goals or means to achieving policy goals which are, in some way, incommensurate or incompatible. Thus for example, a policy might have broad political support, but still be high in conflict because the goals as set out are incompatible with each other. *Ambiguity* refers to how far goals are clear. Thus, for example, the creation of Health and Wellbeing Boards (HWBs) was an aspect of the Health and Social Care Act 2012 (Coleman et al., 2014) which was relatively uncontested in a party political sense, and it generated little overt conflict. However, the goals of HWBs were both ambiguous, with little clarity about what they were supposed to do, and conflicted, with, for example, a clear incompatibility between the stated policy intention that HWBs should be seen as leaders in their local health economy, and the fact that HWBs were given no specific powers other than to comment on other organisations' plans (Hunter et al, 2018).

Bringing these dimensions together, Matland classifies policy programmes and therefore the appropriate approaches to implementation as set out in Table 2.

Table 2: Matland's model of Conflict, Ambiguity and Implementation

	LOW CONFLICT	HIGH CONFLICT
LOW AMBIGUITY	<p>ADMINISTRATIVE IMPLEMENTATION</p> <p>Goals clear, and no conflict between goals or between means of meeting those goals Implementation approach required: rational, top-down</p> <p>key organising concept: resources required to implement</p> <p>example: smallpox eradication</p>	<p>POLITICAL IMPLEMENTATION</p> <p>Goals clear, but conflict either between goals or between means of meeting those goals. Often highly political</p> <p>Implementation outcomes determined by the location of authority – top down</p> <p>key organising concept: power – who has authority to make changes</p> <p>example: bussing children across town to maintain racial diversity in schools</p>
HIGH AMBIGUITY	<p>EXPERIMENTAL IMPLEMENTATION</p> <p>Goals unclear, but little conflict surrounding the topic</p> <p>Implementation will be locally driven and bottom up, with outcomes determined by who is active and what local resources are available. outcomes may be variable and environmental influences likely to be important</p> <p>key organising concept: context</p> <p>example: Health action zones- multiple goals, considerable local variation</p>	<p>SYMBOLIC IMPLEMENTATION</p> <p>Goals unclear, and also conflict between goals or the means to achieving those goals</p> <p>Implementation will depend upon the local assembling of coalitions, with professional values and allegiances having a significant impact on outcomes. Often occurs when there are 'wicked' problems, with multiple stakeholders with own agendas and desired outcomes. Bottom up implementation, but degree of conflict means that top down political influence will also occur</p> <p>key organising concept: collaborative strength and local coalitions</p> <p>example: creation of Health and Wellbeing Boards under the Health and Social Care Act 2012</p>

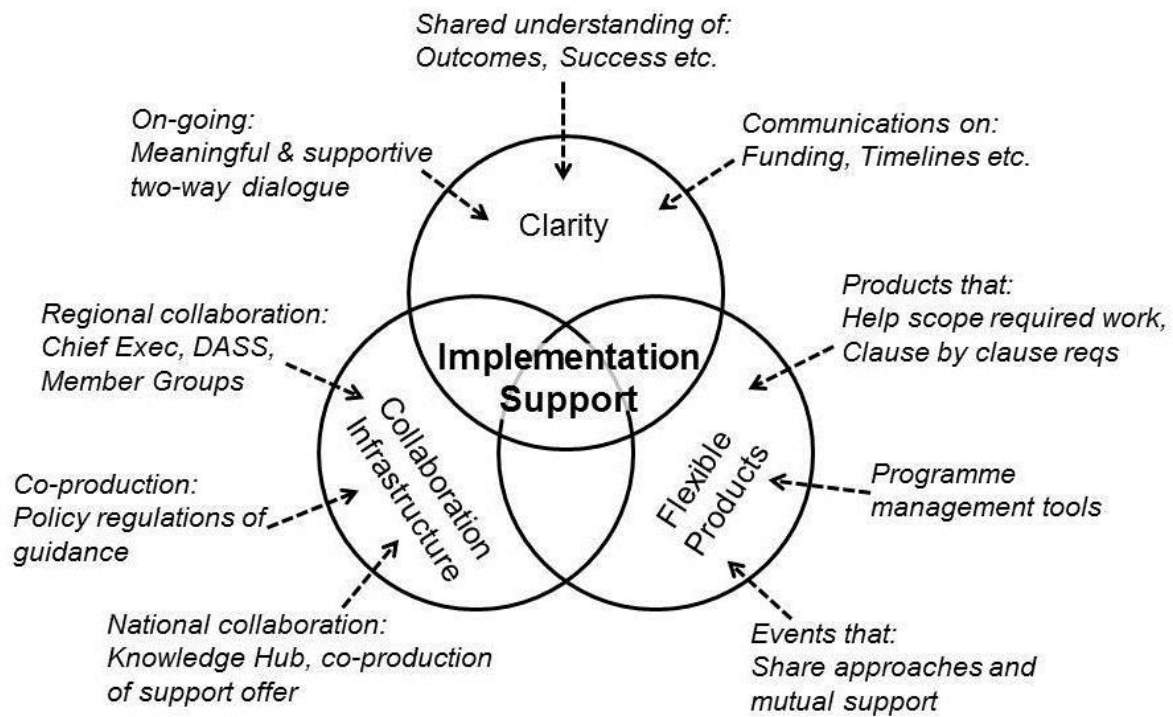
Thus, according to Matland, policy implementation requires understanding both the programme – how clear are its goals? – and the broader context surrounding the programme – how far are the goals or means to those goals contested or compatible with one another? In considering goal

conflict, it is important to look beyond the party political 'noise' surrounding a programme to also explore in more detail the nature of the goals and their relationship with one another. This, in turn, highlights the limitation of purely rational approaches to implementation, which might address resources, but neglect issues of local and national power.

In order to address some of the problems associated with implementation, governments across the world have developed so-called 'delivery units', designed to track the progress of policy implementation, focusing upon reviewing performance, identifying problems and assessing progress (Gold, 2014). Using tools of project management such as PRINCE2, such approaches rely upon a linear-rational view of implementation, in which clear objectives can be established, and progress easily quantified. This approach is best suited to programmes with low conflict and low ambiguity. A 'softer', less rational approach acknowledges the complexities of implementation, and highlights the experiential knowledge of those at the front line in both informing policy formulation and managing its implementation. So-called 'Implementation Support Centres' (Pew Charitable Trust/MacArthur Foundation, 2017) are intermediate-level organisations which seek to support local organisations in implementing change. Hudson et al (p16) identify three areas in which such 'centres' might operate: managing and regulating; problem solving; and capacity building. However, they also identify possible tensions should one organisation/team try to fulfil all of these functions with, for example, regulation and performance monitoring potentially at odds with approaches which support problem solving. Furthermore, such approaches must deal with the issues highlighted by Matland, particularly the degree of conflict and the location of local and national political power.

The Care Act 2014 is an example of a policy accompanied by an intermediate-level support organisation, similar in aims to that developed in the Vanguard NCM programme, seeking to combine top down support with bottom up development of locally-relevant approaches. The Act requires Local Authorities to commission a broad range of local services to support local people who need some form of care or help in their daily lives, and to provide easily accessible information to allow people to access that support. Eligibility for support is clarified, and the Act sets out Local Authority responsibilities for providing assessments of needs. However, the provisions of the Act are relatively broad and lacking in specificity and the services to be put in place will be locally and contextually determined. In this way the Care Act policy resembles the Vanguard NCM programme, and it is perhaps useful to consider parallels between the implementation of both policies. Hudson et al highlight the unusually comprehensive programme developed to support implementation of the Care Act, with the establishment of a programme support board. They note in particular the systematic approach taken in the establishment of this board, with account taken of many of the issues we have highlighted from the policy implementation literature. Building upon this literature, the document setting out the establishment of the programme support board illustrates the design of the programme as shown in Figure 2 (Hughes and Caunt, 2013).

Figure 2: Optimum design of implementation support (from Hughes and Caunt, 2013)



They argue:

This model focuses on flexibility, clarity and collaboration: Clarity of expectations and requirements, of the framework and financial issues, and of the outcomes to be achieved. Effectively communicated to meet the needs of different audiences. Access to a range of flexible products to draw on in a way that meets local needs; reflecting the local starting point; the scale of change and other local issues and to have available a range of products (developed either locally, regionally or nationally) to meet these needs. Within a supported collaborative infrastructure that supports collaboration at local, regional and national levels through an on-going two-way supportive dialogue that builds a collective knowledge base (Hughes and Caunt, 2013 p1)

This suggests an approach which combines top down clarity with bottom up flexibility and collaborative approaches, and in this report we will highlight the extent to which these elements are reflected in the Vanguard NCM implementation support programme. Of particular note is the fact that, as we shall see with the Vanguard NCM programme, the Care Act support programme was intended to develop 'a range of products' to meet implementation needs.

A further body of literature relevant here is that which explores change in public sector organisations. Unlike change in commercial organisations, public sector change is likely to be policy-driven. Kuipers et al (2013) reviewed the literature relating to the promotion and management of change in public sector organisations. Much of this literature focuses upon what Kuipers et al call first or second order change. First order change refers to change in a subsection of an organisation, whilst second order change refers to change affecting an entire organisation. Change affecting more than one organisation, operating across a sector or even across an entire public sector is referred to as third order change. In change programme of this magnitude, research has generally focused upon

the macro level of change, exploring contextual issues relating to policy and politics rather than the mechanisms by which change occurred. Kuipers et al also make a distinction between planned and emergent change, arguing that successful rational planned change implemented in a top down fashion is rare in public sector organisations. Change is more often implemented via a bottom up process, involving 'voluntary and informal reform co-operation' [p9]. Mirroring Matland, Rusaw (2007) identifies four approaches to implementing change in public sector organisations: rational, top down and planned; incremental, small steps locally-driven change, focusing upon visible results to encourage engagement; pluralistic, involving multiple approaches and different 'mental models' of change; and an individual approach, focusing upon learning by individuals and groups. Kuipers et al argue that bottom up approaches are generally favoured as they are less likely to provoke employee resistance than top down approaches, and are more likely to be able to overcome any resistance that is encountered. Co-opting employees in helping to drive change is seen as a promising approach (McDonald, 2004). In enabling successful change, Lindquist (2006) also identifies 'implementation units' as a promising approach, although he does caution against the potential for rivalry when more than one such unit exists in an organisation or sector. Turning to the outcomes of change programmes, Kuipers et al highlight the dominance of the 'new public management' (Hood, 1991) values of efficiency, effectiveness and client choice in public sector reform over the past few decades, with most change programmes explicitly situated in this space. However, many accounts of public sector change do not address the question of outcomes at all, with the impacts of change programmes described in terms of change in staff behaviour or attitudes rather than outcomes. Kuipers et al (2013 p9) draw attention to the inherent complexity in bottom up approaches to change management, asking: 'how can we measure achievement when we do not really know what we are aiming for?'

Thus there is an inherent paradox for those trying to bring about change in public sector organisations: pluralistic approaches that engage employees are most likely to be successful in process terms, but the outcomes achieved will be neither predictable nor uniform.

1.3.3 Piloting and projects

A further useful concept in understanding programmes such as the Vanguard NCM programme is that of piloting. Testing initiatives in a limited area, often driven by early enthusiasts, is an approach often used in the NHS. Thus, for example, GP fundholding was introduced in waves (Glennerster et al., 1994), whilst the development of Clinical Commissioning Groups (CCGs) was led by 'Pathfinder' early adopters (Checkland et al., 2012). This latter example is interesting, as it could be said to illustrate Matland's category of high ambiguity, high conflict implementation. In the early stages of the programme, newly-created CCGs were given a great deal of latitude to develop their own goals and means of meeting those goals. At the same time, there was considerable conflict around the policy as a whole, with the legislation having a stormy passage through Parliament (Timmins, 2012), and a 'pause' in the process was necessary to address the political problems. However, local implementation continued regardless during the pause, and it could be said to have been a symbolic approach, designed to address the political issues whilst not actually affecting local implementation (Checkland et al., 2012).

Both the example of fundholding and the early development of CCGs illustrate an important aspect of policy piloting as it has been applied in the NHS. Conventionally, a pilot might be expected to be a test of a particular approach or programme (Jowell, 2003). Whether or not the approach was to be rolled out further would then depend upon the result of the evaluation of the pilot. However, both GP fundholding and CCGs were further rolled out without any formal evaluation or assessment of their achievements. Ettelt et al (2014) explore this issue in depth, highlighting the fact that policy piloting is altogether more complex than being a simple assessment of policy feasibility. They identify four different purposes underlying policy pilots:

*(a) **Piloting for experimentation ('policy trial/experiment')**: An opportunity to test whether a policy is generally (cost-) effective in meeting specific objectives, thus prioritising robust outcome evaluation, ideally using RCTs, and assuming genuine uncertainty about the superiority of the piloted intervention over the status quo ('equipose').*

*(b) **Piloting for early implementation ('pioneer')**: An opportunity for initiating, and investing in, local change in pilot sites, as a first step towards national roll-out. This requires a sufficiently large number of sites to make a sizeable enough difference in view of national implementation, with its aim being eventual 'mainstreaming'.*

*(c) **Piloting for demonstration ('demonstrator', 'beacon')**: A method of diffusing policy by selecting the most capable or most promising localities as sites to demonstrate to others how to implement policy successfully ('like the expert chef doing a cooking demonstration').*

*(d) **Piloting for learning ('trailblazer')**: An emphasis on learning and development, i.e., learning how to operationalise the policy, how to overcome implementation barriers and how to improve processes and outcomes, indicating awareness of the fact that a policy may still be at an early stage in its development and that it is not clear how it can be implemented. (Ettelt et al., 2014 p329)*

Bailey et al (2017) developed this further, arguing that local policy pilots may, in turn, feedback to influence policy making. When this occurs, the pilot itself may not be straightforwardly rolled out or extended, but some elements may be incorporated into wider policy, potentially ignoring the lessons learned from local 'bottom up' implementation.

Jensen et al (2017) highlight the fact that 'pilots' have many similarities with 'projects': both are usually time-limited (at least initially); and both often have a management structure which sits outside the usual management structure of the host organisation. Using Matland's conflict/ambiguity model, they suggest that each of the four types of implementation identified by Matland (1995) could be facilitated by a project/pilot approach, but argue that the approaches taken by those running the projects will need to be different. Thus, whilst a policy requiring 'administrative' implementation could be usefully managed by the establishment of projects built around conventional rational project-management tools (such as PRINCE2), a low-conflict high ambiguity policy might require a 'learning' approach, in which multiple opportunities for feedback and interaction between pilot projects and the wider organisation in which they are located are provided. In high conflict-high ambiguity policies, projects/pilots may be even more complex to develop and administer:

The main motive behind using project organizations to implement such policies is probably political, where the different actors need to reduce the level of conflict by negotiations and where the project can serve as a means to avoid blame and establish a compromise. The motive can also be organizational, for the quest to showcase innovative action and inspire change in another organization (Andersen, 2014). (Jensen et al., 2017 p12)

Furthermore, in these situations it is possible that those involved in local projects may have conflicting ideas about the nature of the problems being addressed, and about the means by which those problems should be tackled. Jensen et al highlight the fact that 'fickle and fleeting alliances'

(Jensen et al., 2017 p12) between relevant local actors may be critical in establishing such projects, and that project organisation may change and develop over time.

1.3.4 Relevance of policy literature to the Vanguard NCM programme

As is clearly set out in the Five year Forward View (NHS England, 2014a), the Vanguard NCM programme was established in order to test out policy approaches to the challenges faced by the NHS and by social care. Rising demand in the context of an aging population and a challenging financial environment, it is argued, required new approaches to providing services, with an emphasis on local collaboration across organisational and sector boundaries. Whilst not explicitly labelled as 'pilots', the Vanguards embody many features associated with piloting, including a commitment to testing out approaches with a view to wider roll out, and the identification of Vanguard sites as early adopters. Whilst a number of 'types' of Vanguard were established (see p17), considerable leeway was given for local sites to develop their own approaches. As we have seen from the literature, implementing policy such as this is not necessarily easy. Appropriate approaches to implementation may need to be adjusted to take account of the particular nature of the policy or programme, and it is important that power relationships are not ignored.

It is the aim of this phase of our study to explore the national support programme established to support the development of the Vanguards. The literature considered here would suggest that a rational, top down approach to implementation and project management would not be appropriate for a programme in which testing new approaches was said to be an important element of the programme. Indeed, given the similarity between the two policy programmes that we have identified, in particular the need for local adaptation and context-specificity, it could be argued that the principles underlying the Care Act implementation programme (see Figure 2) also apply here, with clarity, opportunities for collaboration and flexible products to support local implementers all being important. Evidence from studies of change in public sector organisations also emphasises the need for such a flexible, bottom up approach, but cautions that such programmes will not necessarily lead to predictable or uniform outcomes (Kuipers et al., 2013).

Building upon this, and the literature which we have discussed, the rest of this report will explore the national Vanguard NCM programme in more detail, addressing the following issues:

- the aims and goals of the programme as a whole, exploring what type of pilot the Vanguards might be said to be, using Matland's framework to analyse the programme as a whole;
- the elements put in place to support the programme, testing these against the different aspects and type of support that we have identified;
- the experiences of those involved in the support programme at both national and regional levels, including the factors which have facilitated or hindered their work.

In addressing these issues we will answer these research questions:

- How has the national support and evaluation programme operated, and which aspects are perceived to have been particularly helpful or problematic?
- What type of pilot are Vanguards, and how do they fit with established typologies of policy implementation?
- What can we learn from this about approaches to policy programme implementation?

In a final discussion section we will return to the literature that we have discussed, analysing the Vanguard programme according to Matland's framework, and evaluating the implementation support programme in this context.

2 Chapter 2: Methods

2.1 Context

This national evaluation sits within a complicated evaluative landscape, including local evaluations commissioned by each Vanguard and funded by the Vanguard programme and the establishment of an Improvement Analytics Unit (IAU) (previously called The Health Data Lab, NHSE 2016d). The IAU is a partnership between NHS England and the Health Foundation, and provides quantitative evaluation to show whether local change initiatives, implemented as part of major NHS programmes, are improving care and efficiency². Each Vanguard was originally asked to produce a logic model and a 'value proposition', and the National Institute for Health Research Health Services and Delivery Research (NIHR HS&DR) programme commissioned five evidence syntheses about the models of care underlying each Vanguard type. Our evaluation has had to be flexible enough to take account of these sources of evidence (and others emerging over time) as they became available, to avoid replication. Thus, for example, we have worked with the National Audit Office both to inform their study (National Audit Office 2018) and to ensure that there is no duplication or excess burden on Vanguards. The project is therefore being conducted in phases (work packages (WP), with an initial scoping phase undertaken to understand different types of Vanguard, the support programme in greater depth and the developing national context. The second phase (running alongside) has involved a synthesis of the findings from local evaluations. The third phase will consist of primary data collection using case study methods to explore in depth the experiences (qualitative) of a sample of Vanguards and outcomes (quantitative) between areas with and without Vanguard sites. A final phase will synthesise the findings. Here we will focus on phase 1 only with phase 2 being written up as a separate report which will be submitted to the funders in October 2018.

2.2 Work package 1

Within this work package, several strands have operated. These include:

WP1a: establishing Vanguard scope and activities and preparation for study;

WP1b: understanding the national context (macro level);

WP1c: exploring how Vanguards fit into the broader local landscape (meso level);

WP1d: economic modelling of the Vanguard programme.

WP1a: Scoping

There is a great deal of information in the public domain about the Vanguard NCM programme and about the individual funded Vanguards. This WP started the process of synthesising this information, and initiated the development of a database which has provided a dynamic resource for the study. This is allowing us to identify commonalities between different Vanguards, and begin the process of making comparisons and establishing important themes to be followed up in more details. Documentation available online and from NHS England has been collated

WP1b: Understanding the national context (macro level)

The aim of this WP has been twofold: to understand in more detail the development of, intentions underlying and activities associated with the national support programme; and to understand the way in which national regulators have engaged with the Vanguard programmes. We spoke to a range of actors at the national level to help us understand the programme and its context. In order to minimise the burden on those involved, we offered participants the alternative of telephone

² <https://health.org.uk/programmes/projects/improvement-analytics-unit>

interviews or face to face interviews. Separate interview topic guides were developed for each group of interviewees.

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. We sought to elicit narratives from interviewees which helped us to 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. For representatives of national regulators, we discussed: their overall approach to regulation of Vanguards; issues which have arisen, including the need to regulate statutory bodies individually, and how these issues have been overcome; and a probe for any specific examples of regulatory decisions relating to Vanguards. In addition, we explored national perspective on the process of specifying and procuring local evaluations and local evaluation leads views on the process of being commissioned and operating as part of a local evaluation.

Between October 2017 and March 2018 we carried out 29 national level interviews with a variety of respondents at the national level – these included current and past employees of NHSE including programme leads (e.g. new care models team, different care model leads, support stream leads) and strategic account managers; advisors to the programme (e.g. National oversight group, Improvement Analytics Unit); and people involved with Arm’s length bodies (e.g. regulators). See Table 3 below.

Table 3: Interviewees

Interviewee type	Numbers interviewed
NHSE employees (current / past)	19
Advisors	7
Arms Length Bodies	3

The interviews were transcribed verbatim, and analysed using the NVivo qualitative analysis software. The analytical approach was thematic, incorporating a priori themes arising from our prior appreciation of the relevant literature, alongside additional issues identified from the data. These additional themes informed later phases of data collection, and will be used to focus the next phase of the project.

During May 2018 we also took the opportunity to interview a selection of local evaluation leads to gain their perspective on the local evaluations – how they were commissioned, how the process was working with Vanguards and delivering results. These 11 interviews / group discussions (see Table 4) were recorded and coded thematically in a database (rather than transcribed and coded) and analysed alongside the national level interviews and synthesis of local evaluations.

Table 4: Evaluation leads (local)*

Model type	Numbers interviewed
MCP	5
PACS	6

*These covered a good geographical spread around the country

Our initial project plan included a survey of Vanguard leads. However, the NAO study of the programme included such a survey, and we were able to collaborate with them, including several of our own questions on their survey. 23 of the participants to the NAO survey were willing to give us

access to their data which the NAO passed on and these are reported as part of this report where appropriate.

Throughout this report we use examples of direct quotes from interviewees (national level, local evaluation leads) where it helps to illustrate the points we are making. To preserve anonymity, we have given each interviewee (national level - ID and local evaluation leads – P) ID / P numbers.

Our analytical approach consisted of the following stages. First, we present ‘the story’ from the narrative accounts of our respondents about how the programme was developed and operated identifying the programme elements such as enabling streams, logic modelling and local evaluations. After explaining the different elements, we have categorised what has worked well (facilitators) and not so well (obstacles) across the support programme. Finally we conducted an in-depth analysis (using Matland’s (1995) framework) highlighting cross-cutting themes identified in the data gathered, building upon our understanding of the relevant literature.

WP1c: Exploring how Vanguard fit within the broader local landscape (meso level)

Each Vanguard is situated within a complex local landscape of health and social care organisations and plans. The objective of WP1c was to establish the position of Vanguards within their local health economies, addressing RQ 2. This is important because Vanguards exist in a complex landscape of initiatives, including Integrated Care Pioneers, primary care Federations, non-Vanguard new care models (e.g. Accountable Care Organisations, Integrated Care Systems) and Sustainability and Transformation plans (STP).

Between February – April 2018 we undertook a survey (by phone) of a sample of STP leaders who had one or more Vanguard sites in their area – this resulted in us speaking to 12 (geographically spread across England, covering different Vanguard types) out of 26 potential interviewees. We have also linked up with the National Audit Office to gain the views of Vanguard leads across England (National Audit Office 2018). We were able to add some questions into the survey sent to leads during May / June 2018 and will be looking to follow this up with a standing panel of Vanguard leads to be established as part of phase 3. The findings of the STP leaders survey has been published as a separate report, whilst data from the NAO survey is included in this report as appropriate (<http://blogs.lshrm.ac.uk/prucomm/2019/01/22/new-care-models-programme-survey-of-stp-leads/>)

WP 1d: economic modelling of the Vanguard programme

It was intended in the early stages of the project to undertake an economic modelling exercise, seeking to use the logic models associated with the Vanguards to model what economic benefits might accrue from the activities of the Vanguards,. However, in practice this proved impossible to do as the Logic Models were insufficiently precise to be clear as to what was actually intended, and the outcomes addressed too diffuse and unfocused. In addition, our qualitative interviews confirmed the fact that, in many Vanguard sites, Logic Models bore little resemblance to what actually happened on the ground. With the support of our advisory group and of the New Care Models Evaluation team we therefore refocused our early quantitative work on an analysis of Vanguard outcomes. A report of this work is currently in preparation.

2.3 Work package 2: synthesising the findings of local evaluations: process and outcomes (meso level and micro level)

In this WP we have undertaken a rapid evidence synthesis to assess the commissioning, conduct and impact of local evaluations. Our focus is not only on summarising the findings of local evaluations, but also on the ways in which national guidance on evaluation has been translated into local specifications and then into actual programmes of work. This has been written up as a separate report which is currently under review by DHSC.

2.4 Future work packages

Following the completion of the initial policy-focused work, the next stage of this project is to explore at the micro (local) level how the Vanguard programme has been enacted. The focus of this work will be upon inter-organisational responses to integration initiatives, using relevant literature relating to organisational responses to policy change as a lens. Through case studies of individual Vanguards we will seek to elucidate the commonalities in factors affecting how policy is implemented, with a particular focus upon how, following the formal ending of the programme, initiatives have been scaled up and spread. This work will also take account of the rapidly changing policy landscape, seeking to explore how policy pilots such as Vanguards inform and influence and are influenced by developing national policy. At the same time, we will continue our quantitative analysis of Vanguard outcomes on both system and individual outcomes, seeking to understand the factors affecting these.

2.5 Oversight and stakeholder involvement

A study scientific advisory group was established containing representation from topic experts. The group met twice during the first phase of the research, and received copies of the interim report as well as commenting via email on proposed changes to the study protocol. The group provided advice and guidance about the research approach, as well as useful information relating to the conduct of other research on both Vanguards and other integration initiatives. Formal patient and public engagement was not undertaken, due to the focus of this phase of the study on policy implementation. Exploration of PPIE within the Vanguard programme will be included in the next phase of the study. In addition the study team engaged regularly with the NHS England New Care Models Programme evaluation team, who provided advice and support in accessing interviewees and the findings of the local evaluations.

2.6 Summary

This report focuses upon the findings from the first phase of the research. The focus in the report is therefore on the macro-level of policy implementation, focusing upon how the policy was implemented and what we can learn from this to inform future national policy initiatives. The next phase of the research will provide a more detailed study of the micro-level of policy implementation in organisations through case studies of individual Vanguards, alongside a quantitative assessment of outcomes.

3 Chapter 3: The Vanguard NCM programme: understanding programme goals and development

In this section we explore the explicit programme goals as set out in the relevant documents, and consider how these played out in practice as experienced by those involved in setting up and running the programme. We apply Matland's framework (1995) in order to understand the nature of the programme and to consider what might be the optimum approach to implementation. In order to do this, we return to the initial documents establishing the programme, and use these to develop an understanding of the programme theory (Weiss, 1998) underlying the programme overall. Programme theories represent the set of assumptions and intentions underlying public policies. Sometimes called 'theories of change', they seek to surface underlying assumptions about what will happen in response to a policy, and how the actions taken will lead to desired outcomes. Often implicit rather than explicit, their identification allows evaluators to test what has happened against the prior assumptions underlying policy development.

3.1 Goals for the programme: substantive service changes

As we have discussed, the Five Year Forward View (FYFV) (NHS England, 2014a) set out an overall vision for NHS reform., based around the creation of a number of 'New Care Models' which would seek to break down barriers between care sectors, and provide integrated care to populations. Importantly, the document was co-produced by NHSE, the Trust Development Authority, Monitor (now NHS Improvement), the Care Quality Commission, Health Education England and Public Health England. This joint authorship symbolises the fact that the programme was presented as being co-developed by all of the major national health care organisations. In terms of policy formation as discussed earlier, this would seem to be an attempt to move beyond 'interest groups' to present the policy as the settled view of all of the relevant national bodies. This may have been important in obtaining the political buy in required to obtain pump priming funding from the Treasury.

The FYFV (NHS England, 2014a p7) firstly sets out 'the problem' with health and social care in England. Building upon the work done by Berwick et al (2008) on the so-called 'triple aim' of improving care, improving population health and reducing system costs. It identifies three 'gaps' which it is said need to be closed:

- Health and wellbeing – focusing upon prevention and population health;
- Care and quality – reducing variations;
- Funding and efficiency – ensuring adequate funding as well as measures to improve efficiency.

In order to close these gaps, it is argued that there needs to be a renewed focus upon prevention within the NHS, and that 'artificial barriers' between primary and secondary care, between physical and mental health care and between health and social care need to be removed. The document then goes on to set out a number of priority areas for change, focusing upon prevention, empowering patients and engaging communities, before setting out a number of proposed 'new care models' embodying these principals. The initial document referred to seven possible new models of care: multispecialty community providers (MCPs); primary and acute care systems (PACS); urgent and emergency care systems (UECs); viable smaller hospitals; specialised care; modern maternity care; and enhanced health in care homes (ECHs). The specifics of what these 'models' might involve is not set out.

Starting from a number of ‘case studies’ of changes occurring in some areas (Kent, Airedale, Rotherham, Cornwall and Greenwich are singled out), a number of broad models are defined, but these do not include any concrete descriptions of what the model might include. For example, under the heading of Multispecialty Community Provider, a core characteristic is identified of GP practices banding together in some way, and this is followed by a list of things which such groups might do, including, for example, shifting outpatient clinics into the community, running community hospitals or employing a wider range to types of staff. Under the heading of ‘Primary and Acute Care Systems’, the central concept offered is of acute providers ‘vertically integrating’ with general practices, with hospitals potentially providing primary care services, integrating community and mental health services along with hospital and primary care services. Under both headings it is suggested that eventually, over time, an organisation (led either by GPs or by a local hospital) might take on some sort of capitated population budget to provide a full range of services for a population. Crucially, across all the models it is argued that ‘one size will not fit all’ (NHS England, 2014a p9), and that diversity of local solutions will be encouraged. Further details were provided in subsequent guidance, including calls for volunteer test sites (Vanguards) (NHS England, 2014b) and plans for investment in the Vanguard sites (NHS England, 2015b). The elements the models are left broadly defined, with a focus on integration, patient empowerment and community engagement, with an explicit intention that bottom-up engagement would be important. This means that the definition of the new models of care was driven by those sites which applied to be earlier adopters of the new models.

Thus, whilst the FYFV (2014) sets out a clear direction of travel in terms of greater integration between all forms of health and social care and the provision of more care in the community, there was considerable leeway – and ambiguity- in terms of what care might look like in the future. Broad themes were identified, including mobilising communities and improving prevention, but the specifics of what an MCP or PACS was or how it might operate were left unstated, with an explicit aspiration for local ‘bottom up’ development of new approaches to service delivery.

3.2 Goals for the programme: Vanguards as pilots

The FYFV did not itself establish the Vanguard NCM programme, although it did suggest that NHSE would work with local health economies to : ‘design a model to help pump-prime and ‘fast track’ a cross-section of the new care models’ (NHS England, 2014a p26). Subsequent policy documents (NHS England, 2015b, NHS England, 2014b) put flesh on these bones, setting out a plan to establish ‘prototypes’ of the new models of care:

Over the next year we will co-design a programme of support with a small number of selected areas and organisations that have already made good progress and which are on the cusp of being able to introduce the new care models set out in the Forward View. Our goal is to make rapid progress in developing new models of promoting health and wellbeing and providing care that can then be replicated much more easily in future years. Achieving this goal involves structured partnership rather than a top-down, compliance-based approach. So we are today extending an open invitation to local and national partner organisations to put themselves forward by the end of January 2015 to work alongside us in creating and implementing these new prototypes (NHS England, 2014b p4)

These initial ‘prototype’ sites were subsequently labelled as ‘Vanguards’, and the initial focus was upon MCPs, PACS and Care Homes care models. In July 2015 further guidance was issued. This set out an explicit goal for the Vanguard programme to develop approaches which could be subsequently rolled out more widely:

Each Vanguard system is rooted in its local diverse community. The national New Care Models programme draws together these individual local threads into explicit patterns, in order to exploit common opportunities for radical care redesign and remove barriers to change. Through the support package, our focus is on creating simple standard approaches and products, based on best practice and co-produced with Vanguards, which are designed from the outset for national spread. (NHS England, 2015b p4)

Thus, Vanguards were explicitly conceptualised as forms of pilot, intended to learn lessons which could be used to support the further development of new care models. As discussed earlier, Ettelt et al (2014) set out a typology of purposes which might be served by policy pilots:

- Piloting for experimentation
- Piloting for early implementation
- Piloting for demonstration
- Piloting for learning

Careful reading of the policy documents suggests that the Vanguard programme was conceived of as supporting *early implementation* (as evidenced by the intention to establish Vanguards in areas which have 'already made good progress') and for *learning*, with an explicit intention that the Vanguard sites would test out approaches to change, which would then be spread more widely. In addition, there was also an element of *demonstration*, with the argument made that: '*All three of these care models [PACS, MCPs and ECH] will demonstrate the reinvention of out of hospital care, with PACS and MCPs organising this for the whole population, and enhanced care homes targeting their approach to a care home setting.*' (NHS England, 2015b p4).

The programme was established with four 'key principles' (NHS England, 2015b p5):

- Design principle 1 – we solve problems through joint national and local leadership;
- Design principle 2 – we create simple replicable frameworks, built for spread;
- Design principle 3 – we encourage and support radical innovation;
- Design principle 4 – we work and learn at pace, demonstrating that change is real.

It is argued that working 'at pace' is essential, as early demonstration of 'quantifiable change' is necessary to justify further investment (NHS England, 2015b p7).

Taking these aspirations and claims together, the documents paint a picture of a programme which is underpinned by a clear set of process or implementation goals, which are held in common by all of the national bodies who are signatories to the documents. These goals can be summarised as:

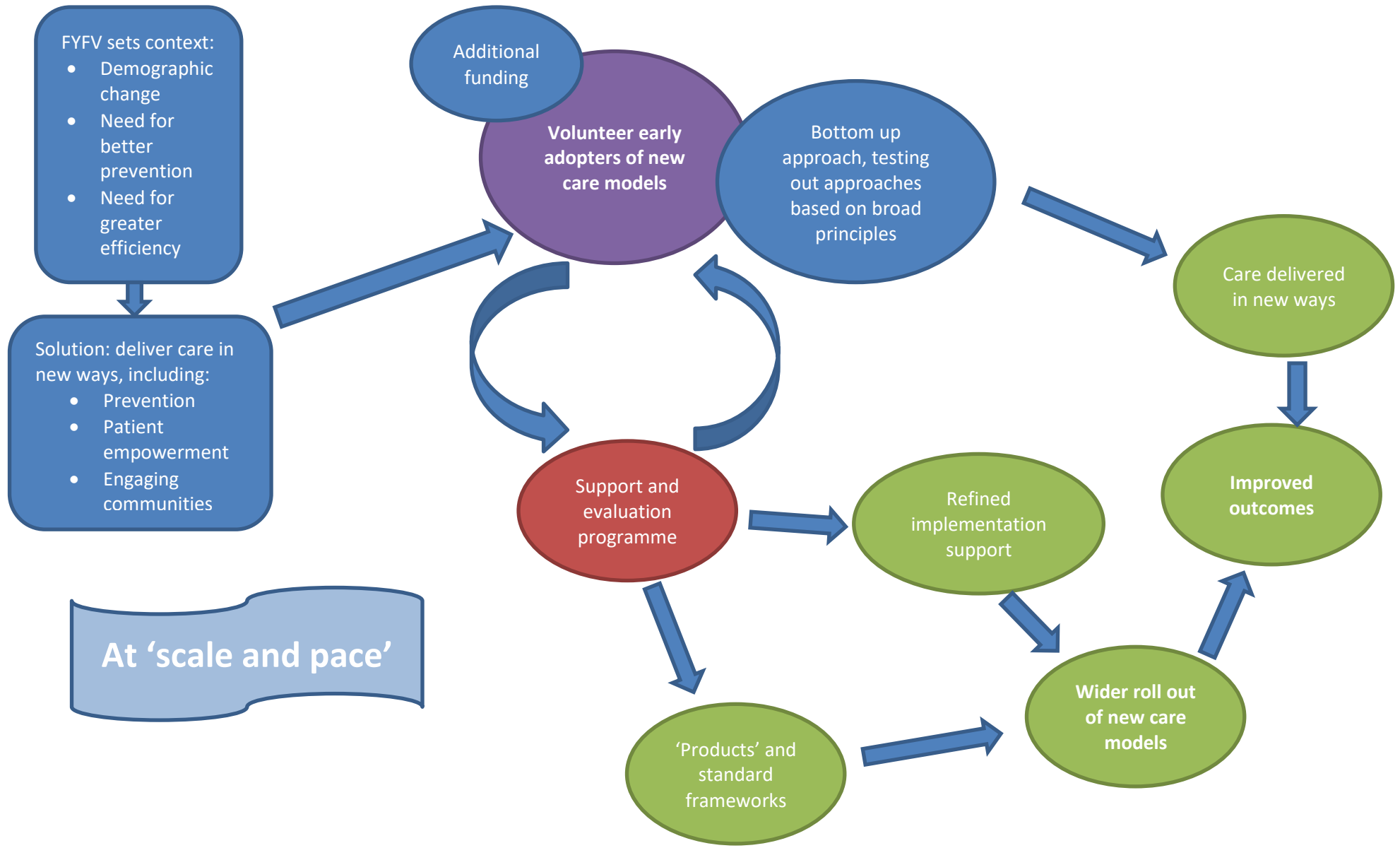
- To test out approaches to integrating care across organisational boundaries;
- To test out approaches to implementing these new ways of working. The policy documents make it clear that there are a number of barriers which commonly prevent inter-organisational working and partnerships, and it was the explicit intention that the programme would test out approaches to making change happen, as well as testing specific models of care;
- To use the learning derived from the development of the models to develop replicable care design frameworks and 'standard approaches and products' which could then be adopted by other areas;
- To use the learning from the implementation of the models to develop common approaches to implementation that could themselves be spread alongside the developed models.

These goals are presented as being the settled view of all of the organisations which co-authored the FYFV, and the plans were welcomed by the Department of Health.

3.3 Goals for the programme: summary

Figure 3 sets out a schematic picture of the overall programme theory underlying the Vanguard new care models programme.

Figure 3: Overview of the programme theory and goals underlying the NCM Vanguard programme



Like all such complex policy programmes, the Vanguard NCM programme embodies a number of different goals. Careful reading of the associated documents suggests that Vanguards were established as forms of pilot (even if this term was not explicitly used), with the ultimate goal of the programme being the wider roll out of new care models, supported by the production of 'standard approaches and products' and 'replicable frameworks' (NHS England 2015b p4/5) which would define the elements of the different models, and by a refined support programme. However, this required a number of interim goals in which both the content of the care models, and the support required to implement them were tested and refined. It was argued that the 'bottom up' development and testing of new ways of providing care would support, via a programme of evaluation, rapid learning and feedback, the development of 'replicable frameworks' (NHS England 2015b p5) which would, in turn, allow other areas to follow suit and allow the care model to be scaled up. Thus, the programme is presented as offering both improved outcomes – framed around the new public management values of improved efficiency, effectiveness and patient choice and control – and outputs which will support the adoption and spread of initiatives elsewhere. However, the specific outcomes to be achieved are left vague, other than the specification that 'efficiency savings' will be made, contributing to closing the identified gap between required and promised NHS funding (NHS England, 2014a p7).

In Matland's (1995) terms, the Vanguard NCM programme was high in ambiguity, with the overarching goal as to what the new models of care would look like deliberately left undefined. There was an explicit intention that local areas would have the opportunity to develop their own approaches, within a broad framework of underpinning principles. In contrast to these ambiguous goals, the goals related to the implementation programme were set out very clearly, and did not attract any dissent. Both of these groups of goals are presented as being harmonious with one another, with an explicit assumption that the process of support, feedback and evaluation would lead to the development and refinement of a set of defined care models, via 'standard approaches and products' (NHS England 2015b p4). This suggests a programme that is, in Matland's terms presented as being low in 'conflict', with the different groups of goals harmonious and commensurate with one another.

3.4 Policy development over time

Whilst it is clear that the Vanguard sites were set up as a form of pilot, the policy documents associated with the programme do not discuss the intended trajectory of the programme, beyond an aspiration towards rapid development and spread, and a statement that the Vanguards would be an 'initial cohort' 'designed from the outset to be replicated by subsequent cohorts (NHS England 2015b p9). In interviews senior managers told us that it was the initial assumption of those involved that there would be further rounds of Vanguard procurement:

I think when the forward view was set out, ...what we envisaged was a series of where you saw Vanguards happening over four or five years, building on one another and, yes, more of that, I suppose, traditional sort of rollout type thing (ID 027)

In practice, however, a rapid commitment was made to roll out new care models more generally:

Everything has happened unbelievably quickly. Commitments [were] made to roll-out work ... within about three, six months of my arrival. So, that...[by the] end of the first year of the programme...they were talking about 20 per cent of the country, by this time....by 2018 or something. Fifty per cent of the country by 2020, 2021 [ID 04]

At the same time, towards the end of 2015 a new policy was announced, establishing Sustainability and Transformation Plans/Partnerships (STPs) across England. NHS organisations were required to come together to initially define a 'local health economy' (Monitor, 2015) and then to create a local plan:

We are asking every health and care system to come together, to create its own ambitious local blueprint for accelerating its implementation of the Forward View. STPs will cover the period between October 2016 and March 2021, and will be subject to formal assessment in July 2016 following submission in June 2016. We are asking the NHS to spend the next six months delivering core access, quality and financial standards while planning properly for the next five years.(NHS England, 2015a p6)

The production of a local plan would trigger access to 'sustainability and transformation' funding. Plans were required to address, amongst other things, the following questions: 'What are your plans to adopt new models of out-of-hospital care, e.g. Multi-specialty Community Providers (MCPs) or Primary and Acute Care Systems (PACS)? Why should NHS England prioritise your area for transformation funding? And when are you planning to adopt forthcoming best practice from the enhanced health in care homes Vanguard?' (NHS England, 2015a p18). It would thus seem that, before the end of the first year of the Vanguard programme, the decision had been made that all areas should work towards adopting these models. Under 'frequently asked questions', the relationship between STPs and new care models is clarified:

One of the original aims of STPs was to develop new care models, blueprints for future care introduced initially under the 'Vanguard' and 'pioneer' programmes. STPs do not replace new care models; instead they will allow more parts of England to build on their success, by providing a collaborative system of leadership and governance in every part of the country which will allow new care models to evolve and spread.

<https://www.england.nhs.uk/integratedcare/stps/faqs/>

During 2016, local health economies came together to form 44 local Sustainability and Transformation Partnerships (NHS England et al., 2016), with each area producing a local plan by summer 2016.

As discussed on p7, in September 2016, 'frameworks' for three of the Vanguard models were published, focusing upon MCPs, PACS and ECHs (NHS England, 2016c, NHS England, 2016a, NHS England, 2016b). Two of these, for MCPs and PACS were very similar. Both focused upon an approach which segmented the population according to care needs, using the so-called 'care pyramid'. This approach identifies four levels of need within the population: whole population, with a focus upon prevention and wellbeing; accessible care for those with self-limiting conditions, particularly when required urgently; co-ordinated and integrated care for those with ongoing care needs; and more extensive co-ordinated care for those with the highest level of need. Both also set out a number of steps that areas would need to take in order to develop a new care model. The MCP framework identifies ten of these, including such things as: build collaborative leadership; establish a transparent governance system; understand population need; describe and explain all the elements of the care model; learn and adapt quickly etc. The PACS framework is very similar, identifying six tasks which overlap closely with those in the MCP framework. Both then go on to suggest approaches which might be taken to address the needs of each of the four population groups identified above, and again these are very similar, including:

- Developing a good understanding of local population health needs, including high quality data, and setting up processes to build community resilience and link people to community assets;

- Providing accessible and comprehensible urgent care, built around a single access number and incorporating accessible out of hours care;
- Providing integrated care to patients with ongoing needs, build around multidisciplinary teams and incorporating care co-ordination;
- Providing more intensive care for those with the highest needs.

This latter group shows the most difference between the PACS and MCP approaches, with the MCP framework focussing on a so-called ‘extensivist’ community model, in which specialists work intensively in the community with high need patients, whilst the published PACS framework also incorporates aspects of inpatient care and appropriate rapid assessment and discharge services to minimise hospital admissions and lengths of stay. Both frameworks then go on to discuss possible contracting models, which offer three options: a fully integrated capitated contract; a partially integrated contract, in which some providers work together under a capitated contract whilst others work alongside them under a looser agreement; and a virtual model, in which providers continue to work under current contractual arrangements but using alliance agreements to also specify what they will do together.

Both of these two frameworks are illustrated with examples from existing Vanguard, but neither offers anything which could be described as a ‘model of care’, being rather an elaboration of the principles and approaches set out in the FYFV and associated documents. Subsequent documents set out potential contractual forms (<https://www.england.nhs.uk/new-business-models/publications/>). These models of contract are flexible and allow for different configurations of organisations, and thus different forms of governance. Whilst the model contract documents are relatively specific in setting out what issues should be addressed by local contracts, they do not offer any guidance as to how agreements about potential financial gains and losses (a crucial element in population management contracts) should be approached, nor what they should address.

The Care Home framework document is much more specific, as might be expected for a care model which focuses only upon a small segment of the population. Specific service models and approaches are offered, including care elements and sub elements, as set out in table 5.

Table 5: Care elements and sub-element for ECH

Care element	Sub-element
1. Enhanced primary care support	Access to consistent, named GP and wider primary care service
	Medicine reviews
	Hydration and nutrition support
	Access to out-of-hours/urgent care when needed
2. Multi-disciplinary team (MDT) support including coordinated health and social care	Expert advice and care for those with the most complex needs
	Helping professionals, carers and individuals with needs navigate the health and care system
3. Reablement and rehabilitation	Rehabilitation/reablement services
	Developing community assets to support resilience and independence
4. High quality end-of-life care and dementia care	End-of-life care
	Dementia care
5. Joined-up commissioning and collaboration between health and social care	Co-production with providers and networked care homes
	Shared contractual mechanisms to promote integration (including Continuing Healthcare)
	Access to appropriate housing options
6. Workforce development	Training and development for social care provider staff
	Joint workforce planning across all sectors
7. Data, IT and technology	Linked health and social care data sets
	Access to the care record and secure email
	Better use of technology in care homes

These are then illustrated with reference to specific interventions, such as weekly ward rounds by GPs, approaches to medicines management and hydration and nutrition support.

In spring 2017, a further policy document set out progress towards the FYFV (NHS England, 2017). Early evaluation results are provided, and it is argued specifically that MCPs, PACS and ECH models are delivering improvements in some metrics, particularly lower growth in emergency admissions (NHS England, 2017 p31). The document goes on to propose that some ‘more advanced’ STP areas will become ‘Accountable Care Systems’ (ACS – now changed to Integrated Care Systems, ICS). The key elements of these are said to be:

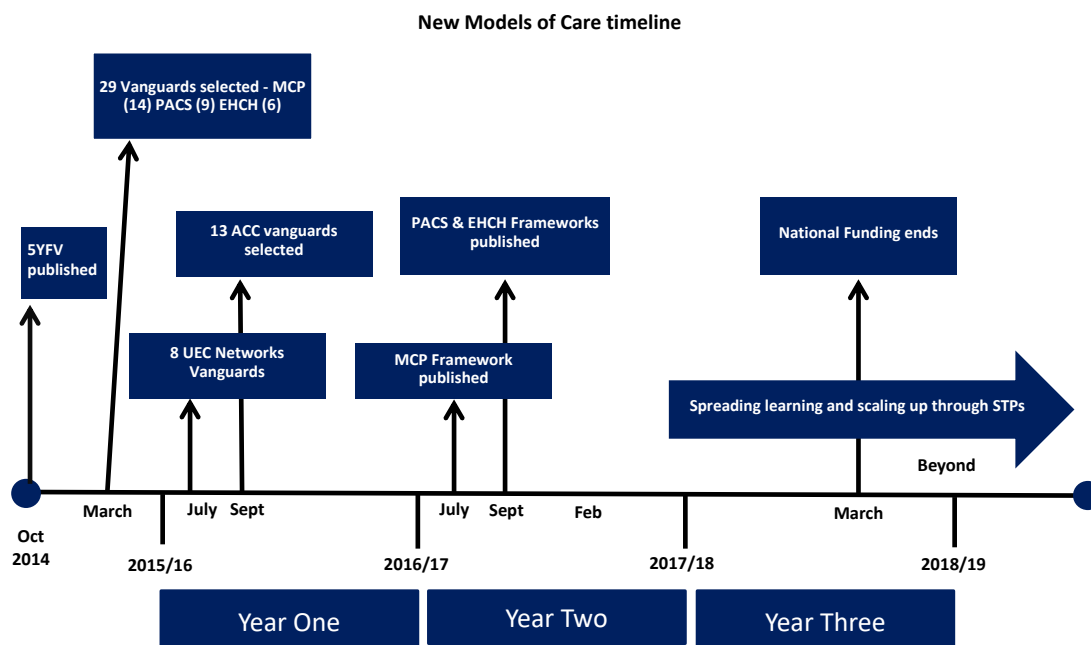
- An accountable capitation-based performance contract, with an applicable ‘control total’ covering the whole population;
- A collective decision making structure;
- Vertical and horizontal integration between providers, including GPs, community services, hospitals and mental health services;
- Population health management approaches, including a focus on prevention;
- Effective engagement with the local population and the retention of choice of provider.

A number of ‘candidates’ for ACS/ICS status are listed, many of which are based around Vanguard sites. Finally, the document sets out a requirement for Vanguards that, to access the final year of their additional funding, must demonstrate that they are ‘earning their passage’ (NHS England, 2017 p47) by demonstrating a reduction in growth in emergency admissions. It is explicitly argued that Vanguards should, in the third year of their existence, be focusing upon demand management.

Some of the elements which make up an ACS/ICS were issues which the Vanguard programme was intended to address. Thus, for example, it was intended that the Vanguard programme would result in the development of ‘products’ and ‘simple standard approaches’ which could be spread, including model capitation-based contracts and service design models. However, at the time that STPs were developed and the ACS/ICS programme was launched, such products had not yet been developed, with the published frameworks amounting to elaborated descriptions of underlying principles and approaches rather than models of how care might be provided.

A timeline for how the programme played out in practice is shown in Figure 4 below.

Figure 4: Timeline illustrating the actual progress of the NCM Vanguard programme



3.5 Summary

In this chapter we have explored the goals for the programme as set out in official documents. From this we have derived an over-arching ‘programme theory’ for the programme, highlighting the crucial role of the support and evaluation programme, and the clear intention that the programme would develop ‘products’ and ‘replicable frameworks’ which would support the wider roll out of the models. We have also highlighted the initial intention for there to be subsequent waves of Vanguards, and the superseding of this by the announcement of STPs and ACOs (later renamed Integrated Care Systems, ICS), which were positioned as ‘scaling up’ New Care Models to cover larger populations. Of note is the fact that in spring 2017 NHSE documents were making claims as to the success of the programme against a small number of metrics (emergency admission growth in particular). The published ‘frameworks’ for MCPs and PACS are non-specific and process-dominated, whilst that for ECH is more specific, and intended standard business models and organisational forms have not been developed (National Audit office 2018 p32).

4 Chapter 4: Understanding the New Care Models Vanguard support and evaluation programme

The support and evaluation programme lay at the heart of the Vanguard programme. In this chapter we describe this, using information from guidance documents and other published material (including the National Audit Office report), and drawing also on interviews with National level actors between Autumn 2017 and Spring 2018. It sets out how the programme was anticipated to run and points to how this began to change and evolve over the lifetime of the programme.

4.1 Selection of Vanguard Sites

According to NHSE, there was an open and well-publicised application process, which saw over 260 groups put forward their plans for potential Vanguard status and funding (NHSE England, 2015b). Groups interested in becoming Vanguards were asked to apply via an Expression of Interest (EoI). As part of the application partner organisations had to state their overall ambitions, what they wanted to achieve and costings by completing a template EoI. In addition to spontaneous applications some potential applicants identified by NHSE were asked to apply.

All successful applicants were invited to an away day event (held at the Oval in London) where they were asked to present their proposal. The application and presentations were scored by all those present on the day - peers, NHSE and other Arms-length bodies (ALBs) (Monitor, TDA, NHSI, PHE). Applicants were then asked to vote for their three preferred Vanguards (themselves excluded) based on level of ambition and the three they would most like to work with. That vote then informed the recommendations put forward by the observers to the new care models board meetings held between March and September 2015. Taking into consideration criteria such as geographical spread, history of successful transformation etc. the 50 vanguards across the model types were chosen. For a full list of the Vanguards see Appendix 1 (NHS England, 2015b).

4.2 NCM Support Programme

Since the outset, the Vanguards have been supported by a support programme consisting of various elements - NHSE team (including a designated lead for each model), the development and operation of 10 support streams, the development of logic models, a system of account management and the encouragement of sharing learning. In December 2015 'The Forward View into Action: support for the Vanguards' was published (NHS England, 2015b). This document set out in more detail the support that would be provided to Vanguards. The programme was underpinned by four core values (p7-8): Clinical engagement; patient involvement; local ownership; and national support. Building on this were 4 design principles to support the offer, which were:

1. "we solve problems through joint national and local leadership
2. we create simple replicable frameworks, built for spread
3. we encourage and support radical innovation
4. we work and learn at pace, demonstrating that change is real" (p23).

In order to ensure that the complicated systems of existing national rules and regulatory procedures in place across the NHS in England did not have unintended effects on Vanguards as they developed, systems were put in place to facilitate collaboration between the various ALBs responsible for regulating different parts of the health care system:

The six national bodies that authored the Forward View are committed to acting with greater coherence, and openly with partners in a different kind of national/local dialogue, guided by the spirit of co-creation. To progress the Forward View, the chief executives of the six national bodies will serve as a single leadership group, working with a broad coalition of partner bodies. Although each body remains individually accountable for its own statutory responsibilities, we will also take a more joined-up approach to working with local health economies and organisations. (NHS England 2015b p4).

During Spring of 2015, the NHSE team undertook a series of 2 day visits with each of the first 29 Vanguards (MCP, PACS and ECHs) to gain a better understanding of the work they wanted to undertake and find out how best they could be supported. The NHSE team carried out a thematic review, introduced the concept of logic modelling and after reflecting back with the Vanguards, devised eight areas of support. These were to help maximise the Vanguard's success and to help to provide replicability across the NHS and social care. It was these identified enablers that were the basis of the initial support programme (NHSE July 2015, updated Sept 15).

The initial support package was informed directly from issues highlighted by the Vanguards and their stakeholders (including clinicians and patients) over time. The national programme was set up to draw together individual local threads (from the wide range of local contexts) into explicit patterns to exploit common opportunities for radical care redesign and remove barriers to change.

4.2.1 Enabling (work) streams

Following a refresh of the support provided in September 2015 (due to UEC and ACC Vanguards being established), the programme was organised through ten enabling areas. Twelve joint workstreams were also developed and each was jointly-led by a Vanguard leader and national subject matter expert.

Priorities for support were said to be driven from the bottom up i.e. what Vanguards specified they wanted in terms of help and support. This caused some issues, at least initially, as in some cases the infrastructure required was not fully established to provide the support required. Different areas of support were needed at different times (technical aspects initially for example e.g. design) in the process and evolved as time went on. The types of support are shown diagrammatically and descriptively in Figure 5 and Table 6. The 10 support streams helped facilitate developments at the local, cohort (MCP, PACs, ECH, UEC and ACCs) and nationally.

Figure 5: Support streams



Table 6: The 9 areas of support (NHS England, 2015b p10)

Support Stream	Description
Designing new care models	working with the Vanguards to develop their local model of care, maximising the greatest impact and value for patients
Evaluation and metrics	supporting the Vanguards to understand – on an ongoing basis – the impact their changes are having on patients, staff and the wider population
Integrated commissioning and provision	assisting the Vanguards to break down the barriers which prevent their local health system from developing integrated commissioning
Governance, accountability and provider regulation	helping the Vanguards develop the right organisational form and governance model, as well as understand the impact on how they are regulated
Empowering patients and communities	working with the Vanguards to enhance the way in which they work with patients, local people and communities to develop services
Harnessing technology	supporting the Vanguards to rethink how care is delivered, given the potential of digital technology to deliver care in radically different ways. It will also help organisations to more easily share patient information
Workforce redesign	supporting the Vanguards to develop a modern, flexible workforce which is organised around patients and their local populations
Local leadership and delivery	working with the Vanguards to develop leadership capability and learn from international experts
Communications and engagement	supporting the Vanguards to demonstrate best practice in the way they engage with staff, patients and local people

In addition, there were some unforeseen issues, for example, VAT and regulation, which could not be solved in-house with Vanguard support only and thus involved negotiations with other bodies

(e.g. HMRC for VAT, NHSI for regulation) and in some cases issues have still to be fully resolved. Some others issues, outside the control of the programme and Vanguards, were highlighted as problematic e.g. BREXIT and competition law.

4.2.2 Logic Models

Logic models (also called impact or conceptual models) were integrated into the process as a way to achieve three objectives:

- to provide a 'road map' for proposed changes. They can help visualise the design of new care models and to demonstrate the chains of reasoning and relationships between components of the programme as well as actions and outcomes;
- these documents could be used for planning purposes. NHSE posited that through these models, a more efficient management process could take place as logic models can clarify thinking and might circumvent poor design;
- seen as a way to assist sites with supporting their business cases. The development of logic models could serve to justify planned changes and demonstrate the credibility of plans in terms of outcomes, risk and accountability (NHS England, 2015a).

In addition, it was intended that Logic Models would support the development of local evaluations. Each Vanguard was facilitated by NHSE to produce a logic model at the outset for their work. Logic models were seen to provide *"a visual means of showing complex chains of reasoning and are a means of representing the new care models"* (NHS England, 2015b p14). Having looked at other large scale programmes, NHSE suggested that *"having a clear logic model is one of the active components for successful change. Logic models can also be used as a planning tool, helping to clarify thinking and reduce the scope for programme failure owing to poor design and untested assumptions"* (NHS England, 2015b p14).

The idea for the logic modelling process came from the NCM team, building upon guidance from the cabinet office about programme evaluation (<https://www.gov.uk/government/publications/the-magenta-book>). Support for the logic modelling process was contracted out to Commissioning Support Units (CSUs), some of whom in turn contracted out to management consultants, as the timescale was very short and CSUs lacked the capacity to do the work in house. Thus, there was diversity in support provided to Vanguards in developing their logic model. The process also involved a small amount of evidence synthesis, with the NCM team commissioning some rapid evidence reviews for each model, which were published internally on the FutureNHS web platform. The idea was that these would support the logic modelling and planning process, but they were not available until summer 2016, which was too late for most areas, whose logic models were submitted during 2015.

The logic models were conceived as "dynamic" documents, meaning that there was an initial expectation that, while assisting in planning, they would change and be updated as implementation unfolded. However they were not always used in this way meaning they often only provided an initial 'snapshot' of service planning and do not reflect the evolving situation across the country. Furthermore, as planning documents the logic models provide a vignette into the planning process, but do not provide information on what is actually going on 'on the ground'. Logic models were seen as variable in quality at outset by our interviewees as many of the Vanguards had no / little previous experience of this way of working. Part of the rationale behind the evaluation programme was that individual Vanguard sites could develop their own, locally relevant models. This means that there are considerable differences between the ways in which services are described, titled and ordered in the logic models. This is explored further in the complementary synthesis report.

Some interviewees saw the logic models as useful at the outset for establishing what the Vanguard was trying to achieve (planning tool) but no systematic monitoring against them took place. Hence some Vanguards have used the logic models and have followed through while others have not revisited the models. In addition, as initially conceived logic models could have been a valuable data source for classification purposes. They were meant to include all planned changes in each of the sites, a clear outline of the care model proposed, and the way this change would be made i.e. the sort of information needed for a national wide categorisation exercise. In practice, however, an internal NHSE analysis and our own appraisal of the documents (see subsequent report on local evaluations) found that, whilst the process of producing logic models had been useful, they do vary significantly, and many do not include enough detail to allow clear identification of the actual programmes of work being undertaken. Despite these issues, logic modelling has become an accepted tool within NHS change programmes, with, for example, bids for additional funding for mental health services arising out of the FYFV requiring bidders to use the approach³.

4.2.3 Account Management

Many Vanguards had strong programme delivery arrangements in place with local teams working across organisations to design and drive change in a coordinated way locally. In order to support these Vanguards' specific arrangements and to create additional capacity, all Vanguards have been supported by a dedicated account management structure. Account managers, at the local level, provided help in problem-solving and facilitate access to the relevant expertise when required (NHS England, 2015b p36). Each account manager worked across a geographical footprint with 2-4 individual Vanguards of the different model types. Account managers were deliberately chosen to have a variety of different backgrounds for example, nurses, managers. The account managers were also supported by a clinical adviser (with variety of backgrounds e.g. nurses, GPs, Occupational therapists).

Working above the account managers at the 'regional level' were 3 Senior Strategic account managers (SSAMs), North, Midlands / East and South, whose role was described as relationship management within their designated geographical area working across health economies. The regional level was described as a '*dating service*' (ID 017) which can facilitate links throughout the regional health economy (including developing STPs) and enable sharing of learning while also reporting upwards to the NHSE team. The SSAMs are experienced NHS staff who can facilitate the necessary links as well as running teams and providing (context specific) support to the sites.

4.2.4 Learning and feedback / communities of practice

NHSE has facilitated bringing Vanguards together via communities of practice, network learning calls, webinars and connecting sites to arm's length bodies. They have provided access to data, learning materials and tools and provided bespoke local support, e.g. quarterly progress reviews, solution-focussed coaching and dedicated account management support (NHS Providers et al., 2018). Recognising that different people learn in different ways, a wide variety of mechanisms to support learning were employed during the programme. These included: an online collaboration tool; publications to read; webinars; face to face meetings; monthly evaluation calls and an evaluation symposium (held February 2017). Geographical and cross model (Vanguard types) events to share learning and information were also held. Some were run within regions and others at national level to share learning between Vanguard sites and beyond.

In addition, think tanks such as The King's Fund for example, worked with NHS and care organisations to support the development of the new care models

³ <https://www.england.nhs.uk/wp-content/uploads/2016/12/mental-health-call-to-bid.pdf>

(<https://www.kingsfund.org.uk/projects/supporting-new-nhs-care-models>). Commissioned by the national new care models programme, The King's Fund led a community of practice for the nine PACS Vanguards which aimed to develop thinking and share learning on the leadership and governance of these new systems, how to effectively engage medical leaders in their development, and how to deliver the necessary cultural change to support them. The Fund also ran a small number of events with the national bodies bringing together all of the Vanguards to share learning so far and establish connections across the sites.

The national Vanguard NCM support programme was staffed by employees of NHSE, many of whom were seconded from their previous roles, although some new posts were also created. We were told that, although staffing varied across the three years, at times as many as 120 people were working within NHSE on the NCM programme. Secondment was said to have the added benefit of allowing individuals to develop their skills and experience in ways which would be valuable when they returned to their previous roles.

The FutureNHS Collaboration platform (hosted by Kahootz) was established as an invite only (virtual) platform to share ideas, information e.g. logic models, evaluations, which can be accessed. Different levels of access are available to different actors in the process (e.g. Vanguard sites, non-Vanguard organisations).

A Population Health Analytics Network and a sister network for Information Governance and Data Sharing were developed to share experiences and challenges and work together to develop solutions⁴ (see later section - evaluation). Over time various publications have been released by NHSE to share the learning emerging from the work of the Vanguards⁵

4.3 Funding and finances

4.3.1 Funding and finances

It is difficult to establish clearly the exact costs of the NCM programme. This would ideally include costs for the direct funding to the 50 Vanguards, the NHSE NCM team, evaluations (national and local) and funding from the Vanguards themselves, set against savings being generated. The following is the best description of these costs, using multiple sources of data including various NHSE publications (reports, websites etc) and the recent National Audit Office report (National Audit Office, 2018) .

Direct funding of Vanguards

At the outset NHSE stated that "This is an intensive programme, but we are not placing a limit on the timeframe – each Vanguard will be different"⁶. However, the three years of funding and support ended in March 2018. According to the NAO (2018 p4) approximately £329m was the direct investment made into the 50 Vanguards centrally between 2015/16 and 2017/18. Across the 3 years this broke down to almost £114 million in 2015/16, £112 million in 2016/17 and £101 million for 2017/18.

Table 7 below shows the distribution of funding by year and Vanguard model as reported by the NAO.

⁴ <https://www.england.nhs.uk/new-care-models/Vanguards/support/>

⁵ <https://www.england.nhs.uk/new-care-models/Vanguards/support/publications/>

⁶ <https://www.england.nhs.uk/new-care-models/Vanguards/about-Vanguards/faqs/#6>

Table 7 the distribution of funding by year and Vanguard model (From NAO review of NHSE documents, NAO 2018 p6)

Type	No of Vanguards	Funding between 2015/16 and 2017/18 (£M)
MCP	14	124
PACs	9	103
ECHs	6	18
ACCs	13	72
UECs	8	13 (One year only)

Every Vanguard was given the opportunity to submit value propositions demonstrating potential delivery against the triple aims of improving health and wellbeing; care and quality; and delivering financial efficiency. Efficiency requirements were core to this, and Vanguards were to demonstrate through their propositions how they were proposing to deliver the requirements of additional efficiencies by the end of 2017/18 (NHS England, 2015a p38).

*“Once Vanguards chosen] We then worked with them to come up with the...it was almost like project costs in the first year. **It wasn’t really transformation costs, it was, you know, what do you need to get yourself up and running?** And I think that must have been in ’15, ’16 when that limited amount of resource then got allocated out to get them going. We then went through a fairly complicated process for ’16, ’17. We contracted with Bain and Co” (ID 006)*

Funding was available to the Vanguard sites each year for the 3 years. Each financial year the sites had to reapply for the following year’s allocation and some sites were not funded in later years but could, for example, be funded in year 1 not in year 2 and back in again for year 3. A funding decision making process was put in place at the outset involving 9 key stakeholders which included the NHSE investment committee, NHSE Executive leadership team, NCM Board, the logic model team and various Arm’s Length Bodies (ID006). As noted by the respondent, the consultancy company Bain and Co also provided some support for this process, including considering return on investment issues. Initial costs were for ‘getting up and running’ not for transforming. Limited funds were provided for 15/16 and a more complicated process was established for 16/17 and 17/18. .

“Each Vanguard has funding conditions and the majority of them are generic funding conditions that the programme has stipulated for all Vanguards. 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. Of course, that they deliver against their delivery plan. So, each Vanguard has a set of funding conditions that were articulated at the beginning of each financial year. 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” (ID 021).

Each year the funding for the Vanguards was delegated to local Clinical Commissioning Groups (CCGs), but in year 3, regional STPs were expected to contribute to the final decision over funding. STPs could chose to withhold some or all of their funding should Vanguards be deemed not to be meeting their targets or savings goals. However, in practice all STPs allocated the funding that was requested, regardless of Vanguard performance against metrics.

The finance team for NCM supported both the overall programme and the individual Vanguard sites. They worked in teams and were organised in different ways depending on the specific Vanguard and its needs and support programme finances/resource allocation liaising with the higher level investment committee. Workshops were conducted with Vanguards to introduce the concept of 'value' and support development of each Vanguard's 'Value Framework'. Each Vanguard was evaluated using a dashboard (including outcomes, risks, resources, strategic decisions etc.)

Since funding officially ended for Vanguards and the Vanguard NCM support programme in March 2018, there has been no more 'transformation' budget for these activities. National support monies were moved to ACO/ACS/ICS developments (under the new NHSE System Transformation group). Local Vanguard driven services will need to fit under this umbrella or find funding from local CCGs to continue their developments.

Funding the support programme

An additional £60m was spent on the Vanguard NCM programme, supporting and monitoring development and included the national evaluation and all local evaluations. This also included the NHSE national team, consisting of up to 120 staff. Delays in recruiting the national support team at the outset, according to the NAO (2018 p22) contributed to an underspend of around £33m by the NCM team between 2015/16 and 2017/18 – this was equivalent to more than a third of their original budget allocated for non-financial support.

The £60m did not include time spent by other staff in other parts of NHSE and other national bodies supporting the Vanguards (NAO 2018 p22). We do not have a full estimate of these costs, as many staff were seconded across to the programme, and it is unclear how far these costs were additional (ie extra staff were required to fulfil the roles that these staff were contracted to cover) or covered by the overall NHSE staff budget. In addition, there were costs associated with events, management consultancy, communications etc. for which it is very difficult to gain accurate figures.

Local funding

The NAO (2018 p17) also reported that local Vanguards also used their own resources to fund and support developing care models. They report "a national total is not available for 2015/16 but in 2016/17 and 2017/18, Vanguards reported they had spent a total of £139m".

Savings generated from Vanguards

There was an original prediction for £324m of net annual savings by NHSE from the 36 Vanguards included in the predictions by 2020-21 (NAO 2018 p36). Every one of these 36 Vanguards predicted net savings over the five year period to 2020/21 and each model type also predicted savings as shown in Table X below (figures from NAO 2018 p36).

Table 8: predicted net savings per Vanguard type (from NAO, 2018 p36)

Model type	Net savings for every £100 spent (prediction)
ACC	£154
ECH	£103
PACs	£96
MCP	£75

The NAO describe these savings forecasts as 'encouraging'. However, it is unclear if costs and savings included in the measures are consistent across Vanguards. For example, in the PACs model the widest range on returns is seen as between £5 and £292 for each £100 spent. For further detail see NAO (2018 p36)

4.4 Evaluation

Scoping of the NCM evaluation commenced in spring 2015. It was described as of a scale (i.e. 50 sites) and complexity (i.e. encompassing the redesign of whole health systems, rather than just aspects, covering large populations) not attempted previously by NHS England.

The aims and objectives of the evaluation were defined, on advice from the advisory group, as well as agreement from the NCM programme team and was detailed in the Evaluation Strategy (NHS England, 2015b), these were to:

- Provide information about the improvements in outcomes that the new care models [were] making in each Vanguard and of the cost-effectiveness of changes made;
- Ensure that information [was] available quickly to facilitate learning and improvement
- Help [NHS England] understand how and why these impacts [were] arising so that the learning about what works, and what does not work, can be shared rapidly among the Vanguards and spread throughout the NHS.

Evaluation of Vanguards was integral to the programme. The 'Evaluation Strategy' (NHS England, 2015b p4)(2016) stated that *'the evaluation needs to provide information about the improvements in outcomes that the new care models are making in each Vanguard, and of the cost-effectiveness of changes made'*. Information was required to be available quickly to facilitate learning and improvement and it was argued that that the information needed to be comparable with findings from other programmes to avoid contradictions and allow comparison. The new care models programme was described as *'complex in its breadth and depth. It also combines experimental discovery with standardisation'*. This in turn needed a suitable multi-faceted approach to measurement and evaluation. NHSE developed their approach to evaluation through discussions with national experts, Vanguards and their evaluation partners, including a diverse national expert group comprising academics and evaluation experts which met during the first year of the programme. It was shared and tested with stakeholders - including through direct discussion with Vanguards, at NHS Expo 2015 and at a Nuffield Trust expert conference on evaluation of complex care programmes. It was also discussed and approved by the new care models programme evaluation oversight group (NHS England 2016d).

The evaluation strategy suggested that: *"Evaluation of the Vanguards will support the delivery of the new care model locally and help develop nationally replicable and scalable models"* (NHS England 2016d p5). This would help to answer a set of questions across the programme:

- *What is the context (e.g. history, culture, relationships, health inequalities, local and national policies, national legislation) in each Vanguard into which new care models have been implemented?*
- *What key changes have the Vanguards made and who is being affected by them? How have these changes been implemented?*
- *What is the change in resource use and cost for the specific interventions that encompass the new care models programme locally?*
- *How are Vanguards performing against their expectations and how can the care model be improved?*
- *What impact are the Vanguards having on patient outcomes and experience, the health of the local population and the way in which resources are used in the local health system?*
- *Which components of the care model are really making a difference?*
- *What are the 'active ingredients' of a care model? Which aspects, if replicated elsewhere, can be expected to give similar results and what contextual factors are prerequisites for success?*

- *What are the unintended costs and consequences (positive or negative) associated with the new models of care on the local health economy and beyond?*

Alongside the principle of local ownership, the evaluation programme was therefore designed around a series of ‘areas’, which formed the methodological structure to the evaluation. Firstly, individual Vanguards were subject to local evaluations which aimed to look across all of the Vanguard interventions to establish impact and to explore implementation and causation. They were also provided with an ongoing ‘dashboard’ of their performance against a number of metrics compared with their baseline performance and with non-Vanguard areas. Secondly, outcomes from the whole cohort of MCP and PACs Vanguards were compared with counterfactuals, using statistical techniques to establish whether or not any changes seen were statistically significant. Thirdly some individual interventions were subject to evaluation, and finally, where interventions were common across a number of Vanguards the team undertook thematic studies in order to understand how different contexts affected these. In addition, the team produced ‘Bringing the Evidence Together’ synthesis reports for Vanguard sites, synthesising all sources of evidence relevant to Vanguard implementation and performance.

4.4.1 Individual Vanguard national evaluation via data dashboard and qualitative enquiry

In October 2015, NHSE published the initial suite of core metrics for the first three new care models (MCPs, PACS and ECHs). The first two metrics (efficiency) that were selected were emergency admissions and total bed days. In addition care and quality metrics were selected, including patient involvement in care (GP and nurse), Care Plan and a quality of life measures (EQ5D score)(NHS England 2016d p16). Alongside these, a set of local metrics chosen by Vanguards and linked to their logic models (including output measures such as the number of patients affected), and bespoke analyses (e.g. the effect of interventions on specific patient cohorts and economic analysis of total cost across patient pathways) were to be formulated. However, during the programme the emergency admissions and hospital bed days measures became those most often reported and quoted and became the de facto performance measures which determined ongoing funding of the Vanguards during years 2 and 3.

To facilitate rapid learning and improvement, the core metrics were supposed to be complemented by:

- *“enabler metrics: these will measure progress against the care model building blocks or enablers, such as a single shared care record. We will develop these with care model leads, Vanguards and others; and*
- *local metrics: these metrics will be defined by each Vanguard, reflect local priorities and be rooted in the logic models. We will be providing guidance to Vanguards on developing local metrics. We expect that each Vanguard will report to us quarterly against approximately six local metrics, although this will be finalised once the logic models for each Vanguard are agreed” {NHS England, 2016 #4301 p16}.*

The Vanguard NCM programme team reported to Vanguards on the national metrics quarterly starting in October 2015, through a dashboard, based on data from routine national data collection and from data gathered from Vanguards where there are no or inadequate national metrics (NHS England 2016d p11). An example of the metrics used in the dashboard for ECHs is provided below (Box 2). Performance was benchmarked against the individual Vanguard’s own baseline figures, and against the population of non-Vanguard sites. The dashboard did not attempt to establish statistical significance, but towards the end of the programme the evaluation team used these data to undertake more detailed statistical analyses, attempting to establish whether or not changes in outcomes seen were statistically significant.

Box 2: Purpose of metrics (used for ECHs) from FutureNHS

Collaboration

Purpose – We (NHSE) have developed a set of core metrics to track the impact of Vanguard interventions. The dashboard reports metrics corresponding to the Efficiency challenge set out in Five Year Forward View. These are reported quarterly. We are currently researching suitable metrics for the Care & Quality and Health & Wellbeing domains within the Care Home dashboard. This dashboard relates to Care Homes Vanguards. MCP and PACS Vanguards are reported separately (Care and Quality, Health and Wellbeing and Efficiency variables used). Note that the Non-NCM area includes GP practices, and their population, that are not part of the Care Homes, MCP or PACS Vanguards.

Data is sourced from Secondary Uses Services (SUS) via NHS England's National Commissioning Data Repository (NCDR). Since release 4 the dashboard has sourced a combination of SUS and SUS+ for emergency admissions and total bed days.

The metric definitions have also been changed. The main definitional changes include counting completed spells based on the date the patient is discharged. Previously emergency admissions were counted from the date the patient was discharged but from the episodes data and for bed days activity was reported against the episode end month. The changes allow us to align more closely with Operational Information for Commissioning and enable reproduction of the dashboard data by other interested parties.

Note ECH dashboard is currently version 5 while PACS/MCP is version 12.

In addition to this data-driven approach, the evaluation team undertook a number of additional pieces of evaluative work, using a broader range of methods including interviews with stakeholders. These included:

- **Ad hoc Vanguard case studies**
Adhoc studies were done to increase understanding of particular issues. For example one study looked at resource usage in key Vanguard interventions (interviewing, review of documentation etc); another early study reviewed a Vanguard's care model and its goals through an analysis of the health and service challenges faced in the Vanguard. This approach informed the evaluation team's overall approach.
- **Bringing together the evidence – summative evaluation**
This is a synthesis of every piece of analysis / research /data collected on each Vanguard. It includes the dashboard data, local metrics, IAU reports (where available), local evaluation reports and informal information held by the account managers.
- **Developing rich learning from 'learning and impact' studies**
The NHSE evaluation team has produced a number of thematic studies which are published internally (via the Future NHS Kahootz platform). These have included thematic studies of use of risk stratification and social prescribing. Further studies are in final draft form, focusing upon urgent care centres and active case management through multidisciplinary team working, and have engaged multiple stakeholders across NHSE.

4.4.2 Local evaluation

Based upon advice from evaluation strategy experts, it was decided that in addition to the data dashboard approach, individual Vanguards should be supported and funded to commission their own local evaluations. In total, this funding amounted to £5,775,000 in 2016/17 and £4,985,000 in

2017/18⁷. According to NHSE (NHS England 2016d) *“Local evaluation will provide another core pillar of the evaluation, and will need to be carefully designed in order to:*

- *Capture and evaluate the transformation changes delivered by the Vanguards appropriately. Alongside knowing whether things have changed (through outcome metrics), it is important we understand how, and in what context, the changes have occurred.*
- *Understand the ‘reach’ of the Vanguard locally. With this in mind, it is important to include output data such as the number of patients affected by changes made.*
- *Feed the information gathered into ongoing, on-the-ground delivery, so that services are continually improved.*
- *Share the learning gathered between the Vanguards and more widely, to promote replicability and scale up. Doing so will also help to ensure that we tackle any barriers/issues collectively, for the benefit of the whole.*
- *Embed a culture of evaluation and knowledge sharing within the Vanguard”.*

In order to support Vanguards in procuring their local evaluation, two sets of evaluation guidance were issued to facilitate and guide the commissioning process. A range of evaluators were commissioned locally by the 50 Vanguards, including Universities, consultancies, CSUs and other NHS bodies. This local approach was intended to generate local ownership of the evaluations, to encourage engagement with the collection of local evidence and support approaches tailored to local needs and circumstances. However, it also necessarily resulted in a lack of consistency in approach and in reporting. The commissioning process was in some cases very slow and in many cases the Vanguards wanted much more work than the budget allocated to the evaluation could cover in the timescale available. As might be expected given the complexity of Vanguard interventions, reporting from the local evaluations in some cases took longer than anticipated. The national team did not specify any particular format for the final reports, because it was intended that the Vanguards should negotiate an appropriate format with their evaluator. This meant that reports were tailored to Vanguard requirements, but it reduces opportunities for comparison across the programme as a whole. This, alongside the quality of local evaluations, is addressed in our accompanying report synthesising the local evaluations.

4.4.3 Independent programme evaluation

In addition to this broad range of internal evaluative activity it was decided from the beginning to commission an external evaluation of the programme as a whole, of which this report forms a part. This programme evaluation was commissioned by the NIHR Policy Research Programme, and is for a four year period from June 2017-May 2021. This will allow the longer term assessment of outcomes in sites initially designated as Vanguards, as well as exploration of their longer term impact on local system change and development. In addition to this report (see methods) the team is undertaking an analysis of national metrics, and is synthesising findings from the local evaluation programme.

4.4.4 Improvement Analytics Unit— NHS England partnership with the Health Foundation

In order to support the overall evaluative programme, and to support ongoing capacity building in evaluation across the health and social care system more generally, the NHS England evaluation team worked in partnership with the Health Foundation to set up what became known as the

⁷ Note these costs were for 44 Vanguards as it did not include the 3 Vanguards associated with Greater Manchester (GM) – these were funded separately via the GM Transformation Fund under health and social care devolution arrangements – or 3 other Vanguard sites which received no funding for local evaluations. The NHS England support team had little contact with all 6 sites not funded by them for local evaluation.

Improvement Analytics Unit (IAU) (initially known as the Health Data Lab). It aims to help spread the use of data analytics in the NHS for the purposes of quality improvement and to strengthen the robustness of evidence to inform policy development. The unit supports delivery of NHS England's commitment to evaluating the impact of major national programmes (such as the new care models). Specifically, it will provide the NHS with the capability of rapidly testing interventions in the health and care system, in as close to real time as possible, so that changes can be implemented to the system as rapidly as possible to improve patient care⁸. The unit aims to provide rapid feedback to local services and decision-makers to enable them to improve care. The three year partnership between the Health Foundation and NHS England was established in 2016, and is overseen by an Oversight Group which has joint representation from NHSE and The Health Foundation, alongside expert advisors. From 2019, NHS England will take lead responsibility for the unit⁹.

According to the IAU website:

"The Improvement Analytics Unit is an important part of NHS England's approach to rapid cycle evaluation being applied by NHS England both nationally and locally in the new care models programme. It is part of a spectrum of complimentary evaluation tools available to assess improvement and support learning, and has close links to the dashboard tool"¹⁰.

To do this the IAU was to compare results in the areas or population groups affected by an intervention with the result that there would have been had there been no change – the so-called counterfactual. It was to use a range of sophisticated approaches to establishing counterfactuals, including constructing matched controls, through access to national data.

Four detailed studies of Vanguard interventions have been published so far^{11 12}, with other reportedly under way, and the IAU continues to work with NHSE in building analytical capacity in the service. Interviewees offered some early lessons from the IAU work:

- Relationships with end users ('and associate advisors') are crucial – the partnership approach is very helpful here;
- Establishing such a resource takes time. Whilst the aspiration was for rapid feedback on sites about their performance, in practice it took some time for the unit to become established. However, it was argued that once established, future analyses will proceed more rapidly;
- Data management is a discipline in its own right;
- Dedicated information governance resource is required ;
- Value of analytics often lies in the ensuing discussions about what data may mean
- The "unmet need" for analytics in the NHS is very clear.

It should be noted that:

"the Improvement Analytics Unit does not aim to judge the success of national programmes or local initiatives. Its purpose was to provide robust evidence about the extent to which there has been a discernible improvement in outcomes following

⁸ <https://www.health.org.uk/improvement-analytics-unit-faqs>

⁹ <https://health.org.uk/programmes/projects/improvement-analytics-unit>

¹⁰ <http://www.health.org.uk/improvement-analytics-unit-faqs>

¹¹ <https://www.health.org.uk/publication/impact-redesigning-urgent-emergency-care-northumberland>

¹² <https://www.health.org.uk/publication/impact-enhanced-support-rushcliffe>

*implementation of a new initiative, in order to inform ongoing learning and improvement at a local and national level*¹³.

Following the end of the formal Vanguard programme, the IAU continues to work with NHSE in order to support analytical activity across NHS programmes.

4.4.5 NCM evaluation oversight group

Delivery of the evaluation programme has been overseen by a NCM programme evaluation oversight group (NHSE 2016d). The group consisted of external advisors chosen for their experience in NHS change and development, policy, current knowledge of Vanguards and expertise in using data. The group provided independent advice and support to the developing evaluation programme and its roles were to:

- Advise on the national and local evaluation strategies;
- Monitor delivery of the elements of the evaluation (e.g. production of logic models, metrics and national dashboard);
- Ensure risks to delivering a robust and timely evaluation are identified and managed;
- Make recommendations about the national support that Vanguards need on measurement and evaluation;
- Advise on emerging issues and how to deal with them (NHS England, 2016d5a p13)

This was a small group, which met a number of times during the programme. Members were keen to stress this was an oversight rather than a steering group.

4.4.6 Evaluation outputs

To be most useful, the different part of the evaluation programme will need to be pulled together to provide wider lessons which are not so context specific. This is a work in progress, with a number of published reports expected by Autumn 2018. Whilst there have been a number of publications from the programme overall during its lifetime, these have tended to focus on success stories and case reports, designed to generate and maintain enthusiasm and share learning, rather than being an objective assessment of progress.

During 2018 there have been a series of events put on by individual Vanguards called 'show and tell' or 'feedback' events. Attending these we have observed the presentation of things that are working well for the individual Vanguard but also those things that have been more challenging. There appears to be recognition that no one model fits all but that elements (or successful ingredients) from the different local programmes could be shared and potentially implemented elsewhere in other local contexts (spread).

NHSE is to produce a synthesis report bringing together all evidence from the programme during the summer of 2018 and the NAO has recently published its findings on the NCM programme (National Audit Office, 2018)

Delivery for the evaluation took place in 3 main phases: During 2015/16, the focus was on scoping and design: developing logic models; starting to define national metrics; producing the Impact Dashboard; and starting the local evaluation commissioning process. By 2016/17, attention had moved to the start-up of the local evaluations: commissioning local evaluators; collection and analysis of local metrics; as well as initial work by the IAU. During the final year - 2017/18, the focus

¹³ <http://www.health.org.uk/improvement-analytics-unit-fags#9>

was on embedding the evaluations and synthesising the evidence: delivering Learning and Impact Studies; and completing the local evaluations.

Some tensions arose across the life of the programme between the programme's need to promote achievements and the need for robust analysis, performance management vs evaluation and need to deliver programme outputs and policy rapidly vs the need for robust evidence.

4.4.7 Summary

The Vanguard NCM programme was thus established with an extensive and multi-faceted internal evaluation programme. There was an initial focus upon headline quantitative metrics, as these were seen as important in policy terms, in particular in assessing progress in order to support decisions about ongoing funding. In addition, the evaluation team also undertook some qualitative work in order to support interpretation of available metrics and to understand in more detail the contextual factors at work. Considerable energy has been devoted by both the national evaluation team and the IAU to finding robust ways of establishing whether or not any changes in metrics were statistically significant and meaningful. In doing this, the team worked on different approaches to establishing 'counter-factuals' (what would have happened if the Vanguard had not been established) and controls. This is important, because outcome metrics in a single site will be subject to significant random variation over time, with regression to the mean. The approach taken by the evaluation team was one of rigorous enquiry, not assuming that Vanguard outcomes would be better than those elsewhere and ensuring that policy makers were informed about any uncertainties about the robustness of outcomes data. In addition, the various sources of data about the outcomes associated with the Vanguard programme were triangulated together and synthesised, in an attempt to generate learning about the factors underpinning any headline changes in metrics.

Returning to Ettelt et al (2014), it could be argued that the evaluation programme treated the Vanguard NCM programme as what Ettelt et al called 'piloting for experimentation': *'An opportunity to test whether a policy is generally (cost-) effective in meeting specific objectives, thus prioritising robust outcome evaluation, ideally using RCTs, and assuming genuine uncertainty about the superiority of the piloted intervention over the status quo ('equipoise').'* (Ettelt et al 2014 p239). This approach was somewhat in tension with the broader programme approach which as we have seen was based upon a premise that new care models would deliver better outcomes and should be more widely rolled out as quickly as possible.

4.5 Governance, accountability and regulation

New organisational relationships need to be underpinned by appropriate governance and oversight structures. As an extension of the work on integrated organisational forms, the NCM team, together with NHS Improvement, have been providing support to Vanguards to understand where accountability and control would lie, and what good governance would look like under different arrangements. Vanguards also received support to understand the accounting treatment and tax implications associated with potential new operating models, although some of these issues remain unresolved.

Within Vanguards, each of the collaborating organisations retains its existing statutory responsibilities and obligations with regard to regulatory, inspection and oversight bodies. All organisations which provide health and social care services in England must be registered with the CQC. It is open to collaborating providers to discuss with CQC the option of registering as a single provider for inspection purposes, but none have so far taken up this option. NHS Improvement is responsible for regulating Foundation Trusts, with a particular responsibility for overseeing the balance between co-ordination and appropriate competition between providers. Since the

publication of the FYFV there have been ongoing discussions at national level as to how best to balance the needs of local organisations (who would prioritise a unified system, minimising the number of bodies to whom they must answer) and the needs of the wider system in which macro-level policy imperatives (such as the importance of choice and competition) are expressed. In particular, discussions are ongoing as to how Vanguards, Strategic Transformation Partnerships (STPs) Accountable Care Systems (ACSs) and Integrated Care Systems (ICSs) should best be monitored and regulated, with a focus on ensuring that regulation takes account of collaborative working across geographical areas.

Vanguards initially asked for help to understand how their new collaborations would be regulated (NHS England 2015c p26) From December 2015, a working group was established comprising Vanguards, NHS Improvement and the Care Quality Commission to understand and address the range of questions relating to provider regulation for all Vanguards. The lessons arising from this work were to be shared with other NHS providers who were exploring the development of new forms of collaboration such as foundation groups, Accountable/Integrated Care Organisations and other similar arrangements. Generally it has been seen that regulators were willing to engage but until there is new primary legislation there is a limit to what can be changed and many areas have been using ‘work arounds’ to circumvent obstacles and make systems work more smoothly. Two respondents to the NAO Vanguard lead survey reported that the regulatory advice that they received from national and regional sources was not necessarily consistent, with their regional advisors suggesting greater restrictions over what they were permitted to do.

As at July 2018, all statutory NHS organisations continue to be regulated separately, and subject to individual CQC inspection. However, CQC has also instigated what could be called ‘meta-level’ work, exploring across sectors how well care is integrated. Thus, for example, in May 2017 a report was published about the extent of integration of care for older people¹⁴. This involved additional site visits and data collection over and above that required for the individual inspection of local organisations.

4.6 Summary

In summary, it can be seen that the Vanguard NCM programme involved an extensive and well-resourced programme of both support and evaluation, designed to support implementation as well as to generate longer term learning to support health system change more generally. Building upon the characterisation of policy implementation set out in chapter 1, it could be said that the NCM support programme constituted what has been called a ‘Delivery Support Unit’ (see p7). As set out by Hughes et al (2013) in relation to the support programme for the Care Act, it was intended that the programme would embody: flexibility, responding to the needs of the Vanguards as they developed; collaborative infrastructure, with multiple opportunities for mutual support and learning; and the development of flexible products to support ongoing implementation. In the next chapter we explore the programme in more detail, examining how the different aspects were experienced by those involved.

¹⁴ <https://www.cqc.org.uk/publications/themed-work/building-bridges-breaking-barriers-integrated-care-older-people>

5 Chapter 5: Experience of the support programme

This chapter we use the data from our interviews with those involved with the NCM support and evaluation programme to explore the programme as a whole, and tease out the aspects of the programme which were felt to have been particularly helpful, and the problems or issues which were encountered. We also draw upon data from the survey of Vanguard leads carried out by the National Audit office (NAO 2018), with whom we collaborated. We look across the programme, exploring thematically across the different elements of the extensive programme, before exploring the extent to which those involved perceived that the programme goals had been achieved.

5.1 Approaches and programme elements identified as helpful

It was found that cross cutting the main elements of the NCM support programme there were some common features, mechanisms and ways of working which helped in achieving the programme's goals and supporting its operation. These included:

- The development of relationships and alliances, incorporating learning and feedback;
- Communication;
- Strong local and national leadership;
- Availability of expert knowledge and skills (within and outside the programme);
- Flexibility within the programme – proactive and reactive;
- Good level of funding (across the programme elements).

5.1.1 The development of relationships and alliances

Local health and care systems are inevitably complicated. However the system is structured, care required by individuals will require co-ordination and cross-boundary working by a variety of individuals. At the same time, the system is multi-layered, with complex accountabilities (Checkland et al., 2013), reporting requirements and governance processes. One of the key roles of the NCM Vanguard support programme was seen as being the brokering and support of relationships within and between the different 'layers' of the system.

"New Care Models, I think, yeah, the New Care Models programme has emphasised that sort of relationship building. [...] you know, you can't do it overnight, but you can actually do it I think a bit faster... [...] And I think perhaps that's been one of the successes of the Vanguards, it's kept an emphasis on relationship building but it's also done something that's speeded up what is a difficult process." (ID027)

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. They provided a platform to build buy-in to new developments and help overcome any difficulties. Relationships were important throughout the system. Table 9 sets out some examples.

Table 9: types of relationship highlighted as important

Relationship	Purpose	Issues
Within Vanguard sites	Working together at local levels to develop a proposal, implement new ways of working,	Some had not worked together previously
Between Vanguards and their wider health economy	Vanguard has to contribute to wider HE plan	STP development and their control over Vanguard funding (if failing)
Between account managers and their allocated Vanguard sites (geographical)	Support to Vanguards by individuals that know the site, facilitation of relationships to national and regional levels, with ALBs etc	Day to day interactions, facilitation and overcoming difficulties vs monitoring, feeding messages down to sites and up to national actors,
Between Vanguards and those providing advice, knowledge and information	Timely provision of advice, knowledge, guidance and support	Clarity and availability of information, knowing who to contact
Between Vanguards (types and geographically)	Mutual learning and sharing	Geographical spread, overburdening of those seen to be 'doing well'
Between those making policy (NHSE team) and those involved in supporting or implementing it	Provision of guidance, help and support in a timely and clear way	Top down vs bottom up developments, imposition vs evolution
Between those developing NCM policy (NHSE team) and the wider policy actors (DH&SC)	Sharing learning, development of policy which join up	Silo working in civil service, job stability, longevity of policy

Within Vanguards, it was clear that the particularity of local relationships was important. Thus, for example, having worked together before, or knowing one another having worked in the same area for a number of years were acknowledged as being important. However, our interviewees acknowledged that the business of developing and sustaining relationships within Vanguards is both important and not fully understood. They were concerned, in particular, to understand how good relationships might be fostered even in the absence of this prior knowledge and experience of one another.

So it's just the more complicated ones that we're trying to work out, well, if you can't have these two people who went to school together and know each other 20 years, what is it about the characteristics of their relationship that you might be able to simulate or you might be able to compensate for, and is that viable?" (ID011)

Account Managers were seen as having a particularly important role in relationship brokering at all levels. In the NAO survey, 22 out of 23 respondents described themselves as being 'satisfied' or 'very satisfied' with the support they received from their account manager. For these people, a long history of working locally in the NHS was seen as an advantage, bringing their reputation and local knowledge to the role:

The account managers, because at the time we wanted to support, challenge, enable, quite tough love, they needed to understand who they were locally and they needed to be able to build relationships locally. So we invested in people who had direct relationships with the Vanguards because, of course, I know most of them but I actually didn't know their day to day. I think we did that really well and that was regionally based.... [ID 001].

Their role was described to us as including: ‘critical friend’; bridging between local and national teams; brokering relationships (they were described by one interviewee 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.

[A]ccount management function. When that’s previously been evaluated, the account management support has been rated very highly by Vanguard. 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, including:

- Establishment of communities of practice;
- Regional and national events;
- Use of social media, including Whatsapp groups and twitter;
- The online FutureNHS Collaboration platform.

Communities of practice (known in the programme as ‘learning communities’) were formalised and met on a regular basis, including those Vanguard who did not receive ongoing funding. In the NAO survey, communities of practice were highlighted as particularly valuable, with 20 out of 23 Vanguard lead respondents responding that they were ‘very’ or ‘quite’ useful. The scale and scope of the community of practice activities varied and each model was separate from the others. However, over time, as the similarities between the MCPs and PACs became more evident, they became one community of practice. 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, as opposed to the infrastructure or the leadership, or something like that, what difference it had made to patients, so that was really good” (ID 002)

Alongside these formal communities (which were designed into the programme), more informal communities grew up around specific functions and issues. Thus, for example, the communication and engagement leads for each Vanguard established a WhatsApp group, and the Account Managers held monthly meetings to support each other and share information on what the Vanguard were doing and what they were achieving.

I heard [XXX Vanguard] had exactly the same problem and they did this. Can I get you case studies? Can I help you with that? so that kind of conversation just takes place all the time (ID 023)

The account managers themselves set up a relationship between each other which was more like a community of practice, where they got eventually. I think the first year they struggled a bit but after that they got to a place where they knew each other, they could share a view. They could just send an email to each other and say, has anybody got x? (ID 023)

In the spirit of open learning, Vanguarders were encouraged to visit one another. However, this quickly became unmanageable as those seen as most successful or high profile became over-burdened with requests. As a result, open days were arranged instead. This over-reliance on a small number of 'good news' stories, potentially represented a degree of tokenism as it became more important to visit successful sites than actually learn from them.

They all committed to doing showcase events, and that still happens, each of the sites opens their doors to anyone who wants to come to see them, or have a conversation with them. What we found in the early days, was that that was okay, people would just be able to pick up the phone and have a conversation. As sites became more well-known, and more well-known for certain things, like the 'Red Bag' or something like that, that is now nationally known about, we had to be a bit more canny about how that was delivered. So, they had open days then, as opposed to inviting someone to come and see them. It became more a, this is the day that everyone will be here, please do come and see us on this day, because then we will showcase what we're doing (ID 002)

However, the geographical dispersion meant that few Vanguarders received visits from outside their own region. Overall, Vanguard showcase events were highlighted as 'very' or 'quite' useful by 17 out of 23 respondents to the NAO Vanguard lead survey.

In addition to the Vanguard open days, regional and national events were organised. Some of these were facilitated by external organisations, such as the Kings Fund and the Nuffield Trust. These were focused on particular issues, such as contracting, or were more general, for example, model types e.g MCPs and PACSs or bringing all the Vanguarders together.

We held a Vanguard event and so did the North...where we brought all the Midlands and East Vanguarders together and invited a wide range of stakeholders to come and hear what the Vanguarders had been doing. That was geographical...I don't think the London and South have done that, but the North and the Midlands and East have (ID 021)

We also had events for them either at a national level or at a work stream level where that sharing was happening, so comms people, communications and engagement people would come together, and they would deliver and they would share (ID 009)

Respondents told us that, whilst multiple modes of communication were used and valued (such as webinars, tweets, newsletters, emails etc), face to face meetings had a special role in developing trust and relationships at all levels. Webinars in particular were regarded as less useful by respondents to the NAO survey, and events which allowed the sharing of best practice between Vanguarders were regarded as most helpful. However, face to face approaches obviously come with associated costs, not least the need to release busy staff from their normal roles in order to attend.

5.1.2 External communication

Over and above the internal role of communication in establishing and cementing relationships at all levels throughout the programme, the national support team also focused on communicating with external audiences. The focus of this was upon highlighting the achievements of the programme, and included ensuring opportunities for Vanguarders to present at national meetings, as well as disseminating stories of success via social media such as Twitter and on the NHSE website. Visibility at national events was seen as important to showcase the Vanguard approach and highlight successes:

Every time there was an Excel or an NHS conference in Manchester, these big ones every year, actually on our stalls we had all these people for the new models presenting, and that was novel too. So you don't have Simon Stevens or any of these people at the top just getting up and making speeches (ID 017)

Account managers were expected to canvass their local sites for 'good news' case studies that could be widely disseminated and local representatives of Vanguards were encouraged to take every opportunity to showcase what they were doing. It was explained to us that the aim of these events and of an active social media presence for the programme was to create a 'buzz' around the programme, which was said to be important in supporting local enthusiasm and engagement. It was argued that highlighting successes and progress would encourage local teams and generate ongoing enthusiasm.

5.1.3 Local and national leadership

As might be expected, leadership was seen as important at all levels of the system, from those developing the policy, through to those supporting the NCM programme to those implementing the changes on the ground at Vanguard sites. Having a clear driving force at national level with clear support was seen as important and we were told that this element somewhat faded during the last 6 months of the programme, as those in NHSE supporting the programme started to move into other roles. Respondents suggested it was important for those leading the programme as a whole, alongside those leading particular models (MCPs, PACS, ECHs etc) and enabling streams to show commitment and buy-in

yes, and 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. (ID 007)

Many interviewees emphasised the particularity associated with leadership – exactly who is in a leadership role matters, as this shapes both how they are seen and how they react 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 in April 2018. This was well-recognised in advance by the support programme, and the acknowledged and established existence of strong local leadership was said to be a facet of the initial decision to admit sites to the programme:

I think that the majority of the Vanguards were chosen because they had a history of successful transformation and re-design...had the capability and leadership within their organisation to do it (ID 021).

In addition to local leadership – embodied in senior local figures, committed to the Vanguard project – it was also argued that successful Vanguards required a strong management structure, including individuals able to lead the hard day to day work of supporting change:

some of it was 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. (ID 023)

5.1.4 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 with the ability to tap into a wide ranging research base. Seconding people into the programme with expert knowledge and utilising an advisory group were seen as positive and the development of new methodologies e.g. those developed by the IAU.

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" (ID 014)

However, supporting work streams were seen to be of varying quality and were not always available at the time most required due to Vanguards all developing at different paces and having different specific needs. Co-ordination of the different sources of expertise and knowledge was facilitated across the programme by using individual sites visits, workshops, webexs etc. The high profile of the programme ensured additional external expertise and support with, for example, The King's Fund contracted to provide some elements of support. Other think tanks such as the Nuffield Trust arranged external learning events, as did conference providers such as the Westminster Forum and The Policy Exchange. At many of these events, local Vanguard leaders were invited to share their success stories. Respondents to the NAO Vanguard lead survey reported that, in general, the advice they received from national bodies was consistent, although issues were identified with the sharing of information about funding and regulation, with the rapidly changing context acting to make such areas particularly complex to understand. Support for designing care models, including help with the logic modelling process and the creation of 'value propositions' was valued, with 17 out of 23 respondents to the NAO survey reporting that they were 'satisfied' or 'very satisfied' with this support.

In addition to access to individuals and groups with expertise, the FutureNHS Collaboration platform was intended to be a live resource, bringing together evidence, and fostering an open approach to sharing local experiences, supporting local sites who were, for example, trying to do similar things. Whilst it was valued, some found it difficult to use, limiting its value in fostering and sustaining relationships. Access to the platform is wide, extending beyond Vanguards to STPs and Pioneers, with over 20,000 individuals signed up for access. It was tracked monthly for the number of hits and its use increased substantially over time. It included case studies of the sites, evaluations and learning resources. Again, there seemed to be an emphasis on sharing successes:

We've been identifying some groups of Vanguards who are kind of ... perceived to be particularly good at one element of the care model, and asking them to kind of, as a group, with representatives from NAHSN and a representative from NICE usually, and a couple of people from the programme, kind of come up collectively with some sort of resources for others, basically (ID 008)

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 a, this is the collected view of the MCPs about how you should best do risk stratification, for example (ID 008)

The FutureNHS Collaboration platform was established to support the development of 'communities of practice' and knowledge sharing across the programme. In keeping with this 'bottom up' ethos, its use grew organically, without had a great any strong central direction. As a result, much of information uploaded by Vanguard sites was not very well organised nor searchable. As a result it did not 'stand alone' as was intended but needed a navigator:

What we usually like to do, is for someone to have a conversation with that individual first, so that, a, someone with some knowledge and understanding tries to understand what the person's looking for, and they can signpost them. Because actually, there is so much on that platform now, that you'll get lost if you don't have that signposting up front, depending on your knowledge of what's happening within the programme itself (ID 002)

More recently, there has been an attempt to organise it, primarily for the purpose of providing a resource as part of the legacy of the NCMs. Whilst this re-organisation of FutureNHS Collaboration has been too late to be useful to the Vanguard as they were developing, it is intended that the resources will be valuable for other areas which may decide to develop their own new models of care.

We've been pulling together a big database of case studies, because we had sort of snippets here and there but, you know, in terms of the kind of quality and level of detail of what we were getting back, it wasn't always fantastically useful. So over the past year, we've, yeah, kind of gathered those case studies in greater detail and put them all in the same place and made it searchable, which I think is good (ID 008)

A robust evaluation programme was widely acknowledged as having been very helpful for the programme overall, both in terms of supporting Vanguard in understanding 'what works' (or doesn't work) and in providing external credibility for the programme. Both the IAU and the NCM evaluation team 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, much more along the advanced end of the methods than you would ever see NHS England implementing it. And so I think they are much stronger study designs than NHS England would produce themselves (ID 029)

5.1.5 Flexibility within the programme – proactive and reactive

The support streams for the Vanguard were designed to be both proactive (using pre-established work streams) and reactive (evolving over time). The 8 spokes of the work streams used at the outset of the programme was based around a template of enablers of transformation developed by the Health Foundation. At the same time, there was a system in place for support to be bottom-up and emerged from site visits to the individual Vanguard at the start of the programme. Over the course of the programme support needs changed, and flexibility was needed to deal with emerging unanticipated issues and the development of the 10 support streams (see p31):

Support needs don't often become apparent until in the actual process (ID018)

it changes as a consequence of the conversation and understanding what was needed, as the sites understood themselves what was needed (ID003)

We'd had conversations with Vanguard about what they needed, but also it was very clear in the early days some of the Vanguard didn't know quite what they would need until they actually started applying their model and developing their model and making it a reality (ID014).

This was regarded as a success of the NCM programme, reporting that “we’ve been good at listening to Vanguard, to make sure that we grow with their needs and adapt according to what they need” (ID021). This was ongoing support that was reviewed at quarterly reviews with sites.

Individual Vanguard were also expected to be proactive in asking for support when needed. Some participants highlighted that this should have been part of revisiting logic models to look at the emerging facilitators and barriers, “we probably haven’t revisited them enough over the course of the programme” (ID007) and one participant reflected that failure to be proactive in seeking help could be problematic:

The sites who have been more conservative in terms of asking for support, and there’s a [myriad] of reasons why that might be, haven’t done so well” (ID002).

Although most of the support streams did not change, the emphasis on certain streams became more or less of a priority over the course of the programme in reaction to changing needs.

So a good example of that would be the contract team and pricing side of things. People really didn’t get it in the early days because they weren’t there, they weren’t in that space of what’s the contract going to look like. But then once they got the care model all sorted and then they’ve been looking to the future and thinking, oh well, I want to commission this, what would a contract look like, then it came up through... all important (ID 022)

5.1.6 Additional funding

As we have seen, the Vanguard programme was well-resourced, both in terms of the direct funding they received and the funding available to support the support and evaluation programmes. Any assessment of ‘what works’ must 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, there was also funding in kind such as the secondment of staff to support different elements of the programme.

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...on the team. And an overall budget of about eight million (ID 006)

Evaluation was perceived as having been well-resourced, having received approximately 3% of the total resource for the programme, amounting to £10 million:

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 (ID 013)

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 and the majority of them are generic funding conditions that the programme has stipulated for all Vanguard. 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. Of course, that they deliver against their

delivery plan. So, each Vanguard has a set of funding conditions that were articulated at the beginning of each financial year. 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 (ID 021).

We will return to this element of the programme in our case studies as we try to explore value for money associated with the programme.

5.2 Factors found to be problematic

We also identified a set of features, mechanisms and ways of working that hindered the programme and its operation. These included:

- Expectations from national programme
- Oversight and performance monitoring
- Engagement with national bodies and processes (trying to make things ‘business as usual’ in relation to national bodies)
- Data availability and quality (evidence base)
- Timetables and timescales

5.2.1 Over optimistic expectations

As a flagship national programme provided with significant additional funding, the NCM 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 was only set up for three years (National Audit Office 2018 p36). Generating sustained and 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. Funding was only provided for three years, with an argument made that this should be long enough for Vanguards to become self-sufficient, generating savings which would cover any additional costs. In addition, in order to gain initial funding Vanguard sites were required to demonstrate ambition in what they could achieve.

I think they were probably more ambitious than it turns out they could be {...} more to do with just the context changing and things changing generally than being completely unrealistic, because at the time there were very strong expectations politically (ID 007)

when 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, 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. There was this whole banter around break the rules, and it was a political rhetoric...So, we set up, I think, a significant expectation about what could be done. And the support was set up in that vein as well. When we actually got into the conversations, the whole philosophy around the support, was that it was co-designed (ID 002)

These high levels of expectation exert pressure on Vanguards, which may itself militate 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. We will return in our final chapter to the tension between showing ambition and promising significant change and the hard local work of making that change happen.

5.2.2 Oversight and performance monitoring

As Vanguard units were provided with significant additional funding, the programme required them to put in place processes to demonstrate how that funding would be used and how it would generate value. However, at the outset NHS England did not want it to be seen as performance management.

So we used those to check them, check them and go through them. I think, at the end of the day, it was a new skill, we weren't just giving money out on a business case and also we were very clear this was not a performance management approach. So, yes, they had to be able to demonstrate any of that and they had to be able to justify and assure what they were doing with the money (ID 001)

The core of this process was the logic model and value proposition but many did not have the expertise to do this. They therefore relied on heavily on external help. Support for logic modelling was initially contracted out by NHS England to CSUs; 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. Some respondents argued that, whilst the logic modelling process was a new one for Vanguard sites, and it had not perhaps been used to its full potential, capacity and capability within Vanguards had improved over the lifetime of the programme.

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. Are we now getting to the stage where people feel they are more and more confident and that if we transfer the knowledge to them or our partners transfer the knowledge? I think in some cases we have (ID 015).

Over time the monitoring of Vanguards was stepped up, with the availability of funding for final year of the programme linked to performance against a small number of metrics.

Whilst the Account Manager role was intended to be supportive and developmental in its focus, in some cases the account managers and stream leaders were perceived as taking on a more performance management role over time with the Vanguards. This potentially led to tensions around their roles 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 (ID 003).

5.2.3 Engagement with regulators

Engagement with regulators was not always straightforward for the Vanguards, despite the ostensible role of CQC, NHSI etc. as co-authors of the FYFV. Engagement of Vanguards with the various regulators was facilitated by NHSE via the account managers, with collective discussions of emerging issues affecting more than one Vanguard, such as emerging issues over VAT. However, not all of these could be settled, promised guidance from CQC was not published, and regulation still occurs separately for individual organisations. However, as we noted early, CQC has recently started issuing reports which look at the extent and effectiveness of cross-organisational collaboration

within health economies. Thus it seems that, 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 (ID 020)

Those we interviewed told us that current legislator framework governing their work was not ideal:

If any of us were trying to draw a regulation system that would work really well for the New Care Models and Accountable Care Systems, we wouldn't draw the one that we've got, but it is the one that we've got for now (ID 008)

We're finding ways to work around and test the boundaries of what we can do within the current system. And regulation is one of the harder things to really change within the current system (ID 008)

Some thought that ALBs, especially regulators, should be more proactive within the system to help its future development. For example, not just inspect but also help with future improvement:

one of the roles of CQC beyond inspection should be around improvement, because they will have unique knowledge of what the good things are other people are doing, and actually what they ideally then should do after an inspection is say 'well, okay, here's our findings', but then almost come back a week later and say, 'and by the way, for your next inspections you might want to think of doing these things and focus on the improvement' (ID 017).

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:

[They said] if you just talk to us in CQC we'll help you. And I think they have. I genuinely think they have. I think they've bent over backwards to understand what we're trying to do while still keeping it safe. They've been very open and honest (ID 023)

I always found the CQC very thoughtful, very open and really thinking through what future regulation looks like (ID 001)

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. And they allocated people per Vanguard to say these would be your contact with us and, therefore, as you start to build your new module, we can ensure that what you create at the end is something that we can regulate (ID 009)

However, the process had been difficult, requiring flexibility. This interviewee pointed out that the variability within the Vanguard programme 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. It was pretty clear that that's not how it's happening and that actually we're getting a range of different kinds of models varying across the country. So actually, 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" (ID 008)

Furthermore, CQC did not necessarily know which organisations were part of Vanguard:

We spent quite a lot of time just identifying which sites are linked with Vanguards, particularly the enhanced care homes, and [we've] set up on our system a way of trying to identify them (ID 019)

Finally, although there would be no direct regulatory impact if one organisation within a Vanguard failed an inspection, this might prompt the CQC to look at other organisations within that Vanguard

It probably would raise a concern and we'd want to look at some of the other organisations (ID 020)

There was also a perceived risk that different regulators (e.g. CQC, NHSI) across the system which touched Vanguards were giving different and sometimes incompatible advice.

5.2.4 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 (ID 002)

In the NAO survey of Vanguard leads, 12 out of 23 respondents reported that IT issues had been a barrier to their progress. This was an area in which it had been hoped at the outset 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 have developed different solutions, based around local organisations interpretations of data sharing rules and legislation. These sometimes differ, as do local norms around data sharing issues.

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:

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 from the NCDR happening properly (ID 029)

5.2.5 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 Vikings 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 at most ACOs in the US the greatest benefits have been seen in the primary care ones who basically had very little in terms of accountability or integrated care. But, if you look across all types of ACOs, 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 back to my point around fewer Vikings. Five year experiments with a view to then working out what the next five years looks like, so almost a five year forward view part one, five year forward view part two. (ID26485)

Implementation of Viking care components continues to be ongoing, with 8 respondents to the NAO Viking lead survey suggesting that implementation would continue into 2019. Some of those responding to the survey highlighted the short timescale of the programme as a challenge, suggesting that time is required to build the relationships necessary to implement change across organisational boundaries. This need for rapid implementation could lead to issues with the availability of staff with the relevant capabilities (some of whom had to be recruited), with 6 Viking leads responding to the NAO survey highlighting 'organisational capacity' as a challenge. Some respondents also reported that staff were required to 'double run' some services, carrying out their usual roles as well as undertaking new duties associated with the Viking.

Local evaluations also had to be procured rapidly, 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 (ID 009)

So the programme was launched in January, we then launched the Vikings in March time. We didn't have a team, we didn't have people, so we were trying to do everything very quickly when the Vikings were launched (ID 009)

By the third year of the programme, there was perceived pressure to demonstrate tangible 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. But there is that slight...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. But if we want to look back in a decade and see it's changed, we've got to hold our nerve and we've got to give them the space in order to make those changes. (ID 022)

5.3 Perceptions of the programme's achievements

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

The second thing I think it's really done is externally I think it has done a combination of disrupting the system by creating something different and thinking different, so outside when I talk to people, they're very excited about New Care Models, they're very excited about the changes, and they start to say, well, we're doing this and this, we're doing this, we're doing that, and they're taking on elements of what we've described here. The other half to that is I think not only is it disruptive, but it's actually given realistic hope to people. So one of the things I would reflect on talking to people is how grim it is, and people tell me about how hard their jobs are and how grim it is, and how little fun they have at work, and then what I then hear when people talk about this is they're alive, they're excited, they're reconnecting with why they came to work in the morning. [ID007]

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. [ID 002]

This bottom up sense of excitement and energy was repeatedly identified as a key outcome by staff at all levels within the programme, particularly those with most contact with Vanguard sites. This went hand in hand with a feeling that, whilst hard numerical data about performance against outcome metrics were important, the intangible benefits associated with bringing people together to work together in new ways were as important. Moreover, the approach taken based upon empowering local teams to develop in their own way, had generated a feel that was different from that associated with previous change programmes:

I love the way it just feels different from what we've done before and actually potentially quite transformational, and you know, the bit I love about my job is I see clinicians particularly, very jaded clinicians who've tried other change programmes, saying to me this is why I went into this job in the first place, this is why I became a doctor, this is why I became a nurse, why I became a therapist, and linked to that, 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]

It was argued that this energy and enthusiasm in part, at least, arose out of the values embraced by the programme and the supportive and enabling approach adopted:

So [we were] determined that [the programme was going to] live true to the values of enabling and supporting rather than directing. So the values of the programme around clinical engagement, user involvement, locally delivered and nationally supportedrun all the way through on everything we did, and certainly right at the very beginning. So that drives me to be clear that our role was to support and enable as opposed to the other way. So that's where we started. [We were] also clear that this had to feel different and it had to feel different because it's exciting, it's new and, therefore, it's scary, it's frightening and it's not something that necessarily...if we're really going to fundamentally change the way care is delivered across whatever that patch is then you

have to want to be able to do it. And you have to be able to criticise your organisation or constructs.[ID 013]

So worked well I think the way the programme was set up, the way that we set out our kind of values and the way that we wanted to support the sites. So this wasn't a top down imposition of a national model, it was, you know, trying to empower the local leaders and the clinical leaders, and nationally sort of being subservient slightly to the local leaders in terms of them telling us what support they wanted and, you know, us saying at a national level, we are here to do the things that only need doing once and to escalate your national issues, but we're not actually here to tell you what to do. And that's I think really made it feel different on the ground is the feedback that we get, you know, in terms of the Vanguards themselves, what it's felt like to be part of the programme and what, it's let them...it's given them the kind of permission to get on with stuff. And although all of that stuff sounds sort of fairly obvious, it's actually not the way that most national programmes run.[ID 008]

However, a distinction was made between the success in generating enthusiasm for change in the Vanguard sites, which was felt to have been significant, and the more limited progress towards developing a set of defined care models. 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. But it was so much of the emphasis was around the infrastructure and broader things you need to get in place to help things go ahead. 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? And try and draw those out and summarise them in documents and say, look, there are the core building blocks that you need to have in place.[ID 018]

However, working in this way inevitably results in a wide variety of different approaches:

...and they've done some exhaustive work to try and classify things; so I'm in touch with [the evaluation team] as well because I think it's going to be quite a crucial thing really. If we can try and pull out some sort of classification of the different things that people are doing, that that's going to make the sort of overall story easier to tell. But it is proving difficult, partly because some of the things that they are doing...particularly looking at the logic models and the value propositions and things, are quite poorly specified. [ID 024]

Moreover, this difficulty in classifying what was being done locally made the development of 'products' or frameworks which could be rolled out more difficult:

There was inevitably an element of organic emergent design of the different models, which is why we partly said look, there's some key themes that we produced a document which set out the different elements of the support package early on and some of the things people were trying to do, and then we said we would construct the frameworks

through the act of doing with things like the MCP and the PACS framework and the care home framework. So there's an element of how do you construct some prototyping and to what extent you get the design principles versus more detailed operational blue printing as you start to think about wider spread of change. A personal reflection of mine is that I think on balance in this really tricky challenge of how do you unlock clinical engagement and energy verses generate reproducible models I think we probably veered too much towards...this is in hindsight, we veered too much towards the local tailoring and insufficiently tightly towards the construction of more standardised methods that multiple sites then were trying to trial. [ID 012]

This senior manager involved with the programme highlighted the different skills required for generating reproducible models than were required to generate local enthusiasm and buy in:

...actually, I'd quite like to get some evidence about the best operational methods, say, for running an MDT, including the clarity of the expected benefit and the real world financials on this. So what did strike me I think is a huge gap still and I don't think Vanguard programme fixes is a proper discipline around the almost engineering piece on the way in which they operationalised things. So I think you need the charismatic leadership to be able to get people willing to transcend their own management boundaries and redesign care, and that's brilliant and important, but you then often need quite a different skill set to be able to say right, actually, if we're now going to run it here's the minimum efficient scale, here's the caseload and so on.[ID 012]

The FYFV and subsequent documents put some emphasis upon the development of new forms of contract to support new care models, but interviewees highlighted the complexities of this process, explaining that actually much could be done without formal contractual change:

And they've made amazing progress and they've published the contract, but actually it's really hard. And a lot of the Vanguard sites, you know, big novel contracts in the NHS are really risky and a lot of people are not, you know, necessarily too keen to be the first ones to have a go....But it looks very different now to what we'd envisaged at the start. I don't know if that's necessarily good or bad. It has created a little bit of...it's taken a bit of kind of explaining from...you know, rationalising basically why actually you can do a lot without having to go through a contracting process. And yes, ideally, we still would because it gives a different level of robustness and stronger incentives but, you know, even if that's not a realistic option for you, you still do the care model. [ID 008]

It was acknowledged that designing a more concrete and specific care model was easier in the Care Home Vikings than it was in the more broadly focused MCPs or PACs, with the six care Home Vikings regarded as a tight knit and coherent group:

I think there are certain areas like the care home piece where we've highlighted a much bigger set of challenges, and we've got a load of people who are now driving this irrespective of the Vanguard piece and moving towards some of the more actionable elements of the 20 point care home Vanguard model. So moving towards single GP per care home, realising because of our ready reckoners and the things that we've been doing on meds management the extent to which there are quite easy pickings through tackling avoidable polypharmacy in care homes by just getting pharmacists in there and doing meds management reviews, hasn't really happened before. .[ID 012]

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. [ID 013]

In summary, therefore, our respondents suggested that the programme had been very successful in generating significant enthusiasm and activity on the ground, but less successful in turning this into some sort of products and frameworks which could be straightforwardly rolled out.

5.4 Summary

In this chapter we have explored the perceptions of those involved of the support that was provided and highlighted the elements which were perceived as having both supported and inhibited the programme across the support streams and different programme elements. A very significant element of the programme was the facilitation of relationships at multiple levels. Account managers played a very important role in this. Multiple approaches were used to support and develop these relationships, but face to face meetings were highlighted as being particularly important. However, these are costly, both in terms of organisation and in freeing up staff to attend. The workstreams were regarded as important in providing expertise, with high-level engagement with CQC regarded as particularly helpful. However, the variability of Vanguard models and the existing legislative framework has meant that regulation and inspection of collaborative working within Vanguards is an additional regulatory obligation rather than replacing the regulation of individual organisations. The sharing of resources on the online FutureNHS Collaboration platform was regarded as helpful, but the sheer volume of available resources may be an issue in the search for codified frameworks, with a simple search on the FutureNHS platform for 'information governance' revealing 17 pages of results. Many of these are documents from individual Vanguards detailing their approach to developing a shared local record. There is not, however, an easily retrievable definitive guide to the issues involved. The over-arching evaluation programme was perceived to be well-designed and helpful to Vanguards, and this judgement was confirmed by the National Audit Office report on the programme (National Audit Office, 2018). The impartial nature of the national elements of the evaluation (including the data dashboards and the IAU) were felt to be helpful, as was the rigorous approach to assessing outcomes. 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. 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. The linkage of funding to a small range of measures in the third year of the programme was felt to be problematic, putting pressure on Vanguards. It was argued that these narrow metrics were not necessarily in alignment with Vanguard's locally developed goals.

Those we interviewed were fulsome in their praise for a programme which was regarded as being genuinely 'bottom up' and facilitative, with the generation of significant local engagement and enthusiasm frequently remarked upon. However, senior managers acknowledged that the aspiration to generate replicable 'models' of care which could straightforwardly be 'spread' more widely was not achieved. At the time of writing, although model contracts have been produced, no contracts have been let to new forms of provider organisation based upon new care models.

6 Chapter 6: Cross theme analysis: understanding the programme as a whole

In addition to the specific issues relevant to the different aspects of the support programme, we also found a number of issues arising across the interviews. In this chapter we explore these issues, with a particular focus upon what they can tell us about future approaches to policy implementation.

6.1 *Being a pilot: licence to do things differently?*

We have highlighted the fact that the programme set out with ambiguous goals as to what New Care Models should look like. The Vanguard NCM programme was seen as representing an opportunity to do things differently, in keeping with its status as a 'pilot'. This was an aspiration that was genuinely felt by those supporting the Vanguards and by the Vanguards themselves. This difference was evident early on during the selection process, the way in which support was offered and ultimately in the design of the Vanguards. Many of those involved at a senior level within the programme had worked at senior levels in the NHS for many years. All emphasised how different this programme felt to others in which they had been involved:

There was an attempt to do something differently compared with previous transformation programmes and there's a lot that seems promising in the approach that was taken (ID 030)

That was very different to how we normally do it, which is everyone sends in a massive form, you get together a committee (ID 027)

This desire to do things differently was based on an explicit set of values around clinical engagement, user involvement, local delivery and national support. There was a clear commitment to a bottom-up approach with an emphasis on co-production:

It was a bottom-up rather than a top-down thing, so the idea was to get the Vanguards to say what it was that they were doing, and then support them in doing what they're doing and trying to break the barriers down that were stopping them from doing what they wanted to do. Almost trusting them that they knew what the ideas were, and it wasn't that they needed telling from above. They needed supporting in clearing all the obstacles out the way to allow them to do what they needed to do (ID 006)

This new approach to transformation programmes, created a real buzz early on:

generating a bit more energy and enthusiasm than we normally manage to do for any of our centrally driven Initiatives (ID 027)

There was a sense that the programme was developing something innovative and experimental which had not been done before and a collective ethos and a level of ambition which was meaningful and appreciated.

Some of these whole system models I think the good thing about having the breadth in the sample size if you like was that those different areas of the country, it was basically a set of experiments and they were doing different things (ID 028)

However, 'doing things differently' sometimes involves acting outside established norms and ways of working. This meant that those supporting Vanguards were required to have the confidence to support Vanguards who might have been breaking with established approaches. This suggests that such programmes require support from relatively senior managers who are able to take responsibility for acting outside existing norms. This can be problematic at times with, for example, two respondents to the NAO Vanguard lead survey reporting that they had received inconsistent advice from regional and national levels about what they were allowed to do.

As the National Audit Office Report (2018) pointed out, the Vanguard NCM programme represents one in a line of initiatives designed to facilitate and support integration. Our interviewees were keen to point out the ways in which this programme differed from previous ones, in particular the Integration Care Pioneer programme which immediately preceded it.

The pioneers programme is free jazz, i.e., everyone play how you want to and just make beautiful music, and let's see where we go. Whereas the Vanguard programme is a little bit more classically orchestrated, in that we want, certain people have got jobs, and there's a certain thing that we want to be seeing emerging from the programme. So it's a lot more defined and honed (ID 009)

I think having care models, care model leads and dedicated resource to look at particular types of change has been really powerful, again contrasting to the Pioneer programme where there wasn't a clear archetype or a clear type of model (ID 007)

Vanguards were meant to be more sophisticated in terms of analysis than Pioneers, they were given quite large budgets to help with evaluation, which a pioneer didn't get. And it looked a rather more structured approach... to ensure that they learned something from them (ID 026)

In spite of this perception of licence to be different and to innovate, a high proportion of the Vanguards were funded for developments that were not new but were already in existence, with 16 out of 23 respondents to the NAO survey reporting that their Vanguard included existing as well as new initiatives. Indeed, 6 out of these 16 sites had also been part of the Integration Care Pioneer programme (National Audit Office, 2018). In this sense, there was less innovation, rather the opportunity to gain funding and support to accelerate the development of existing models. Being labelled as a Vanguard gave the sites national recognition, which made applying for the programme even more attractive. This does not seem to have been an unintended consequence, since organisations known to be developing new ways of working, were approached directly and invited to apply for Vanguard status.

My sense is that there was quite a lot of that going on, because these sites know how to play the game. The one Vanguard that I did visit as part of the selection process, I was left with the impression that a lot of what they were doing they were doing anyway (ID 013)

My experience is for the vast majority, so if I was going to do a split, I'd say it's a 75, 25. 75 were already doing something and this was, you know, the jet fuel to push it along (ID 022)

Also, the branding was very impactful. Being labelled a Vanguard had a significant impact on them being able to push forward and make progress (ID 022)

Thus, the programme was clearly designed to support 'bottom up' development, and was experienced as being different from other previous programmes. As part of this, individual Vanguards were encouraged to establish and monitor their own local performance metrics. However, over time, there was a shift away from a bottom-up approach and the freedom of the Vanguards to develop in their own ways was reduced, in part due to an increasingly hostile financial climate, and because the programme as a whole was seen as needing to prove its worth. This was given official force in policy documents with reference to Vanguards 'earning their passage' (NHS England, 2017 p47). This resulted in greater pressure to deliver key metrics around hospital admissions and bed days, rather than specific local metrics set out by the Vanguards, which became a condition of ongoing funding. Thus, whilst the programme set out with a very broad-brush approach to desirable outcomes, framed around efficiency, this was, in the latter half of the programme translated into a narrow focus upon two particular limited measures of efficiency.

We started off in a developmental programme and we've ended up in more of a performance management programme. And I think that's just the timing between when we started, when things were a little bit better financially, to where we are now which is as bad as we've seen (ID 006)

There is some ambiguity around whether these metrics were specified at the beginning of the programme or developed during it. For some, they were explicit from the onset:

The emergency admission metric was actually defined by the Vanguards. Every single [one] said they were going to reduce, absolutely, the emergency admissions, right? That is a fact. However, the extent to which they were led down that path by national leaders, I don't know (ID 009)

The metrics were clear all the way through, so the Secretary of State was very clear that he wanted emergency admissions and emergency attendances as the key metrics and that's, of course, right (ID 001)

For others, this was not explicit and there was a sense of moving the goal-posts both in terms of the hospital admissions metrics and linking these outcomes to ongoing funding.

On the third year as we moved into that, expectations around them delivering certain things at a local level were added in that maybe we hadn't communicated to them previously.... So we changed, rightly or wrongly, the goalposts for them and I don't know how far in advance that was communicated with them (ID 009).

Some Vanguards would actually argue that we were never set, you know, to think about emergency admissions, you know, there is more we are doing. But, if they haven't reduced their emergency readmissions then they will be penalised for that (ID 015).

This shift in focus from bottom up development to performance monitoring and potential intervention led to some tensions for the programme. The commitment to learning and spread generated a lively traffic in 'case studies' and public endorsement of particular Vanguard 'successes'. However, when the more narrow metrics were focused upon, some Vanguards lauded as having been particularly good were found to be not meeting these specific targets.

Thus, Vanguards were pilots that fulfilled all of the 'purposes' ascribed to piloting by Ettelt et al (2014) (see p24). The programme was underpinned by an explicit intention that Vanguards were 'early implementers', who would pave the way for national roll out, whilst at the same time the

encouragement of health economies regarded as already well advanced in integration suggests a simultaneous desire for 'demonstration'. These approaches required early championing of perceived 'success'. Finally the architecture of the programme, with an emphasis on doing things differently and on learning and feedback suggests that piloting for learning was also an underlying intention. At the same, time, as we have seen (p49) the evaluation team established their programme in such a way as to suggest piloting for 'experimentation', with this element of the programme clearly not assuming superiority of the Vanguard's approaches over the status quo. Furthermore, the emphasis in the last year of the programme on performance management against a narrow range of metrics highlights the need to show value for money. However, at a policy level the decision to further roll out new care models was taken regardless of the evaluation results, raising questions about how those results should be used in supporting the future development of new approaches to care provision.

6.2 Temporality, sequencing and timing

In keeping with the potential tensions embodied in the multiple purposes underpinning the set up and development of the Vanguard's, time also had multiple meanings. The programme was both 'long term' and 'too short', with a very real tension between a narrative that emphasised long term and meaningful 'bottom up' change and one which required the demonstration of results within a timetable which satisfied the political needs associated with the programme.

The pace 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 Vanguard's 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. This meant that although things were agreed quickly, there was often a lag getting things formalised and having the workforce to achieve this:

I arrived ... when the programme was [already underway]. But, it was unbelievably...immature is not the word, but not well...it was very formative at that stage....So, they were grappling with policy issues about contracting or about workforce, that...they were just talking about them, there wasn't lots and lots of action. (ID004)

So the programme was launched in January, we then launched the Vanguard's in sort of March time. We didn't have a team, we didn't have people, so we were trying to do everything very, very quickly when the Vanguard's were launched. We also knew that we had a short period of time to deliver to them as the full package. (ID009)

The speed of development also led to issues of sequencing. By this, we mean that parts of the programme did not necessarily develop in the intended order. For some participants, this led to concerns that perhaps the enthusiasm for the programme came in advance of evidence on whether the programme was viable or valuable:

Everything has happened unbelievably quickly. Commitments made to roll-out work were made within about three, six months of my arrival. Before there was, really, a shred of evidence that this new way of...I mean this is before we even knew what a...if an MCP was an actual thing. Were the Vanguard's doing something that was unique and different, or just a collection of things that sounded good to do, because of that sort of logic model thing? So, that commitment was made, just unbelievably early, but by quite senior people... So, everything happened so quickly. I would argue, far too quickly, but because we just...we didn't really know anything. (ID004)

There were additional issues in sequencing as certain aspects of the programme were prioritised during the first year whilst others were delayed until a later date. For example, a number of participants highlighted that necessary guidance about the different care models was not published until the programme was underway, with an early focus on contracting which was unhelpful:

There was a focus on contracting rather than defining the care model. I think the actual thinking is still not always happening in the right order. Because you want to do all that thinking before you start thinking about contracts (ID018)

One of the biggest lessons learned...is the development of the Care Model Framework. So, you know, this was about a year into the programme after the Vanguard were up and running, saying, okay, this is now actually our working definition of what an MCP is (ID008)

Now my personal view was that define the model of care, define the impact to the workforce, define a contractual mechanism of doing that is the right way of doing it, but in that order but definitely not starting with the contractual element of it. (ID001)

Instead, Vanguard often had to work flexibly to continue progressing without necessary guidance and wait for the wider programme to catch up. This was problematic when the NCM programme was perceived to be rushing ahead without thinking things through:

A lot of people are rushing...hang on a second, first of all work out what those things are that you're going to do, and make sure you have sufficient attention on that (ID008)

In addition, NHSE commissioned a number of rapid evidence summaries which brought together the evidence relating to the most common interventions planned by Vanguard, including multidisciplinary team working, risk stratification approaches etc. However, the initial rapid pace of the programme meant that Vanguard were required to set out their logic models and 'value propositions' before these were available, limiting the extent to which Vanguard had easy access relevant evidence.

The pace at which things were required to move was also challenging given the size and spread of Vanguard. One such issue was the large amount of variance in preparedness across the sites. Some sites were seen as "starting from a sitting position" whilst others were "already jogging or running" (ID003). Reflecting on the programme, some participants felt that trying to get all the Vanguard up to speed and running was too ambitious:

In hindsight, I mean, if I were doing this I would probably say fewer Vanguard and give them more of a budget to actually bring about that change. And accept that it will probably take about three to five years to bring about that change (ID015)

In addition to the speed at which the programme was required to get up and running, respondents reported that the expectations about the length of the programme and the delivery of outcomes from Vanguard changed over time. Most participants emphasised that ethos of the Vanguard NCM programme was unique in its focus on long-term transformation:

At the start of the programme there was a very, very strong message that transformation takes time (ID018)

However, there were different definitions of what 'long-term' meant. For some participants, the Vanguard NCM programme was part of the wider FYFV and should be viewed within this time frame:

The Vanguard was promised the five year funding...it was a five year programme based on a five year funding strategy. So what I was saying is there was a five year programme that we're not anywhere near five years in an agreed strategy, a funding and programme and everything for five years which is basically stopping after three. Slightly tricky (ID025)

There was an agreement amongst other participants that the programme was there to develop and set-up the Vanguards without the usual NHS pressures to deliver results within that time. However, this expectation was not shared amongst all participants, with some reporting that in fact there was always the expectation that they would need to produce results within the programme itself:

The first one [year] was about setting themselves up, the second one was about delivering and understanding what they were trying to deliver and set up, the third year about delivery itself (ID002)

As the focus shifted from long-term to short-term outcomes there was frustration that the goal posts had changed:

We're too impatient, we don't allow enough time for projects to bed in. We underestimate the amount of time it needs to make this type of organisation change, and we set ridiculously high expectations to delivery, and I think that's an important part of the story (ID024).

By year three they're being asked for hard outcomes which some of them haven't even set up some of the programmes by which they're going to produce the outcomes that we want, and that was the biggest tension. (ID025)

These changing expectations about time frames led to uncertainty over the course of the programme, often attributed to the change in political context:

In practice, what we found, a very strong interest, very often politically driven, to start demonstrating results very quickly. And so, suddenly there'd be reports, the Secretary of State wants an update every Monday morning on rates of non-elective admissions in Vanguard areas, versus other areas. Well, hang on a minute. That's not how the programme's supposed to be up and running, and within a year you're starting to ask those questions. (ID018)

Public and political perceptions played a role in setting the expectations of what outcomes should be over the time, and the need to demonstrate immediate impressive change put a strain on teams:

The outside world wants whizzy, amazing innovation, instant change, quick fix, when actually what you've got is a vast number of small marginal gains over time which will make a significant difference (ID007)

However, there was also an acceptance that the speed and pace in the rollout of the Vanguard NCM programme was the norm within the NHS. For participants with a long history in the NHS it was part and parcel of the job, 'to be fair, if you've been in the NHS any length of time, you sort of ride with that, you kind of know that it will always be slightly moving and adjusting' (ID022). Part of this was a

recognition that political demands will dictate where attention, and funding, will go. Although participants recognised that some Vanguard units would naturally transition into Accountable Care Systems or Integrated Care Systems, there was also frustration that leadership had moved on before the Vanguard NCM programme was completed:

By year 3, attention had moved onto the next shiny thing... (ID013)

In turn, the three year limit on the programme meant that: “*people are slowly leaving*” (ID017) and consequently there were concerns that the demands to move on to the next thing would have a detrimental effect on the ability to learn from the Vanguard units, as staff moved to the next project. The Evaluation programme, by contrast, was explicitly designed to last the length of the programme. Given that the first year of the Vanguard programme was for many a ‘set up’ year, it is not plausible that meaningful changes in outcomes that arose as a result of Vanguard activity would be seen until the later stages of the programme. Over this time, the evaluation team, alongside the IAU, developed increasingly sophisticated approaches to determining whether any changes in outcomes seen were statistically (and clinically) significant. However, the political timetable required outcomes to be reported earlier than this, putting pressure on the NHSE evaluation team.

As we saw in Chapter 1, research on emergent, ‘bottom up’ approaches to organisational change highlights the value of demonstrable short term achievement of elements of change in order to maintain enthusiasm and reduce staff resistance. On the other hand, sober assessment of the outcomes of a particular change requires a long term approach. There is thus an inherent tension between celebrating early achievements in order to facilitate change, and the possibility that those celebrated changes may not have actually generated the required beneficial outcomes. Furthermore, the variability inherent in a bottom up emergent change programme means that the desired *outputs* – codified frameworks and ‘products’ to support spread of initiatives – were also unlikely to be achieved, at least in the short timescale of the programme. As a politically high-profile initiative, the programme was subject to significant scrutiny, exacerbating these tensions.

6.3 The nature of data and evidence

The tensions that we have identified so far also speak to issues relating to the contested nature of evidence. As we have seen, piloting for implementation and for demonstration, as well as the maintenance of staff enthusiasm and engagement requires the early championing of ‘success’, whilst experimentation requires a more sober assessment against metrics relevant to efficiency. These latter became increasingly prominent as the programme went on, leading to some contestation about what ‘counted’ in judging success:

I think there is a danger that the analysts come in, look at what can be looked at and that is not what actually matters, but the analysts end up driving decision making in a potentially unhelpful way (ID030)

Because we’re limited, at the moment we only have access to SUS data, so hospital records and patient registration data [...] So we can’t look at quality of life, for example, we can’t look at number of GP appointments (ID029)

[If] staff satisfaction suddenly went through the roof, national evaluation wouldn’t even touch that (ID002)

This is true at both local and national level, with the two levels at times producing specific tensions.

Vanguards themselves were encouraged to identify a broad range of metrics against which they wished to be judged, and these were intended to drive local evaluation approaches. Some argued that this didn't matter, because local metrics were designed for local quality improvement, rather than being about performance assessment:

And then, in terms of a local evaluation, when the strategy was initially articulated, it was very much your local metrics, you decide what you want to do and lead them. But, there is now a school of thought that, and we probably won't go to this, but certainly some folk believe we need to start thinking about how we aggregate these into something, because you have five hundred local metrics. My argument still remains, which I think will hold, I don't see any similarity in the metrics or if there is, between very few. So, what is the point of aggregating and in fact that is for actually local learning, what I would call quality improvement.[ID015]

However, a disconnect between metrics seen as meaningful locally and those pursued at national level to show overall programme performance could lead to issues. Sites which did not self-identify those measures which became the core programme metrics as important could then fall foul of the performance assessment process:

[B]ecause it's just looking at one metric, we don't see brilliant correlation in the results between the Vanguards that we think are doing quite well in terms of implementing a complete care model and seeing good evidence on other metrics and how they come out on that headline metric (ID008)

In addition to some tension around the 'what' of performance measurement and assessment, there was also tension around the 'how'. There were perceived differences between academic and practical evidence. Academic evaluation partners were criticised for being 'too academic' by some interviewees, and not focussing enough on operational implementation. .

[T]here was a disconnect between an academic view of the evaluation, and what we were looking at from an NHS perspective [...] there was a cultural disconnect (ID002)

[E]valuation is not just an academic thing and it's too important to be just viewed as an academic thing (ID001)

[O]thers were looking at it from, and this is a bias that I have ... from a very academic perspective whereas what we were looking at from local evaluation, was, what does it mean operationally? How would you then implement that operationally, and what is the impact, what are the outcomes from an operational perspective? and there was a disconnect between what an academic view of evaluation, and what we were looking at from an NHS perspective, of evaluation (evaluation lead, P02)

This perceived difference in approaches was also seen in contrasts made between local and national evaluations. It was argued that because nationally representative data were only available for a relatively narrow range of metrics, the local evaluations offered an opportunity for 'richness' to be brought back in:

[S]ome of the measures we don't have good frequent data to be able to determine whether or not the Vanguards are shifting the needle on them. So the activity measures are easier; bed days, emergency admissions. Population health measures, patient

experience measures are not collected [...] national evaluation is slightly lopsided [...] given those constraints on the data (ID003)

[T]he very serious risk that in the absence of clearly available data the national evaluation wouldn't be able to shed that much light, so one of the big benefits of the local evaluation programme is just the richness of the material that is being able to be constructed (ID012)

Alongside these quite detailed discussions of metrics and approaches to evaluation, with concern over what might constitute meaningful evidence of improvement, there was, at the same time, an active programme by which account managers and others were charged with collecting and collating 'case studies' of success. This was characterised as being about what was needed to enable spread:

I think the bit that was knottier, and was like, well how do we do this how do we share [it].... replication was a huge thing, in other words we want you to develop replicable models for other people to copy. Well, how do we begin to share that, and at what point? So, do you do two years' work, see what people manage to do, evaluate it, slowly, slowly, and then publish something, and they say, everyone, here's this thing that's been published about this thing we did four years ago, you might want a copy of that, because you want to think about certain things. Or, do we seek to do something that's a bit messier? In other words, do we just start to drip feed out there stuff that says, actually, here's some great examples of something they're doing at Symphony, here's a fantastic example, publish stuff in the HSI, saying, last week, let's do an article on what Tower Hamlets MCP are doing, to improve mental health services for people admitted to hospital, or whatever is it, you know? (ID 18)

This extract illustrates the very real tension inside the programme, as it implies that *local perceptions of what has worked* are enough to underpin their spreading elsewhere. However, not all innovations are valuable, and 'rolling out' before there has been a serious attempt to determine how far new approaches are better than what went before and in what way carries with it significant issues. This dilemma speaks to the policy piloting question, as it implies that the purpose of the pilots was to facilitate roll out rather than to determine what worked. On the other hand, the inclusion of a rigorous evaluation programme which tried to determine objectively whether there had been any meaningful improvement in outcomes implies experimental pilots, seeking to determine 'what works'.

6.4 Legacy, scale and spread

The tension between a pilot intended from the outset to demonstrate, implement and learn and one designed to experiment and determine what 'works' was also reflected in the end of the programme. The System Transformation Group was formed within NHSE before the second year of the Vanguard programme was finished, and it was only in the third year that the NCM team were moved across into this group. Interviewees highlighted the need to transfer learning across to the new focus upon ICSs. Some were sanguine about the continuity between the programmes:

And I think an awful lot of what is underpinning the thinking on Accountable Care Systems and STPs, even if people don't use the same terminology, I think it flows quite clearly, from the work we've been doing with the New Care Models. So, you know, different bits of terminology go kind of in and out of favour and that's human nature. But actually, the Accountable Care Systems are all being asked to implement population

health approaches and network with hospitals and, you know, look after people in care homes better.[ID 008]

Others were more concerned:

And that's what the new models is all about. It takes time. You cannot do it overnight. And the great pity for me is that the project comes to an end at the end of March and its biggest legacy is those changes that have been made and the skill that's developed in the health service, and I don't see any plan to maintain any of those legacies. [ID 017]

Some commented on the disadvantages of a 'bottom up' programme in allowing the development of a meaningful legacy, highlighting the lack of evidence underpinning some of the Vanguard interventions:

So I think it would have been unfair to expect each Vanguard to have the literature at their fingertips about what's the evidence of this, what essentially they should do, and so there's been a bit of reinventing the wheel locally or doing what feels like common sense rather than actually being aware of what the literature is. One of the down sides of this mantra that they're led by the Vanguards is that if the Vanguards are doing something it's automatically assumed to be correct, whereas I happen to know that the literature suggests that they could be doing things quite differently.[ID 001]

Interviewees suggested that the intended legacy of the Vanguards was not clear from the outset, possibly in part because it was intended that the first wave would be followed by subsequent waves, much as has happened in previous NHS reform programmes (Moon et al., 2002).

There was no legacy built in other than we'll produce products from the support package and then there will be the success of each of the site (ID 011)

What we're doing now is trying to get thinking about our legacy and what do we leave behind when we're not here anymore to organise lots of events and tweeting and goodness knows what else. So that's the work that we're doing in terms of our Kahootz [FutureNHS Collaboration] site (ID 014)

To date it's been about letting a thousand flowers bloom in terms of communicating what Vanguards have been doing. We're conscious that we're nearing the end of the programme, we need to get that tied down into – and the word we're using at the minute has been productised, you know, into products that people can pick up and refer to and look on Kahootz [FutureNHS Collaboration] for, oh, you know, we think we want to do something about x, y, z, they can easily find it (ID 014)

The NHSE evaluation team used their experiences and resources to generate evidence syntheses, seeking to set out clearly the evidence relating to particular aspects of the different Vanguard models. These were also made available via the FutureNHS collaboration platform, with a view to supporting other areas seeking to replicate Vanguard approaches. Examples include a summary of the evidence relating to the use of risk stratification models, and the evidence relating to social prescribing. The tone of these is judicious, and quite different from the tone of the positive case studies published in the Health Service Journal or online on the NHSE website. The documents point out the paucity of evidence in some areas, as well as highlighting issues which might arise and summarising what is known about approaches which may carry greater likelihood of success.

Although in year two of the programme there was not yet strong evidence of improvements in outcomes associated with Vanguard (although the internal evaluation using national data pointed to some possible small improvements against the headline metrics), it was explicit policy from the beginning that Vanguard should be 'scaled and spread'. However, it was not clear how this might be achieved.

We used to talk a lot about spread, this question that says, look we're starting with just 50 areas, how do we get this to grow? And I remember we said that it's two different models, one is that an individual area grows outward, and another is that it's just copied by another area, that's doing nothing at the moment (ID 009)

The creation of the STPs was then said to be a vehicle for spread:

Eventually the STP process helped to do some of the heavy lifting around spread, because it said, show us how you are adopting new care models in your area? and that almost set the question (ID 009)

In STPs where they have existing Vanguard the STP itself provides a kind of mechanism for scaling up across the broader geography (ID 028)

The significance of the Vanguard within their respective STPs depended on a number of factors, most importantly the geographical footprint of the STP and whether or not it included one or more Vanguard. Where an STP did not have a Vanguard within it, learning from the new care models lacked relevance.

I hear from most of my STPs, so the ones where there's a Vanguard in it, yes, we're absolutely using the care model and the lessons learned from the Vanguard in the design and the development of our STPs (ID 022)

it's very, very hard if you haven't got local account management, or a local site to get at and spread outwards. So as a result, a lot of STPs, including STPs with Vanguard with them, wrote their plans without reference to the Vanguard" (ID 011)

In the places where there's not a Vanguard, they're sort of saying, oh, yeah, the new care models, and I have to say that there are still those doubting Thomas' that raise their eyebrows at me when I start to talk about the new care models and they go, oh, really? You know, and I do have people who say to me, there's nothing new about it (ID 022)

The extent to which Vanguard were seen as integral to or irrelevant by STPs was said to depend, in part, on the visibility and reputation of local leaders:

This idea of putting [Vanguard] with the STPs, I don't buy it. And accountable care. It's not automatically going to happen. If they are well respected as leaders, yes. But you've effectively created a new structure in the STP, and that will be completely dependent on the leadership (ID 017)

The speed at which STPs were implemented, 'almost overnight', led to a lack of joined-up thinking around the relationship between the Vanguard and the STPs.

STPs were not well thought through, it wasn't considered in the context of Vanguard as new care models, I don't think that the impact of Vanguard was thought to be significant enough on the financial control totals which were the driving force behind the introduction of STPs (ID 011)

There was a feeling that in setting up the Vanguard programme with direct links between local and national teams, there was a lack of engagement at the regional (meso) level where the STP operates.

There was no level of education and awareness below the national level other than very locally on the programme, really, and because we'd disenfranchised some of the regional teams early on, they weren't our biggest advocate, you know? So we created a direct line between local managers and the national team, really, which I think was unhelpful (ID 011)

Although, ICSs were officially presented as scaled-up MCP/PACs Vanguard, in the absence of clearly defined 'products', exacerbated by the launch of the STP/ICS programme before the Vanguard had completed their second year, learning seems to be mostly organic:

we can see a difference in conversations, from those ACSs who have Vanguard sites in them and those who don't, because of the journey that they've been through, which I think, you'd expect that, but it's good to have that validated in a sense. So those have an automatic progression journey through to ACS (ID 002)

This interviewee argued that what had been learnt about the process of enabling and generating that local enthusiasm could be harnessed to support the development of STPs and ICSs. S/he suggested that STPs may have better accepted and understood if they have been framed as being about enabling the development of new approaches, rather than being purely structural:

I also think that it's been really successful, much more successful than virtually anything else we've done in terms of generating energy, enthusiasm in the system, so I think that's really good. I think doing STPs is the right thing to do... [but]. I think in doing STPs, we have slightly lost...we haven't, as I say, explained STPs as well as we could, linking back to the Vanguard, I think. And I think maybe it just wasn't possible to do that. But I think if we'd been able to tell a story like the Vanguard are doing fantastic work, we now need to take it on more quickly than we were planning to, and, therefore, we're setting up STPs to allow people to do that, that would have been better. It feels a bit...I sometimes wonder whether some of the Vanguard stuff's got lost .. the reform agenda is now seen about STPs and ICSs, and that's important, but by talking like that, we sometimes make it sound like it's all sort of structural, you know, shuffling deckchairs, et cetera, when actually it's about, or it should be about getting people into a position to work better together to deliver better care, doing the Vanguard on a sort of faster, wider scale. [ID 027]

Some of those involved in the extensive NCM support and evaluation team have now moved into the system transformation group at NHSE and this continuity was seen as helpful to ensure the learning from the Vanguard remains a central focus going forward:

The care models programme team is now part of the system transformation group within NHSE and that has responsibility for taking forward the STP and ACS agenda. And so we're all working hard on making sure that our programme is seen as central to the development (ID 014)

There is a sense that the longer term fate of the individual Vanguard is now being passed back to a local and regional level, with continuation of funding now based on STP and local CCG funding decisions. The responsibility for doing this was placed firmly with the Vanguards.

The money's now being earmarked for accountable care organisations, accountable care systems, and many of the Vanguards are part of the Wave 1 of ACO / ACSs [ICSs]. And so therefore, they will hope to get some of their resources from there. But for the ones who haven't, they need to convince their CCG locally, don't they now, that actually, what they're doing is worthwhile doing, they are having a positive impact on emergency admissions (ID 006)

It's absolutely in the best interest of the Vanguard to make sure, a) that their work is well publicised within the STP and that it also aligns with the objectives of the system. Because, Vanguards also need to ensure that they're...you know, we've invested a lot of money in them and therefore the work needs to be...the models need to be sustainable beyond the end of the funding from the Vanguard programme (ID 021)

A recent briefing publication by NHS Providers sets out some of the learning from the new care model programme (NHS Providers et al., 2018). It looks at 3 aspects of the programme:

- Supporting people and communities to stay well;
- Staff at the heart of new care models;
- Spreading and scaling up change.

This report suggested that “*The relatively small scale of Vanguard sites, the temporary nature of the national support programme, and the focus for many Vanguards on defined populations has presented a challenge for spreading and scaling change*” (NHS Providers et al., 2018 p1) and that “*There is an opportunity for STPs and ACOs to build on the Vanguard leadership and momentum, the expertise and energy of the staff and local communities, and their understanding of what has worked and not worked.*” (NHS Providers et al., 2018 p11).

The initial development of STPs therefore occurred in relative isolation from the learning which had been generated by the Vanguard programme and at great speed. It could be argued that this is appropriate, given that MCPs, PACS and ECH Vanguards are on a local scale, whereas ICSs are designed to have a regional footprint. However, this then raises fundamental questions as to what the appropriate relationship might or should be between an MCP or a PACS and an ICS. The question identified by one of our interviewees as to whether the wider roll out of new models of care should mean replication of successful local initiatives (as implied by the initial programme goal of developing ‘products’ and frameworks to support wider roll out) or scaling up of successful initiatives to cover wider populations remains unanswered.

6.5 Summary

In this chapter we have highlighted the cross-cutting themes which we identified running through our findings. Seen through the theoretical lens of policy implementation and piloting, we have highlighted the tensions inherent in a programme which was seen as both long and short, bottom up whilst meeting narrowly defined top down goals, and capable of both scaling up and spreading out.

These dichotomies draw attention to the multiple purposes served by elements of the programme. For example, the FutureNHS collaboration platform was seen by some of the national interviewees as an exemplar, providing a great showcase for the programme by virtue of the success stories it showcases. This view promotes the notion that more information is better, with a wide variety of

successful case studies and examples highlighted as a positive feature of the site. For others, its usefulness was limited by the volume of information it contains, which militated against its use as a vehicle for codifying and specifying model frameworks. Similarly, local evaluations were perceived as serving a number of different purposes. One purpose was to support local learning and feedback, and provide formative evidence for sites. Another was to provide context for the findings coming out of the broader analysis of data – if metrics are improving, what are the local ‘ingredients’ of success? It was initially suggested that the collation of local evaluation findings to identify these ingredients would support the design of ‘products’ that could be rolled out, but, as we found for many elements of the programme, the timescale associated with the local evaluations – some of which are not yet complete – made this unlikely within the lifetime of the programme. Finally, national evaluation of realtime data by the IAU was initially intended to support Vanguards through feedback, but reports from the IAU only started to appear in the third year of the programme, and the need for positive outcomes to provide political support for the programme and for its extension into the development of STPs and ICSs led to an increasingly narrow focus on specific metrics and sometimes urgent requests for evidence to support ongoing policy.

Beyond this, viewed as a pilot, the programme itself would seem to have had multiple purposes. Piloting for demonstration, implementation and learning are all visible in the initial design and set up of the programme, whilst the evaluation team took an approach which constructs Vanguards as experiments which may or may not deliver better outcomes.

7 Chapter 7: Discussion

7.1 Introduction

In this report we have explored the setting up and running of the NCM Vanguard programme, elucidating the expressed goals of the programme, and exploring the operation and perceived impacts of the support and evaluation programme. In a number of ways the programme has demonstrably been a success. Supported by additional investment of some £325 million, and by an implementation and evaluation programme costing at approximately £60 million, Vanguard sites have worked across organisational boundaries in order to establish new ways of working. Moreover, the programme generated significant local enthusiasm, with a wide range of events and the establishment of new networks between those trying to change the way services are delivered, allowing learning to be shared. Within a short timescale, Vanguard sites successfully procured local evaluations, the findings of which will be available to support longer term learning from the programme. The evaluation element of the national programme was praised by the National Audit Office (National Audit Office, 2018), and the team have pioneered new approaches to real time evaluation using administrative data sets. The latter show some evidence that Vanguard sites may have begun to reduce the growth in emergency admissions. However, the programme has not generated tangible products or frameworks codifying models of care which could straightforwardly be transferred elsewhere. Our analysis suggests that the design of the programme as a bottom up, developmental programme made it unlikely that such defined products could have been produced, as the pilots embodied a very wide range of approaches, services and local system redesigns. Moreover, the programme was not set up in a way that would have allowed these to have been narrowed down into a 'recipe' for new service models in the time available, with the focus upon support and problem solving rather than on identification of a single 'best approach' for each model. The evaluation team is in the process of trying to capture key learning from the programme by, for example, summarising evidence and experiences of implementing some of the elements common to many Vanguards, such as risk stratification and social prescribing, but there is, as yet, no clear definition of a single type of MCP or PACS. The Care Home Vanguards have come closest to defining a model of care, with a published framework which provides some detail to support replication of the model. Whilst the programme was conceived of initially as the first in a number of 'waves' of Vanguards, in practice the early establishment of STPs and moves towards the development of ICSs has generated some confusion over the legacy of the programme. ICSs cover significantly larger populations than those covered by Vanguards, and the extent to which lessons learnt from Vanguard service developments can be 'scaled up' is as yet unclear, as are the mechanisms by which this should occur. MCP and PAC Vanguards generally consist of a number of new services targeting particular segments of the population. These tend to be local and specific, embedded in local communities and in the local NHS landscape. It is therefore unclear how these might relate to the broader goals of ICSs in putting in place new approaches to population health management.

In the introductory chapter we set out three research questions for this part of our study (see p26:

- How has the national support and evaluation programme operated, and which aspects are perceived to have been particularly helpful or problematic?
- What type of pilot are Vanguards, and how do they fit with established typologies of policy implementation?
- What can we learn from this about approaches to policy programme implementation?

In answering these we have explored the elements of the national support programme, and highlighted the aspects of this regarded as important by those involved. The importance of

facilitating and maintaining relationships was clear, with a particular emphasis on face to face meetings and on trusted individuals capable of bringing people together across boundaries. The generation of energy and enthusiasm was seen as vital, and was facilitated by the widespread dissemination of perceived successes. At the same time, the pace of the programme was an issue, as was the perceived pressure to perform and demonstrate success as quickly as possible against a narrow range of metrics. We have also shown that the Vanguards could be regarded as policy pilots fulfilling all four of the 'purposes' identified by Ettelt et al (2014). In this final chapter we return to the theoretical ideas set out in Chapter 1 in order to seek to explain the outcomes that we have identified, to consider the broader lessons for policy implementation and to suggest priorities for ongoing policy development in this area.

7.2 *Matland: the nature of the programme and approaches to supporting implementation*

We have argued (p34), that the programme was conceived of and presented as a programme high in ambiguity – with an explicit commitment to allowing bottom up development of the new models of care, with minimal pre-specification of what these should look like - and low in conflict. This latter was buttressed by the presentation of the programme as developed and endorsed by all significant national level Arms' Length Bodies responsible for aspects of the NHS. However, in practice, it appears that the over-arching goal of allowing bottom up development of new care models was, in practice, incompatible with the goal of producing tangible/clearly defined 'products' and frameworks which could be rolled out more widely. Whilst there was little political conflict surrounding the programme, there was, at least over this relatively short timescale, a degree of incompatibility between the bottom up, low specificity approach which saw generating local buy in and enthusiasm as paramount, and the clearly stated intention of creating defined frameworks which could be spread. The Care Home Vanguard example suggests that, whilst it was possible to develop a clear model framework to describe a model of care focused upon a limited population in a single setting, it was not possible to do this for care delivered to a much wider population in a full range of settings. Overall, therefore, it would seem that the programme fits Matland's definition of a high ambiguity, high conflict programme, requiring an approach to implementation which seeks to build local coalitions. The perceived importance of relationship building, and the value placed upon face to face meetings support this interpretation. Jensen's (2017) synthesis of Matland's model with the project management literature adds further depth to this analysis, highlighting the fact that high ambiguity high conflict programmes may be valuable in 'showcasing innovative action' and 'inspiring change in other organisations' (p12), both espoused goals of the NCM Vanguard programme. Furthermore, Jensen highlights the role of 'fickle and fleeting alliances' (p12) between local actors in supporting the implementation of such policy programmes. This is an issue which would merit further study with regard to the Vanguard programme, in order to understand the dynamics by which change was facilitated in complex local environments.

The literature exploring change in public sector organisations provides some insights as to why the programme goals may have been incompatible with one another. Kuipers et al (2013) highlight the value of bottom up approaches to change, whilst adding the caveat that the outcomes – and outputs – arising from such change programmes will be unpredictable and can rarely be specified in advance. Horton et al (2018) explore change in complex systems, highlighting the difficulties associated with 'codifying' innovations and the role of local adaptation. It would thus seem that the ambition that a broad range of diverse and locally developed projects to bring about locally specific change would result in codified frameworks was always unlikely to be achieved. Creating such products would have required an initial assessment of the strength of the evidence base underlying proposed interventions, alongside robust analysis of outcomes, in order to distinguish beneficial from non-beneficial change, a strong architecture to capture and codify the factors underlying those changes,

and a mechanism for changing the permissive approach to one focused upon the implementation of these specific, codified approaches. However, this is unlikely to be possible in a programme lasting only three years, in which impacts on outcomes are likely to take several years to develop. This highlights the inherent contradiction in the programme between an underlying assumption that the new care models *would* be beneficial (evidenced by the initial intention to have waves of Vanguard and by the requirement for STPs to demonstrate that that were going to roll out MCPs, PACS and ECHs) and the commitment to robust evaluation designed to explore in depth *whether or not* new care models delivered better outcomes. This contradiction is made more acute by the narrowing of national focus on outcomes down to a small number of measures of hospital use, as it is possible that Vanguards may have been delivering service improvements not captured by these metrics.

7.3 Vanguards as pilots: what were they for?

We have shown (p74) that, as pilots, Vanguards could be said to be designed to fulfil three of the ‘purposes’ identified by Ettelt et al (2014) (implementation, demonstration and learning), whilst the evaluation programme also embodied an approach based upon experimentation. This is potentially problematic, as each of the four purposes carries with it different underlying assumptions about what is known about the value of the pilot intervention, and implies different approaches to their wider roll out. Thus, if Vanguards are seen as pioneers, then subsequent waves should follow quickly, as was initially intended. If, on the other hand, Vanguards were supposed to be ‘demonstrating’ how to implement change, then the encouragement of Vanguards to submit case studies and present their experiences as widely as possible would be appropriate. Piloting for learning was clearly embedded in the programme from the beginning, with a strong emphasis on networking to capture commonly experienced issues and an understanding that the models were not initially defined, but this is somewhat at odds with the notion that Vanguards were demonstrators and pioneers who were showing others how things should be done and initiating further ‘waves’ of change. The approach taken by the evaluation team is clearly underpinned by an idea of ‘experimental’ pilots, with the superiority of pilot interventions not assumed. Moreover, in a speech launching the programme in 2014 the Chief executive of NHSE, Simon Stevens explicitly argued for an experimental approach, suggesting that:

The new models need to show how they help solve the particular issues confronting that particular health community, with proper safeguards against unintended consequences. Patients need to be able to make meaningful choices. Providers showing they are equitable, can meet high clinical standards, and live within the locally sustainable funding envelope. There’ll need to be independent evaluation, and regular performance benchmarking against comparable area, with periodic opportunities to decide whether to continue, with or amend, the arrangements.¹⁵

From this perspective, widespread roll out should wait until the value of different approaches is elucidated.

Clearly, many government programmes will embody different ‘purposes’ in this way, but the Vanguard programme is unusual in the extent to which resources were invested in supporting these potentially incompatible purposes. Furthermore, these tensions are particularly acute in a programme which set off with no established ‘model’ of intervention. Seen in this way, the decision early in the second year of the programme to advocate both wider spread and scaling up of the models under the new ICS programme may be problematic. Not only was it not clear by this stage

¹⁵ <https://www.england.nhs.uk/2014/06/simon-stevens-speech-confed/>

whether *Vanguards* were delivering which types of better outcomes, but the elements of the models were also not defined.

In understanding this paradox it is perhaps possible to discern an additional ‘purpose’ underlying these pilot interventions. The FYFV was produced at a particular political moment, when all government national and local health and welfare programmes were under pressure from an ‘austerity’ policy designed to rapidly reduce the overall fiscal deficit (The Centre for Local Economic Strategies, 2014). The NHS was predicting a significant funding shortfall (Torjesen, 2012), and was negotiating with the Treasury for additional funding. This was obtained in the form of ‘sustainability and transformation’ funding, a proportion of which was used to support the NCM Vanguard programme (NHS England, 2014b). A key element of that additional funding was an expectation that there would be significant changes to the way services were delivered as a result (‘transformation’), with the money invested in new approaches rather than simply being used to pay down deficits (although a significant proportion was used in this way). Thus, the NCM Vanguard programme had an important role to play in demonstrating that the NHS could change, and could do so quickly, and that additional funding would be wisely invested. This is evidenced by our respondents’ references to a ‘politically driven’ need to ‘demonstrate results quickly’. The declaration in the second year of the programme that *Vanguards* should be ‘earning their way’ (NHS England, 2017 p47) to access a third year of funding would also seem to support this interpretation, as does the speech made by the Chief Executive of NHSE, Simon Stevens, in November 2017¹⁶. The speech argues that the ‘*Five Year Forward View ‘recipe’ is working*’, before asserting that the main problem facing the NHS is not excess demand but problems with ‘*fragmentation and funding*’. The speech finishes with the argument that significant additional funding is required to support and accelerate the changes towards more integrated care which were started by the NCM Vanguard programme and continued in the moves toward integrated systems. Thus, the case for additional funding is explicitly linked to the assertion that the NHS has demonstrated effective change.

It could therefore be argued that the NCM Vanguard was a pilot with the additional purpose of ‘performing’ for an external audience – in this case, demonstrating to HM Treasury that the NHS would use any additional investment wisely and that such investment would finance a change programme which would improve performance. This may also, in part at least, explain the strong emphasis in the programme on collecting and disseminating ‘good news stories’ of successful change, and the relative generosity of funding available both for investment and to support implementation.

7.4 Lessons for policy implementation programmes

As discussed earlier, the NCM Vanguard programme was perceived as having been very successful in generating enthusiasm for change at local levels. Moreover, the changes involved are complex and cross multiple organisational and sector boundaries. There are therefore important lessons to be learned in terms of a practical approach to policy implementation, as well as a number of issues which require following up at local level in order to understand in more depth how they were experienced. The following seem to have been important:

- **Active approaches to relationship building**, with local account manager support and opportunities for face to face meetings;

¹⁶ <https://fabnhsstuff.net/fab-stuff/simon-stevens-ceo-nhs-england-speech-nhs-providers-birmingham-november-8th-full>

- **A permissive approach to change**, which encouraged local areas to develop their own approaches within a broad framework of support;
- **Celebration of small successes** to encourage ongoing engagement;
- **Access to expertise** and the opportunity to engage at national level with regulatory bodies to solve problems.

However, other issues were not always helpful such as:

- **Data availability** and sharing issues;
- The **rapid pace** of the programme overall;
- Undertaking **multiple local evaluations** was an expensive and time-consuming approach, which requires further assessment. Whilst local areas have valued their local evaluations, the overall benefits and costs of this approach to evaluation are not yet clear.

Significant investment was allocated to **the evaluation programme**, which was praised as rigorous and professional (National Audit Office 2018). The focus by the national evaluation team on establishing whether or not headline improvements in metrics are **statistically significant** is also important, and it is to be hoped that future innovations are subject to a similarly rigorous approach, although this may generate conflict with an approach designed to facilitate engagement by celebrating early successes. Whilst we believe that the approach of commissioning multiple local evaluations requires further investigation, some respondents to the NAO Vanguard lead survey reported that they felt that they now had the capability to continue to evaluate new initiatives, and the NAO has suggested that ongoing local evaluations in Vanguard sites should be encouraged (National Audit Office p11). This is a potential benefit from the local evaluation approach which will be explored further in the next phase of our research.

The provision of **additional resources as direct payments to local areas** as well as underpinning extensive support and evaluation programmes was important, and this will be explored further in our ongoing study.

In relation to policy implementation design, when implementing a programme in which the desired outcomes are unclear, a more **cautious approach**, with an **initial assessment of relevant evidence relating to proposed interventions**, and subsequent **careful assessment of how far particular service interventions have been beneficial in what ways** might be more likely to **yield products which could support wider roll out** as outputs. However, this approach would not be compatible with the desire to rapidly demonstrate progress.

In terms of future policy making and planning we suggest that the **multiple purposes** underpinning the NCM Vanguard programme **may have been problematic**. For example, there is a tension between the need for 'good news' from a programme and the need to really understand in depth whether and how particular changes to services are actually beneficial.

We have highlighted the **lack of clarity** over how the NCM Vanguard programme **was intended to be disseminated and spread** and shown a **tension between approaches to 'scaling up' and 'spreading out'**. It may be useful for those involved with the NCM Vanguard support and evaluation programme to work closely with the team now responsible for supporting developing ICSs, with the explicit intention of considering whether and how the different local NCM Vanguard service models might best be implemented over a wider population.

Whilst local areas have valued their local evaluations, the overall benefits and costs of this approach to evaluation are not yet clear, although the NAO report has suggested that ongoing local evaluations should be encouraged (National Audit Office 2018 p11). Some respondents to the NAO

Vanguard lead survey reported that they felt that they now had the capability to continue to evaluate new initiatives, and this is a potential benefit from the local evaluation approach which will be explored further in the next phase of our research. Local evaluations are addressed in an accompanying report.

In addition, the investment in evaluation seen with the Vanguard programme has potentially had a beneficial impact on the general approach to evaluation in the NHS. In particular, the impetus for the development of the Improvement Analytics Unit partnership between NHSE and the Health Foundation arose out of the Vanguard programme, but will continue after the programme has ended, providing analytical capability for the service in the longer term. The focus by the national evaluation team on establishing whether or not headline improvements in metrics are statistically significant is also important, and it is to be hoped that future innovations are subject to a similarly rigorous approach.

Clearly, the provision of additional resources as direct payments to local areas as well as underpinning extensive support and evaluation programmes was important, and this will be explored further in our ongoing study.

In terms of policy implementation design, we have suggested that developing replicable frameworks was unlikely to be possible based upon a permissive and 'bottom up' change programme. We suggest that, when implementing a programme in which the desired outcomes are unclear, a more cautious approach, with an initial assessment of relevant evidence relating to proposed interventions, and subsequent careful assessment of how far particular service interventions have been beneficial might be more likely to yield products which could support wider roll out as outputs. However, this approach would not be compatible with the desire to rapidly demonstrate progress.

At the level of policy making and planning we have identified the multiple purposes underpinning the NCM Vanguard programme as potentially problematic. It is likely that policy programmes will always embody multiple purposes in this way, but we have highlighted the tensions and issues that may be generated, in particular highlighting a very real tension between the need for high profile 'good news' alongside a need to really understand in depth whether and how particular changes to services are actually beneficial. Our study suggests that more clarity over those purposes at the start of a programme may be helpful in determining the approach to be taken.

Finally, we have highlighted the lack of clarity over how the NCM Vanguard programme was intended to be disseminated and spread, including how such changes would be funded in future. In particular, we have shown a tension between approaches to 'scaling up' and 'spreading out', with lack of clarity over how NCM Vanguard – local initiatives, covering a limited population – might relate to the changes anticipated under ICS models covering broader geographical populations. It may be useful for those involved with the NCM Vanguard support and evaluation programme to work closely with the team now responsible for supporting developing ICSs, with the explicit intention of considering whether and how the different local NCM Vanguard service models might best be implemented over a wider population.

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