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National Evaluation of the
Vanguard New
Care Models
Programme
FINAL REPORT

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ABSTRACT

This is the final report of the National Evaluation of the Vanguard New Care Models Programme. Whilst assessments of some local Vanguards have been published, this report represents the only comprehensive assessment of the programme as a whole. We address 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 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?

We find that, whilst individual Vanguard sites felt that they had made beneficial changes, and there is some evidence of a modest reduction in the rate of growth of emergency admissions in Vanguards compared with non-Vanguard sites, the programme overall did not fulfil its stated purpose of developing reproducible and scalable 'models of care' that could be straightforwardly implemented elsewhere. The cost of the programme was substantial (£357 million), with £60 million spent on support and evaluation. Those accepted to join the programme set out savings that they intended to make as a result of their Vanguard activities, but it is not possible to test whether these were achieved or to calculate whether the programme was cost effective, as there are no records of individual Vanguard expenditure or putative savings. The National Support Programme was valued by those involved, and local areas expressed enthusiasm for their experience in programme, particularly citing the increased trust and productive collaborations across organisational boundaries that they had developed. We identify a number of factors which supported local implementation of the Vanguards, including leadership and the development of a compelling local narrative.

Our exploration of outcomes associated with the programme suggests that improvements in headline metrics such as emergency admissions rates can be achieved by such programmes, but these are modest, take time to develop and tend to be concentrated in areas with a track record of taking part in other integration initiatives. This suggests that future integration programmes should focus upon fostering longer term change. Assessment of individual user outcomes found an increase in quality of life for Care Home residents associated with the Enhanced Health and Care Homes Vanguards. Although the Vanguard programme is cited in policy documents as underpinning subsequent policy developments such as Integrated Care Systems, it is not possible to demonstrate that this is the case, with Vanguards operating at a much smaller scale and focusing on service and clinical integration rather than the organisational integration represented by ICSs. However, there is some evidence that the roll out of the Enhanced Health and Care Homes service across primary care did arise out of the Vanguard programme, and we consider the factors which may have facilitated this roll out, including the fact that the service addresses a relatively small defined population, and that this sector was previously relatively neglected.

Overall we argue that in *programme* terms the Vanguard programme was: a *process success*, in that it was successfully implemented quickly; a partial *outcome success*, in that there was evidence that desired beneficial impacts on emergency admissions were partially achieved; but not an *effect success* in that the desired 'models of care' were not developed nor implemented beyond the rather limited case of Care Home services, and projected savings have not been demonstrated. However, in *political* terms the Vanguard programme was rather more successful: the *process* of Vanguard initiation was used politically as a demonstration that the NHS was capable of rapid change; early signals of a potentially beneficial effect on *outcomes* was used to bolster arguments for more

NHS investment; and the political *effect* of the programme is such that it is still referenced in policy documents relating to ongoing reform of the NHS.

We consider the implications of these findings for future policy programmes.

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ABBREVIATIONS

FYFV	Five Year Forward View
NCM	New Care Models
MCP	Multispecialty Community Provider
PACS	Primary and Acute Care System
EHCH	Enhanced Health in Care Homes
UEC	Urgent and Emergency Care
ACC	Acute Care Collaborative
NHS	National Health Service
NHSE	NHS England
NIHR	National Institute for Health Research
STP	Sustainability and Transformation Partnership
ACS	Accountable Care System
ICS	Integrated Care System
CCG	Clinical Commissioning Group
SAF	Strategic Action Framework
CQC	Care Quality Commission
PCN	Primary Care Network
DES	Directed Enhanced Service (PCN add on contract)
SMR	Structured medication Review
ICO	Integrated Care Organisation
HES	Hospital Episode Statistics
SUS	Secondary Uses Service
EA	Emergency Admissions
TBD	Total Bed Days

CHAPTER 1: Introduction and background

1.1. Introduction

The Vanguard New Care Models programme was established following the publication of the Five Year Forward View (FYFV) (NHS England 2014). 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 2014 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. Several types of New Care Model (NCM) were proposed, and these were eventually narrowed down to five types: Primary and Acute Care Systems (PACS); Multi-speciality Community Providers (MCP); Enhanced Health in Care Homes (EHCH); Urgent and Emergency Care (UEC); Acute Care Collaboratives (ACC). In order to support the implementation of and learning from the Vanguards, an extensive support programme was established, led by NHS England (NHS England 2015, NHS England 2015). A comprehensive evaluation programme was also established (NHS England 2016), comprising:

- Internal evaluative work led by the NHS England Operational Research and Evaluation Unit;
- Funding for each designated Vanguard to undertake a local evaluation of their work;
- An independent national evaluation, commissioned by the NIHR Policy Research Programme.

This report represents the final report of that national evaluation.

1.2. Report structure

This report brings together the findings from a four-year research programme. In order that our work should be as useful as possible to those involved with the Vanguard programme and with subsequent integration initiatives, we have published a number of interim reports and academic papers throughout this time (Billings, Mikelyte et al. 2019, Checkland, Coleman et al. 2019, Wilson, Billings et al. 2019, Coleman, Billings et al. 2020, Coleman, Croke et al. 2020, Morciano, Checkland et al. 2020, Checkland, Coleman et al. 2021, Morciano, Checkland et al. 2021, Wilson, Billings et al. 2021). In order to avoid repetition, in this final report we include the executive summaries of those reports, with links to the full reports added as an appendix, as well as new material relating to our final qualitative work and our quantitative evaluation. Some of the background text has previously appeared in those reports. We also include the links to the published academic papers in the appendix.

The report is structured as follows. This initial chapter provides an overview of the programme and sets out a timeline of integration initiatives in the NHS in England. This forms the backdrop for this report, setting the Vanguard programme in the wider policy context. Chapter 2 sets out the overall design of the project. Our methods have been described in detail in our interim reports, and so in this report we provide an overview, with the details provided in the appendices. We also set out the various theoretical frameworks which informed the different phases of the research. Chapters 3-7 address each of our research questions in turn, whilst chapter 9 brings these findings together into an overall summary considering the impact of the programme as a whole. Our final discussion chapter considers what can be learnt from this for policy pilot programmes more generally, and considers the implications for the current Health and Social Care Bill.

1.3. The Vanguard New Care Models programme

The Vanguards 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 Vanguards 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). 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.

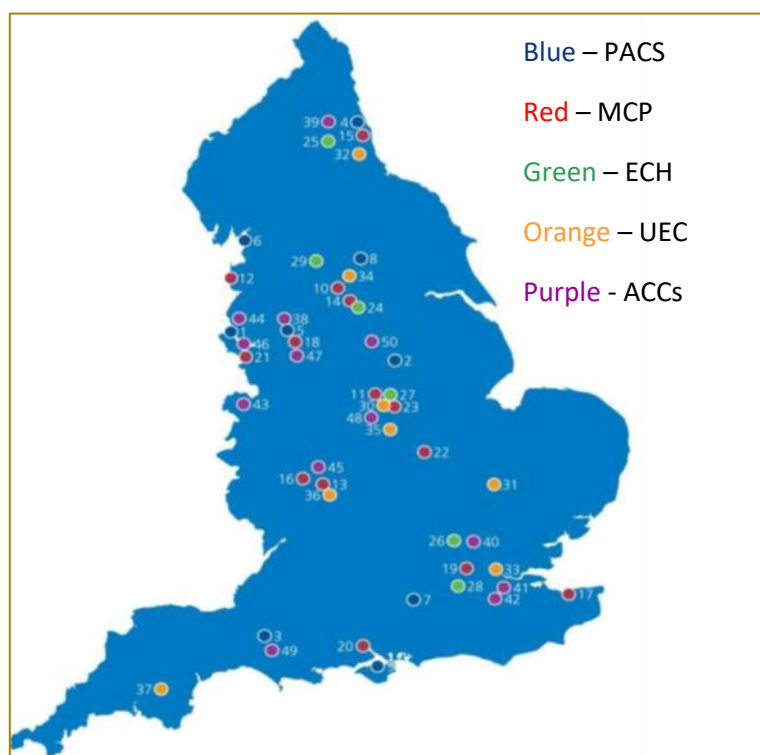
At the outset, there was an intention for successive cohorts of NCM Vanguards to be developed (NHS England, 2014b p10). The support programme was to be co-developed rapidly with the initial sites. It was to “blend the provision of technical expertise with peer learning, and removal of barriers to change”.

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 were different numbers of each model as shown in Table 1 below. They were geographically spread around England.

Table 1: Vanguard types and funding

Vanguard Type	Date	Number	Description	Funding (£million)
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.	130
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.	124
Enhanced health in care homes (EHCH)	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.	18
Urgent and emergency care networks (UECs)	July 2015	8	New approaches to improve the coordination of services and reduce pressure on A&E departments	13
Acute care collaboratives (ACCs).	Sept 2015	13	Linking local hospitals together to improve their clinical and financial viability, reducing variation in care and efficiency	72

Figure 1: Distribution of Vanguards across England



PACs and MCPs were very similar. Both included primary, community, mental health and social care, but a PACS also includes most hospital services. As a result, it was initially envisaged that a PACS offers the potential to transform an entire hospital business model, across inpatient, outpatient, medical and surgical pathways. A PACS could also be larger than an MCP, serving the population of its local hospital as a minimum (NHS England 2016). However, the goals, focus and operation of PACS and MCPs were very similar and the distinction between the two became less relevant over time. EHCHs were more limited, focusing only upon care provided in Care Homes.

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
- EHCHs (<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 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 transferred to a different national director, and was no longer managed by the NCM team becoming, 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 Vanguards 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.

As set out in table 1, the Vanguards received significant additional funding, amounting to a total of £357 million over the three years of the programme. This was allocated on a yearly basis, with year 2 and 3 funding dependent upon performance in previous years; some Vanguards in fact received no funding in year 2 and some received none in year 3. UECs were only funded for 1 year. Alongside this funding, a multi-faceted support programme was also established. In our Interim report (see Appendix) we set out in detail the organisation and extent of the support programme. This included:

- A 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 tEHCHnology; workforce redesign; local leadership and delivery; and communications and engagement;
- Local account managers for each Vanguard;
- A variety of learning and networking events and opportunities.

The support programme received £60 million in funding, over and above the money allocated to each Vanguard.

1.4. Programme goals and changes over time

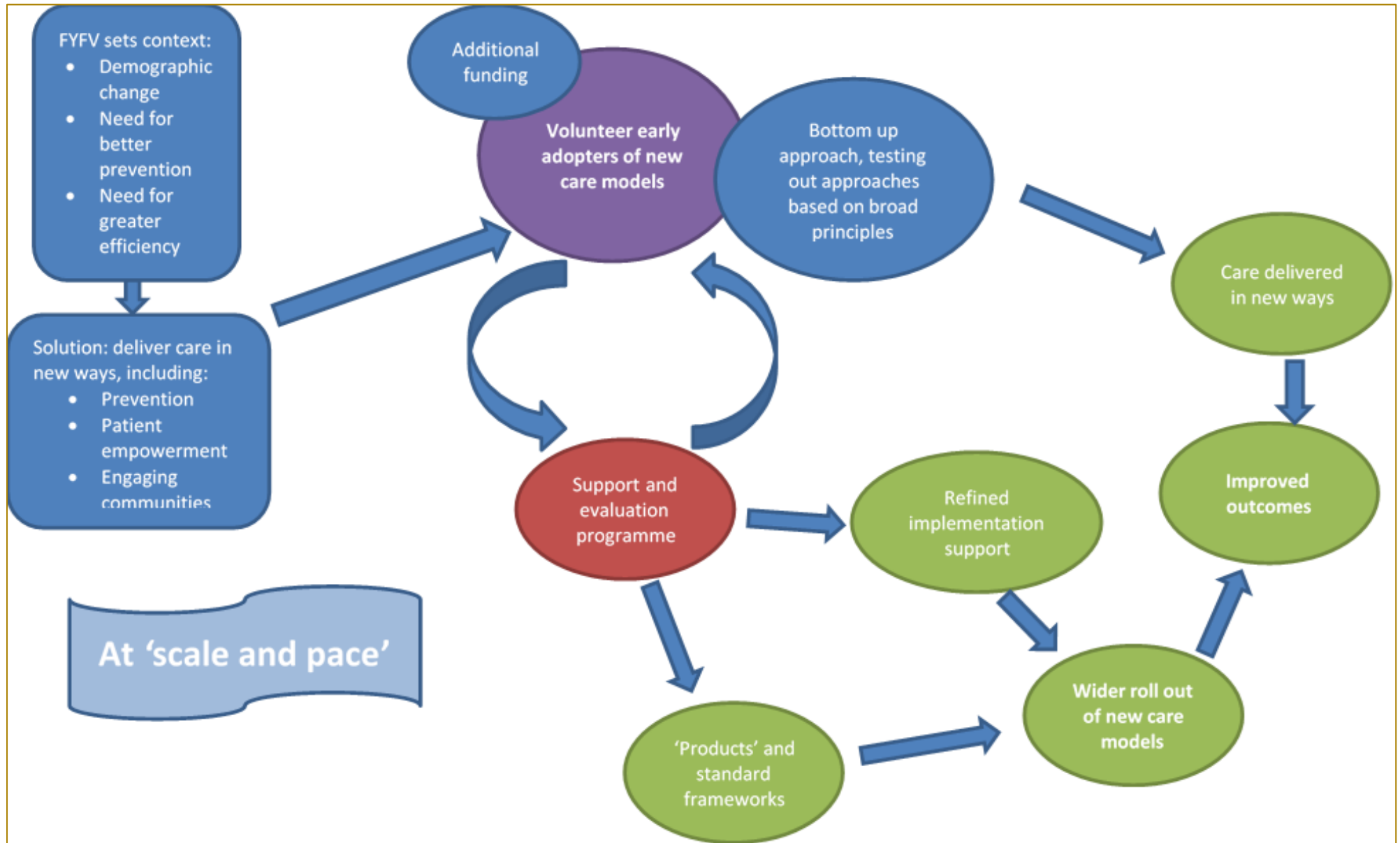
In the early phases of our research (see Appendix), we interviewed senior managers involved with the programme and explored associated policy documents in order to understand in more depth the goals underlying the programme and the underlying assumptions as to how those goals would be achieved. We identified four distinct goals:

- 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.

Figure 2 sets out how the programme was intended to meet those goals (the 'programme theory' (Weiss 1998) at work).

Figure 2: Programme theory underlying the Vanguard New Care Models Programme



The programme itself lasted for 3 years; in spite of an initial assumption by some involved that there would be further rounds of new Vanguards in subsequent years (Checkland, Coleman et al. 2019), the initial pilots were the only ones established. Towards the end of 2015 (in the first year of the Vanguard programme) 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 2015 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 Vanguards?' (NHS England 2015 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 was 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, NHS Improvement et al. 2016), with each area producing a local plan by summer 2016. In spring 2017, a further policy document set out progress towards the FYFV (NHS England 2017). Early evaluation results were provided, and it is argued specifically that MCPs, PACS and EHCH 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). 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 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 was explicitly argued that Vanguards should, in the third year of their existence, be focusing upon demand management.

Some of the elements which were said to make up an ACS were issues which the Vanguard programme was intended to address. 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.

The policy document states that:

In time some ACSs may lead to the establishment of an accountable care organisation. This is where the commissioners in that area have a contract with a single organisation for the great majority of health and care services and for population health in the area. A few areas (particularly some of the MCP and PACS vanguards) in England are on the road to establishing an ACO, but this takes several years. (NHS England 2017 p37)

However, in practice, models of ‘accountable care’ including capitated budgets and large provider contracts did not develop, and subsequently have largely been dropped from the policy discourse, in favour of looser collaborative arrangements.

Over time, the name of these new, larger scale integration initiatives changed, with ‘accountable care’ dropped in favour of ‘integrated care’. This was largely due to the association of ‘accountable care’ with the US health system, which garnered considerable political opposition (Thomas 2018), with a report from the Health and Social Care Select Committee concluding:

Given the controversy surrounding the introduction of accountable care organisations in the English NHS, we believe piloting these models before roll-out is advisable. There should be an incremental approach to the introduction of ACOs in the English NHS, with any areas choosing to go down this route being carefully evaluated. (House of Commons Health and Social Care Select Committee 2018 p41)

Subsequent policy, as set out in the NHS Long Term Plan (NHS England 2019), focused upon the creation of Integrated Care Systems, with proposals included for legislative changes which would facilitate their operation. The Long Term Plan specifically references the role of the Vanguards in informing policy:

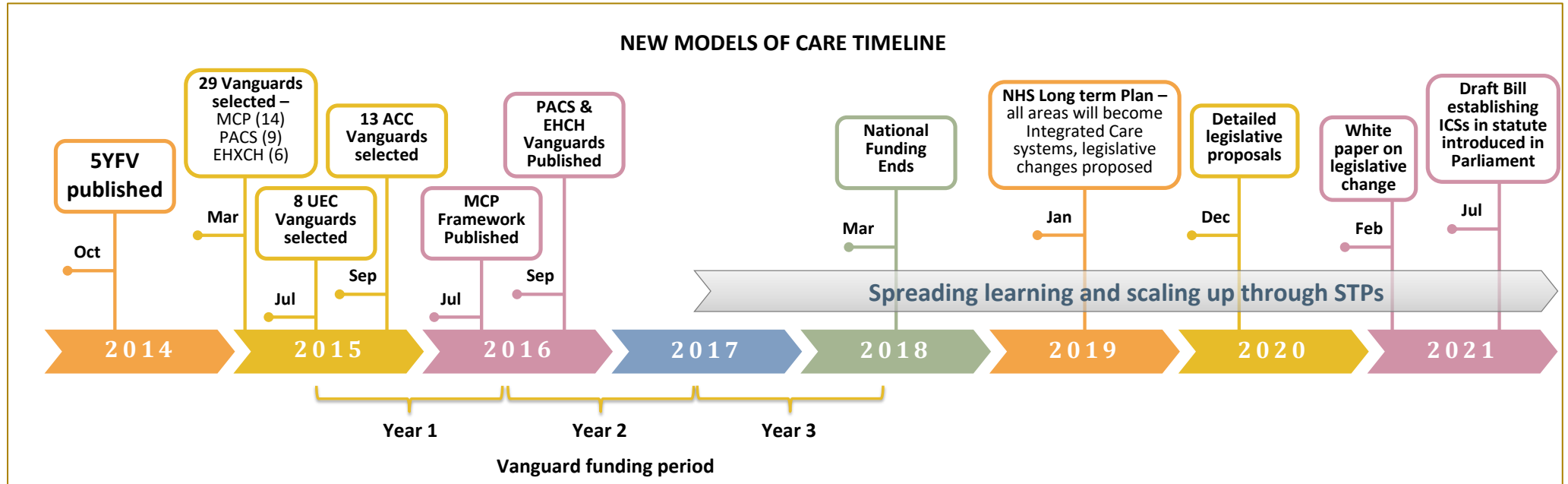
Following three years of testing alternative models in the Five Year Forward View through integrated care ‘Vanguards’ and Integrated Care Systems, we now know enough to commit to a series of community service redesigns everywhere. The Vanguards received less than one tenth of one percent of NHS funding, but made a positive impact on emergency admissions, and demonstrated the benefits of proactively identifying, assessing and supporting patients at higher risk to help them stay independent for longer. (NHS England 2019 p13)

We will return to the evidence underlying these claims in later sections of this report. Most recently, a draft Health and Social Care Bill (Department of Health 2021) is, at the time of writing, making its way through Parliament, setting out proposals to establish 42 Integrated Care Systems (ICS) as statutory bodies, responsible for overseeing the provision of NHS care to their population, working closely with Local Authorities.

In summary, the Vanguard programme was set up to develop new ways to provide more integrated care in the NHS. It was the explicit intention of the programme to develop ‘simple, standardised approaches’ that could subsequently be straightforwardly rolled out. This included an intention to develop new contractual models which would bring together service provision under a single provider. Local areas received significant amounts of money, and a well-funded support and evaluation programme was intended to draw together learning from the programme to support the development of integrated care more generally across the NHS. We will return to the question of how far this was achieved in our discussion, but, notwithstanding the claims made in the NHS Long Term Plan (NHS England 2019), it is hard to see a direct relationship between the proposals in the current Bill and Vanguard programme. In particular, the scale of these initiatives is very different, with Vanguards generally focussed around single Clinical

Commissioning Groups (CCGs) and their associated providers, and consisting of a range of locally-focused initiatives designed to integrate care at the front line, whilst Integrated Care Systems cover large populations and multiple providers and focus on structural integration. Figure 3 sets out the timeline of these various integration programmes and initiatives, setting the context for the rest of this report.

Figure 3: Timeline of integration policies



CHAPTER 2: Research design, methods and theoretical frameworks

2.1. Study aims, objectives and research questions

The aim of this evaluation was to investigate the effects of the Vanguard programme on the NHS, including its local organisations, wider partnerships and service users. There were 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.

The following research questions have been addressed to meet these broad objectives:

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 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?

2.2. Study design

We undertook a mixed methods evaluation, incorporating qualitative and quantitative study of process and outcomes at national, regional and local level. This study took place within a complicated evaluation landscape, with a number of other local and national evaluations taking place. Our study was therefore designed to complement rather than duplicate these, and we worked closely with both the National Audit Office and the NHS England Evaluation team throughout the early stages of the project. As set out in our initial proposal, aspects of our original plans were modified to take account of the rapidly moving policy context. We conceptualised the programme as operating at three levels: the national, macro-level, encompassing the national support and evaluation programme; meso level, the integration of the Vanguard pilots into their local health and care economy; and micro level, the operation of the pilots themselves. We therefore designed a study which would explore each of these levels.

We carried out three workpackages, as set out in table 2:

- An initial scoping of the programme, including understanding the national context (macro level) and the way in which Vanguards were integrated into their local areas;
- A synthesis of the local evaluations which were commissioned by each Vanguard;
- A process and outcomes evaluation, exploring:
 - The impact of the national support programme
 - The processes of change within local Vanguard sites
 - Examination of outcomes associated with the different Vanguard types.

The detailed methods used in each of these work packages have been described in the various interim reports and academic papers which are included as appendices to this final report. This final report brings together the findings from each of these elements to consider what can be learnt about the conduct of such policy pilot programmes in the future.

Table 2: Workpackages and associated outputs

Workpackage	Component parts	Associated outputs (see appendix p133)
Understanding the programme	Collating information about Vanguard activities and scope	
	National level interviews exploring support and evaluation programme	Interim report and academic papers
	Interviews with regional leaders to explore how Vanguards integrated within their local area	Short report
Local evaluations	Exploration of the local evaluation programme, including considering the value of this approach	Evaluation report and academic paper
Process and outcomes	Impact of the national support programme and the factors affecting this	Interim report and academic papers
	Process evaluation of Vanguard pilot operation	Case study report
	Qualitative study of longer term Vanguard impacts, focusing upon 'scale and spread'	Qualitative report
	Quantitative study of initial Vanguard outcomes – NHS/service use	Academic papers
	Quantitative study of longer term outcomes associated with Vanguards – NHS/service use	Section 5.5
	Quantitative study of patient-level outcomes	Section 5.4

2.3. Modifications from the initial study design

This was a complex and rapidly moving programme, set in a wider context which, as we have set out in section 1.4 (p15), was also changing. In particular, the initial goal of using the programme to establish a number of coherent and discrete 'service models' which could be straightforwardly implemented elsewhere was not realised. This had knock on effects for our evaluation, as some of the issues which we had initially intended to address became less salient or impossible to study. The principal modifications made to our original design are set out in table 3. Major modifications were discussed and agreed with the study steering group and the Policy Research Programme oversight team.

Table 3: Modifications from original design

Original intention	Modification	Rationale
Initial economic modelling of potential Vanguard impacts	Not carried out	Our original conception, based on the documents associated with the programme, was that we would be able to use Vanguard logic models to establish chains of potential impacts which could be modelled. However, our initial scoping of Vanguard activities and exploration of available logic models revealed that each Vanguard was in effect a collection of disparate initiatives, most of which were not amenable to economic modelling, as both inputs and expected outputs were unclear.
Vanguard leads survey	Carried out by National Audit Office	At the same time as our study was taking place, the National Audit Office (NAO) were undertaking a survey of Vanguard leads. To minimise the burden on respondents, we co-operated with the NAO on the survey, modifying and adding some questions. We reported the findings in our interim report.
Synthesis of local evaluation findings	Our study of these focused upon the process and value of local evaluations rather than reported outcomes. We extended the work to include interviews with evaluation leads	Local evaluations were found to be poorly designed and specified, with limited attempts to evaluate outcomes in any meaningful way. Synthesis of findings was therefore impossible.
Assessment of economic benefits of the programme	Quantitative study of outcomes addresses overall Vanguard funding, but does not consider return on investment	It proved impossible to gain a clear picture of expenditure associated with the Vanguards. In part this is because many sites used models of staff secondment and cross-subsidisation of the programme. Detailed accounts of expenditure were not required by the programme, and therefore are unavailable. This lack of information about inputs, alongside the volume of other initiatives affecting both Vanguard and non-Vanguard sites makes it impossible to assess economic benefits associated with the programme.
Quantitative study of patient-level benefits	Our initial design included local study of outcomes using new data collection. In practice we used routinely collected administrative and survey data for this analysis.	The diffuse nature of Vanguard initiatives and the fact that once the programme ended many of these initiatives ceased made it impossible to identify individual patients who may have benefited from the programme. Our analysis therefore focused upon average population-level impacts, looking for changes in measures of personal function associated with Vanguard status using routinely collected administrative and survey data.

In addition, our eventual study included a number of elements which were not initially part of the design, set out in table 4.

Table 4: Additional elements of the study not originally planned

Additional element	Rationale and findings
Exploration of local evaluation leads' experiences	A significant amount of money was allocated to local evaluations, which in many cases proved to be of limited value. Issues that we found included: lack of local expertise in commissioning evaluations; difficulty in gaining relevant data; and lack of guidance and standardisation in approach. We therefore included findings from interviews with evaluation leads in our report, with a view to supporting future evaluation programmes (Wilson, Billings et al. 2019) and section 3.3.
Quantitative comparison of Vanguards with Integration Pioneers and other integration programmes	Our engagement with a wider community of research teams evaluating different integration programmes led us to undertake a comparison with Integration Pioneers (Morciano, Checkland et al. 2021). This showed that apparent benefits associated with the programme were concentrated in those sites which engaged with both programmes, highlighting the importance of long term engagement if integration efforts are to yield benefits. In addition, our study contributed to an academic paper synthesising the qualitative findings from this and other evaluations of integration programmes (Lewis, Checkland et al. 2021).
Quantitative study of the impact of Vanguard after the termination of the programme on hospital activity	Our quantitative analysis highlighted that outcomes for integrated care and other initiatives should be assessed over the long-term. We obtained from NHS England new data on hospital activities that extends beyond the period after the Vanguard programme was terminated and until the start of the COVID-19 pandemic (Section 5.5).
Qualitative study of factors affecting whether or not Vanguard-related initiatives were 'scaled and spread' beyond initial sites.	Our initial scoping of the programme and its overall programme theories highlighted the intention that Vanguards would support the development of discrete services models which would subsequently be spread more widely. We therefore included a final qualitative phase which explored the factors which supported or hindered such spread, making comparisons between the spread of the EHCH model via a contractual mEHCHanism with less structured approaches for other models (section 3.5)

2.4. Theoretical frameworks

In keeping with the complex and evolving nature of this study, a number of theoretical frameworks were used to make sense of the different aspects of the research. Some of the text below is reproduced from relevant reports.

2.4.1. Understanding the programme: theories of policy design and implementation

In this section we set out the theories and concepts which underpinned our initial exploration of the programme. It has long been understood that simply developing and mandating policies is unlikely to result in local change without paying serious attention to implementation (Pressman and Wildavsky 1984). Approaches to implementation are usually thought of as falling into two groups: 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).

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 – i.e. if you achieve one goal you cannot 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. 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, Checkland 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.

Bringing these dimensions together, Matland classifies policy programmes and therefore the appropriate approaches to implementation as set out in Table 5.

Table 5: Matland's model of ambiguity, conflict and implementation (from Matland 1995)

	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><i>example: smallpox eradication</i></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><i>example: bussing children across town to maintain racial diversity in schools</i></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><i>example: Health action zones- multiple goals, considerable local variation</i></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><i>example: creation of Health and Wellbeing Boards under the Health and Social Care Act 2012</i></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.

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.

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 (Glennister, Matsaganis et al. 1994), whilst the development of Clinical Commissioning Groups (CCGs) was led by ‘Pathfinder’ early adopters (Checkland, Coleman 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, Coleman 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 (‘equipoise’).

(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, Mays 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, Johansson 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, Johansson 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.

As is clearly set out in the Five year Forward View (NHS England 2014), 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 Table 1 p14 **Error! Bookmark not defined.**), 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 was the aim of the first phase of our study was 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. 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, Higgs et al. 2013).

In summary, in exploring and seeking to understand the nature of the Vanguard programme, we brought together Matland's conflict-ambiguity model of policy implementation with consideration of the nature and purpose of policy pilots. Our analysis is set out full in our interim report (see appendix), with the executive summary from this report reproduced in Chapter 3.

2.4.2. *Initial process evaluation: the Strategic Action Framework*

The initial phase of our qualitative process evaluation required a theoretical framework within which to consider not only local actions to implement change, but also the potential influence of both meso-level interactions and national policy drivers. Moulton and Sandfort (2017 p144) provide such a framework, arguing that policy implementation occurs in 'multilevel strategic action fields', and suggesting that research should explore the multilevel fields relevant to particular policy contexts.

The ontological assumption underlying the framework comes from symbolic interactionism, holding that humans seek meaning and identity construction in social interactions. The framework builds upon the work of Fligstein and McAdam (2011) on Strategic Action Fields, which posits a meso-level social order between organisational units (a 'field'), within which organisations with similar goals interact and jostle for position. The important insight here is that individuals and groups within these organisational units collectively and individually 'make sense' (Weick 1995) of the field, and that organisational action arises out of these social processes, albeit institutionally constrained. Thus, whilst neo-institutional approaches (Scott 2008) can explain much about organisational responses to change, specific local action will depend upon the agency of and interactions between individual actors as they respond within a specific institutional context. Variation in the implementation of policy interventions is thus inevitable. 'Social skills' are the mechanisms by which active individuals seek to generate shared meanings and forge collective identities (Moulton and Sandfort 2017 p146).

Moulton and Sandfort (2017) also emphasise the multiple levels relevant to policy interventions (Sandfort and Moulton 2015, Høiland and Willumsen 2016). They identify three such levels, and argue that Strategic Action Fields at each level will affect local interventional operationalisation. For Moulton and Sandfort (2017), the macro level consists of Policy Fields, which are '*bounded networks among organizations carrying out a substantive policy or program in particular places*' (Stone & Sandfort, 2009 p152). At the meso level, within Organisational Fields, individuals interpret the intervention and associated requirements and adapt them to 'fit' the local institutional environment, whilst at the micro level of the 'frontlines', workers exchange experiences and tell stories as they wrestle with practical implementation (Moulton and Sandfort 2017 p153, Lavee 2020).

In studying public service interventions, Moulton and Sandfort (2017) argue that the first task is to define the intervention, including processes of change (and associated assumed causal logics), methods of co-ordination, the extent to which change happens and the impact on outcomes. The framework then identifies three categories of 'drivers of change or stability' (p148). These are: sources of authority; social skills; and exogenous shocks. They argue that socially skilled actors interpret and wield sources of authority and respond to exogenous shocks, using these to motivate local action (Moulton and Sandfort 2017 p154)

Drawing upon the work of Ostrom (2011), Moulton and Sandfort (2017) highlight the polycentric complexity of most institutional contexts, within which overlapping systems of rules and norms will operate. Skilled social actors operate within this complexity, drawing upon, utilising or responding to a variety of sources of authority. They identify four broad, often intersecting categories:

- Political authority - what is legally permissible, mandated processes, legal responsibilities, and hierarchical governance relationships between fields;
- Economic authority – incentives, contracts, payments;
- Norms – professional appeals to ‘best practice’ or training offered to make particular changes;
- Beliefs and values – shared cognitive beliefs about what should happen, what will be effective – often informed by past experiences.

Sources of authority figure in implementation as rationales to act, but they are not objective; they are mobilised in particular ways in particular settings, and exactly which are mobilised in what way will depend upon the characteristics of the field. Importantly, sources of authority may conflict, and individuals will make choices over which to mobilise in particular circumstances.

Social skills encompass the agency of those implementing an intervention. Individuals in formal and informal leadership roles interpret and frame issues and actions, mobilising sources of authority to do so. This addresses the micro-level of implementation and is not the focus of this paper. Exogenous shocks incorporate factors from outside the field which initiate, derail or refocus implementation activity. Examples might include an economic crisis, legislative change or unintended personnel changes. Such shocks will be interpreted in locally specific ways.

We used this framework to structure our exploration of local Vanguard implementation, as it allowed us to synthesise evidence about the factors supporting local action with our understanding of the wider context, including the national support programme.

2.4.3. Understanding the wider impact of the Vanguard programme: exploring scale and spread of innovations

The Vanguard programme formally ended in mid-2018 (see Figure 3 p21), but as discussed in the introduction, it was the explicit intention that the Vanguard programme would generate new approaches to service delivery which would be ‘scaled and spread’ more widely. Furthermore, subsequent policy initiatives both required local areas to explicitly state how they had built upon the Vanguard programme, and suggested that new initiatives were derived from what had been learned from the programme (see section 1.4 p15). In the final part of our study we therefore focused upon the legacy of the Vanguard programme, seeking to trace how elements of the programme had been scaled and spread beyond the initial pilot sites, and the factors which had affected this.

The field of implementation research is both broad and rich, with a systematic review in 2015 identifying as many as 49 frameworks for guiding or understanding implementation from a wide variety of disciplines (Moullin, Sabater-Hernández et al. 2015). To support our exploration of the spread of Vanguard models beyond the initial Vanguard pilots sites we required a conceptual framework which moves beyond considering the individual behaviours of local implementers and which takes seriously the wider political and policy context within which implementation is occurring. Nolte (2018) reviewed this broad literature and adapted it to the context of the spreading of pilot innovations beyond their initial implementation sites, arguing that translating local apparently beneficial projects into more general system-wide change in service delivery is complex and difficult, for a number of reasons:

For one, the introduction of novel delivery structures is not a one-off event. Instead, it comprises a series of interlinked, and at times overlapping processes, which encompass adoption, implementation, sustaining, spreading and scaling. These processes involve different actors at different points in time and with different roles and responsibilities that will vary from setting to

setting. Further, implementation processes are complex, and their success is strongly dependent on the context within which service innovations are being introduced. [Nolte 2018 p9]

Drawing heavily upon Greenhalgh et al's work on the diffusion of innovations (Greenhalgh, Robert et al. 2004, Greenhalgh, Robert et al. 2005), Nolte (2018) reviewed a number of European health policy initiatives, testing them against Greenhalgh et al's (2004, 2005) criteria for successful adoption. These include:

1. an **organizational structure** that is adaptive and flexible, with structures that support devolved decision making;
2. **leadership and management** at different tiers that are supportive of and committed to change, including the articulation of a **clear and compelling** vision;
3. early and widespread **stakeholder involvement**, including staff and service users;
4. **dedicated and ongoing resources**, including funding, staff, infrastructure and time;
5. Effective **communication** across the organization (and, where relevant, between organizations);
6. **adaptation** of the innovation to the local **context** and integration with existing programmes and policies;
7. ongoing **monitoring and timely feedback** about progress; and
8. **evaluation** and demonstration of (cost-)effectiveness of the innovation being introduced, including assessment of health benefits.

Nolte (2018) then goes on to look across the policy innovations that she has explored, concluding that:

- not all innovations will be beneficial, and that selection of those to be scaled and spread should be judicious and transparent;
- dynamic policy contexts make such scaling and spreading difficult to achieve, with political and cultural issues as important as the technical details of the change desired
- continued evaluation is vital;
- the voice of the public is often not heard in the process, potentially limiting the democratic legitimacy of health system changes.

In our final qualitative work, we therefore used these eight criteria to examine the processes by which a particular service model associated with the Vanguard programme was spread across England. We then explore what additional factors have been of importance, and consider these against the conclusions drawn by Nolte (2018) in order to answer our research questions.

2.4.4. Understanding major system change

Best et al (2012) undertook a realist synthesis of literature reporting empirical studies of large scale change in health systems, and identified 'five simple rules' which underpinned successful change programmes:

- blend designated leadership (i.e. formal leadership) with distributed leadership (i.e. opportunities for individuals to take ownership of aspects of a programme);
- establish feedback loops;
- attend to history;
- engage physicians;
- include patients and families.

They emphasise that the operation of each of these rules is context dependent, such that it will never be possible to identify 'one best way' to implement large-scale change. However, they argue that their findings suggest some relevant 'mechanisms' underpinning each of these rules which may operate in different contexts.

This framework is largely focused at what we have called the 'micro' level; i.e. the factors within local health systems which support or inhibit change occurring. Turner et al (2016) apply Best et al's framework to a study of large scale system change in the UK, exploring the implementation of new models of stroke care in the NHS, comparing programmes in Manchester and London. They conclude that Best et al's framework is of value in understanding such programmes, but suggest a number of 'adaptations' to the rules. Table 6 sets these out.

Table 6: Turner et al's adapted rules for major system change in health services (adapted from Turner, Ramsay et al. 2016)

Rule	Adapted rule
Blend designated leadership with distributed leadership	System-wide authority is needed to align multiple stakeholders over a large scale and encourage clinical commitment to system-wide improvement goals.
Establish feedback loops	Feedback may need to be combined with other tools to encourage behaviour change, e.g. financial incentives.
Attend to history	Contextual factors can be a barrier to implementing lessons learned; political authority may be needed to challenge the existing context and enable more radical forms of transformation.
Engage physicians	Need to involve a range of stakeholders in planning major system change, and have a system-wide governance structure to align their interests.
Include patients and families	Awareness that the drivers of major system change (e.g. clinical, political, social, financial) influence how different stakeholders' views come to count during implementation; potential tension between patients' and others' perspectives.

In terms of our overall conceptualisation, it could be argued that some of these modifications are in fact necessary in order to take account of what we have called the 'meso level' affecting system change. For example, local 'system-wide authority' and ability to act will generally arise out of individuals' and organisations' positions within the local population of organisations –the 'local health economy'. This is particularly true in the current English context, with local organisations brought together at regional level to establish 'Sustainability and Transformation Plans' which cross organisational boundaries (NHS England, NHS Improvement et al. 2016). Similarly, the argument that 'political authority' is required if historical contexts are not to be overly deterministic of outcomes suggests that meso level mechanisms are needed to support those trying to bring about change.

This over-arching framework has informed the design of our study and its conduct throughout, providing sensitising concepts that have been used in the design of our data collection approaches. We return to this framework in our Discussion to consider what this evaluation has added to our understanding of major system change in health services.

2.5. Research methods

The detailed methods used in each phase of our study are reported in the full interim reports (see appendices), with brief summaries provided where appropriate in the main text. For our qualitative work, we used three main approaches:

- Initial exploration of the programme as a whole.

For this part of the study, we first undertook a documentary analysis of the relevant policy documents related to the Vanguard programme. From this we identified the programme theory (Weiss 1998) underpinning the programme, including the underlying assumptions and goals. We then undertook 29 semi-structured interviews with: national NHS England staff involved with the programme; relevant stakeholders from other organisations (e.g. the Care Quality Commission); and regional account managers. Our interviews explored elements of the over-arching programme theory, including respondents' interpretations of the goals we had identified, and

asked them to reflect upon their experience of the programme. We were particularly concerned to understand how elements of the theory had played out in practice, including which underlying assumptions proved flawed, and how the realities of the programme had differed from the initial plan. Our analysis first used Matland's (1995) framework to explore the nature of the programme as a whole. We then considered the extent to which the espoused goals of the programme had been met, and identified factors that had supported or inhibited this.

- Exploration of the meso-level relationship between Vanguards and other initiatives

We undertook 12 telephone interviews with Sustainability and Transformation Plan (STP) Leads across England, sampled to cover the different Vanguard types. Respondents were asked to reflect upon the integration of the local Vanguards into the wider plans of the STP, their future sustainability and the factors supporting or hindering Vanguard integration into wider STP plans. These interviews were analysed thematically to explore the place of Vanguards in their region, and to look for commonalities in factors affecting this

- Process evaluation of Vanguard implementation and operation

We took a case study approach. We selected six Vanguard sites, two each of MCPs, PACS and EHCHs. In each site we interviewed a wide range of those involved with the Vanguard, both individually and in focus groups. We also convened focus groups of local patient and public contributors. Our data collection took place in the final year of the Vanguard programme, and those involved were asked to reflect upon their experiences across the three years of the programme. We first developed case descriptions for each site, exploring the timeline of the initiative and identifying the relevant Vanguard-associated activities. A cross case analysis then used the Strategic Action Field framework as a framework within which to consider the factors supporting or inhibiting local Vanguard implementation and development.

- Vanguard scale and spread

As the programme was intended to develop models and frameworks, which could be scaled and spread more widely, we focused the final phase of our qualitative work on the legacy of the Vanguard programme. Our focus was upon the spreading and scaling of the Care Home Vanguard framework, and on understanding what other Vanguard elements had endured or spread more widely. We returned to each of our case study sites and interviewed a range of staff involved, exploring their experiences of spreading the Care Home framework more widely. We also explored the extent to which other elements of the programme had spread or endured. We then compared these experiences with those of non-Vanguard areas required to implement new Care Home services, analysing across the data set using Nottle's framework for the scale and spread of policy innovations to understand the factors at work.

- Quantitative study of outcomes

The relevant methods used in the quantitative elements of the study are described in the corresponding chapters.

Table 7: Overview of qualitative data collection

Phase of evaluation (qualitative work only)	Participants	No of interviews*	Case study sites
Phase 1: understanding the national context and exploring how Vanguards fit into the broader local landscape	NHSE employees (current / past); Advisors; Arms Length Bodies	29 interviews	N/A
	Evaluation leads	13 interviewees	Covered 18 vanguard sites
	STP Leads	12 interviews	N/A
Phase 2: synthesising the findings of local evaluations: process and outcomes	NHS employees (current / past); Local Authority staff; Private/Community/Charity sector employees; Public contributors	62 interviewees and 4 focus groups (including a total of 14 participants)	6
Phase 3: understanding the impact of the national support programme	Local staff involved with the Vanguards	26 interviewees	6
	National programme leads	2 interviewees	N/A
	Non-vanguard sites	31 interviewees	N/A

2.6. Summary

In this chapter we have set out the overall design of our study and indicated how our approach was flexed and changed to account for changes in the programme and in the wider context surrounding it. We have also set out the theoretical concepts and frameworks which underpinned aspects of the study and which shape this report, and provided a brief overview of the relevant methods used. Detailed descriptions of our methods are provided in the full reports attached as appendices, with summaries provided in the following chapters. In the following chapters we consider each of our research questions in turn.

CHAPTER 3: Vanguard implementation

3.1. Introduction

In this chapter we address research questions 1 and 3:

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?*

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

These issues have been addressed in our interim reports, and we therefore reproduce here the executive summaries from those reports. The full reports, including detailed accounts of our methods are available in appendices 1, 7 and 8.

3.2. Initial goals, early implementation and the National Support Programme

This section reproduces a summary of our first interim report (see appendix p133)

3.2.1. Introduction and background

The Five Year Forward View (FYFV) (NHS England 2014) 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); Multi-speciality Community Providers (MCPs); Enhanced Health in Care Homes (EHCHs) Urgent and Emergency Care (UEC); Acute Care Collaboratives (ACCs). This report focuses largely on PACs, MCPs and EHCHs.

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 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.

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.

3.2.2. 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 Vanguards 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.

3.2.3. 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 Vanguards, 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 was 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 involved 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 synthesised the findings.

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) - First, we analysed a wide range of policy documents in order to understand the overarching programme theory underlying the programme. Between October 2017 and March 2018 we carried out 29 national level interviews with a variety of respondents at the national level. In addition, in spring 2018 we collaborated with the National Audit Office (2018) in carrying out a survey of Vanguard leads.

3.2.4. Findings

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

¹ Although the word 'pilot' is not explicitly used to describe vanguards, 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

an in-depth analysis (using Matland's (1995) framework) highlighting cross-cutting themes identified in the data gathered.

3.2.4.1. 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 EHCHs were published. These are generally non-specific and process-dominated, although that for EHCH is somewhat more specific. Intended standard business models and organisational forms have not been developed (National Audit Office 2018 p32).

3.2.4.2. 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.

3.2.4.3. 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 (IAU) was set up in partnership with the Health Foundation in order to provide advanced analytics support to NHSE. The Unit produced 2 detailed analyses of individual Vanguard performance whilst the programme was ongoing, with a further 4 analyses published subsequently.

3.2.4.4. 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.

3.2.4.5. Assessment of programme success

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. 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.

3.2.4.6. 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 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 which were 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 that constructed Vanguards as experiments which may or may not deliver better outcomes.

3.2.5. 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.

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, 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, (Ettelt, Mays 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. Thus, if Vanguards are seen as pioneers, then subsequent waves should follow quickly, as was initially attended. 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.

Many government programmes embody different ‘purposes’ in this way. However, the tensions are particularly acute in a programme which set off with no established ‘model’ of intervention.

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.

3.2.6. *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.

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, 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. However, it is regrettable that this well-resourced and extensive evaluation programme did not lead to any wider analysis of what went well/less well with the programme. In particular, whilst the internal evaluation team carried out some detailed studies of a number of aspects of the programme, the results were not published.

The national support programme received £60 million in funding. In evaluating the value for money of the programme overall, the National Audit Office (2018) recommended that NHS England should evaluate and publish its overall learning from the programme, including: learning about the provision of national support; an explicit explanation of the links between the Vanguard programme and subsequent transformation programmes; overall learning from the programme; and a plan for longer term evaluation, including of the spreading and scaling of Vanguard initiatives. No such evidence was published, suggesting that there was a missed opportunity for learning

from an extensive and well-resourced support programme, and bringing into question the value for money of the national support programme.

In relation to policy implementation design, when implementing a programme in which the desired outcomes are unclear, a more **cautious approach**, with **careful assessment of how far particular service interventions are 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.

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'**. The trajectory of policy following the end of the programme demonstrates that this tension was not resolved.

3.3. Synthesising the local evaluations

This section reproduces a summary of our report on the local evaluations commissioned by each Vanguard site (see appendix p133).

3.3.1. Introduction

The provision of funding to allow each Vanguard to procure its own local evaluation was a key tenet of the programme. The objective was to provide formative evaluation to support Vanguards as they developed, as well as providing some quantitative assessment of their success in achieving their goals. We undertook a synthesis of these evaluations, and interviewed evaluation leads from 13 Vanguard sites. In the event it was not possible to formally synthesise evaluation findings across Vanguards, as evaluators took very different approaches. We therefore focused upon considering the approach taken by the different evaluators, the problems they encountered and the extent to which they were successful in their aims. In our interviews with evaluation leads as asked them to reflect on the process and to consider what had worked well and what had not. The full report from this phase of the research has been published and is available online (see appendix p133). We reproduce here the discussion and our conclusions from this report.

3.3.2. Summary of findings from synthesis across local evaluation reports

Significant investment was made available by NHS England to support independent local evaluation of the individual Vanguards. This review represents the first attempt to systematically assess the nature and quality of the evaluations commissioned and to capture methodological learning to inform future endeavours of this type. The synthesis summarises a significant grey literature of 108 evaluation reports not all of which are publicly available. This review therefore represents the only comprehensive mapping of this knowledge base and may serve as a key resource for researchers and policy makers, both within the NHS and internationally.

3.3.2.1. Synthesis Limitations

We have not been able to access reports of some local evaluations - publication bias occurs when the results of published studies are systematically different from results of unpublished studies. However, we think it unlikely that any other evaluation reports will be significantly different in design and or methodologically more robust than those presented in this synthesis. There is no definitive checklist for assessing the quality of mixed methods evaluations, and so there are some limitations with the approach we have employed. As such, there is a degree of subjectivity in our assessments of the feasibility and appropriateness of each evaluation design. Our assessments were often

hampered by a lack of methodological specificity in evaluation reports, making it was difficult to make judgements about the extent to which individual components were either feasible or indeed realised. Despite this, the criteria proposed by O'Cathain et al (2008) at least provides a structure for interpretation and comparison across Vanguards.

3.3.2.2. Evaluation characteristics

Most evaluations were both resource and time limited (12 months). As a consequence, most employed mixed methods or more accurately a mix of methods and often attempted but did not address all of the wide range of questions posed in the tender specifications. Most evaluations largely focused on describing the implementation context and capturing stakeholder reflections on and experience of the development and implementation of the Vanguard. Although a majority stated intentions to capture patient experience and conduct 'economic' or 'cost' related analysis, a combination of resource, data, time constraints meant that these components often lacked depth, were often not fully realised or not conducted at all. A similar pattern could be seen with outcome analyses where some evaluators have struggled to access routine data on health service utilisation and other performance metrics which has hampered the conduct of analyses. We have identified a number of common methodological challenges and limitations across the local evaluations and these are discussed below.

3.3.2.3. Logic Models

The new care models consistently produced and reported logic models which was a requirement of their funding, and which they were supported to produce. These described the anticipated inputs, outputs and impacts of the new care model. However, the proposed impacts are only partially reflected in the research questions proposed by many of the evaluations. It was rare for any evaluators to explicitly frame their approach with reference to the logic model or indeed to refer back to the outputs and impacts original proposed as part of their reporting of evaluation findings. This reinforces the apparent disconnect between the process of producing logic models and then commissioning evaluations. Logic models therefore appear to have been used as a sense making tool for initial programme development. Any potential value to the evaluation process and as an ongoing programme management and improvement tool is not apparent in evaluation reports overall.

3.3.2.4. Questions

Local evaluations were expected to generate evidence that would inform the main national evaluation questions set out by NHS England (NHS England 2015, NHS England 2016). Although originally issued as guidance, there is some evidence of a 'lift and shift' approach to local question formulation with very literal use of the questions circulated by NHS England. This 'lift and shift' may be rooted in the national emphasis on examining the entirety of a Vanguard's programme of activity. This meant that many Vanguards were often asking for an 'evaluation of everything' when a more specified approach to question formulation may have led to more focused/meaningful evaluations.

3.3.2.5. Data sharing and other information governance issues

While a number of methodological challenges were discussed in evaluation reports it is the evaluators struggle to access sources of routine data on health service that is most prominent. Where data sharing agreements were lacking and or there were data access issues, this significantly curtailed outcome analyses. As well as delays in accessing data, some evaluators also experienced significant issues around data quality. Where local sources of routine data have been available, completeness and accuracy of datasets has been a significant issue. Secondary analyses have therefore been constrained by time data cleaning and accounting for missing data. As many evaluators spent significant time and resource pursuing data sharing agreements, this has significant implications for future evaluation programmes of this type. Indeed, it can be argued that without data sharing agreements in place from the outset, many plans for quantitative analysis were not feasible. Given this, the responsibility for data access may best lie with those specifying and then commissioning evaluations.

3.3.2.6. Counter-factual

The second greatest challenge that evaluators have faced is the pursuit of the counterfactual with most struggling to create meaningful comparators. Significant time and resource was spent by evaluators trying to generate meaningful comparators. As counterfactual analysis relies on generating carefully matched controls it can be argued that few local evaluation teams had the time, resource or crucially the skill set to conduct assessments of this type. Given this, and the investment in parallel national-level analysis of service utilisation and other performance metrics, future programmes may be best to leave the pursuit of counterfactual to national-level evaluations instead.

3.3.2.7. Qualitative methods

Whilst the above has focused on the key methodological challenges associated with quantitative aspects of the local evaluations, this synthesis also highlights that qualitative methods are often poorly executed (or written up in a way that suggests that). Good qualitative research offers explanatory power and nuanced insight into change mechanisms, barriers and facilitators and intervention transferability and sustainability. Too often in these evaluations, the qualitative aspects are largely descriptive accounts with no real attempt to theorize, generate themes or integrate findings with other data sources to explain or enhance the credibility of the findings. There was some evidence of intentions to use specific approaches such as Normalization Process Theory but without more detailed reporting it was difficult to gauge whether these approaches were really applied beyond the superficial. Other shortcomings across reports included a lack detail on participant selection, sampling and non-participation; only one evaluation team explicitly referred to efforts to elicit stakeholder views beyond those directly involved in the development of the Vanguard programme.

3.3.2.8. Reporting in general

A key expectation of local evaluations was that efforts would be made to share local learning both between the Vanguards and more widely, to promote replicability and scale up. As with research generally, it is crucial that evaluators provide sufficient detail on their methods and the relationship between the analysis and the findings in the report so that readers can assess the credibility of the findings. No standardised reporting requirements were proposed at the outset of the Vanguard programme and as a consequence many of the local evaluation reports are lengthy and challenging to navigate. This lack of standardised reporting has made it difficult to identify the methods used and to describe the key findings. Findings are often not linked back to the research questions proposed. A more consistent reporting style would have made the reports much more accessible and improved clarity on the methods used in the evaluations.

Transparent reporting of evaluations is therefore essential if we are to understand what was done and ensure that learning is systematically captured in a generalisable format and or to enable evaluators to use or replicate the methods in other evaluations. There are a wide range of structured reporting frameworks (www.equator-network.org) that can and should be used. This should include enhancing the quality of intervention description – it was often difficult to work out what was being implemented. The Template for Intervention Description and Replication (TIDieR) is now widely used in health research and could be applied to describe the key components of emerging models of care.

3.3.3. Conclusions

Independent local evaluation was a key pillar of the evaluation plan for the new care model Vanguard programme. NHS England made significant resource available to individual Vanguards to procure and fund a local evaluation from an independent evaluation partner. We undertook a systematic assessment of the nature and quality of the evaluations commissioned and provide insights from evaluation leads into their experience of the evaluation process and of the Vanguard programme overall.

Our synthesis reveals that most local evaluations sought to address a wide range of questions many of them drawing on the questions set out in guidance from NHS England (2015; 2016). It is understandable that there was a desire to

capture as much insight and learning from individual Vanguards as possible. However, the number of questions to be addressed in each evaluation may have been overly ambitious given the resources and time available.

A significant amount of money was spent on commissioning and conducting multiple local evaluations, but each was relatively small scale and context specific. It is perhaps unsurprising that the regionally funded evaluation of the five North East Vanguards represents the most coherent attempt to address a wide range of questions through use of rigorous and transparent methods. Through pooling funding, the North East evaluation had significantly more resources than the other Vanguards. Even then, this evaluation was not without some operational challenges and acknowledged limitations. Each individual North East Vanguard also commissioned additional small- scale evaluations to explore aspects deemed locally important but that fell outside of the regional evaluation. This suggests that NHS England's multi-faceted evaluation strategy including recognition of the need for 'local evaluation for local people' was right but that achieving the balance between delivering a detailed understanding of what was working, why, how in each context and local formative insight to shape implementation was harder to operationalise in practice.

Future evaluations of large-scale service change should continue to consider multi-faceted strategies but perhaps with less prescription of what should be explored in depth at the local level. If we consider counterfactual analysis to be the preserve of national level analysis then that would enable a greater local focus on the formative and or on in depth exploration of patient experience and on capturing the costs of change. The relative success of the combined North East evaluation in surfacing common barriers and enablers of system change offers a meso level of analysis through which generalisable knowledge can be generated. The aims of any evaluation strategy of course need to balance what is desirable with what is actually achievable within available time and resource constraints.

Our synthesis and interviews have highlighted a number of common issues across the local evaluations. We summarise our recommendations for each of these as follows:

3.3.3.1. Research Questions

The evaluation synthesis found that many of the Vanguards copied most or all of the research questions provided by NHS England as a guide. This was reflected in contributions of the evaluation leads, who reported being given unclear and/or unfeasible research questions during the tender process, which did not sufficiently tap into specific interventions/initiatives of the local Vanguards. The issue may have occurred because local Vanguard teams issuing tenders for the evaluation did not have specialist understanding of research/evaluation methodologies.

Recommendation 1: it may be beneficial for evaluators to become involved at an earlier point of new initiative development and/or liaise directly with NHSE to determine research questions that are both locally relevant and meet national requirements.

3.3.3.2. Data sharing and other IG issues

Data sharing agreements and information governance more broadly posed a significant barrier to obtaining relevant data (this was especially, but not exclusively true for the quantitative part of the analysis). Interviews with evaluation leads further supported this finding and emphasised that even were solutions were eventually found, information governance procedures created significant delays that subsequently compromised the feasibility of original plans.

Recommendation 2: information governance agreements should be in place before the evaluation commences whenever possible; alternatively, evaluation plans should consider scenarios where data sharing cannot be established in determining what can be feasibly achieved

3.3.3.3. Counterfactual

Many of the evaluations could not obtain a suitable counterfactual. The data synthesis found that few local evaluations had the time, resource (or skill set) to conduct comparative impact assessments on improvements to the quality and efficiency of care, while interviews with evaluation leads demonstrated that most interviewees did not see the counterfactual as useful and favoured other comparative methods.

Recommendation 3: obtaining a counterfactual may not be possible for local evaluations and may be best placed with national-level evaluations instead.

3.3.3.4. Quality of research methods

Evaluation leads often focused on the challenges associated with quantitative aspects of the evaluation. However, the evaluation synthesis highlighted that qualitative methods were often poorly executed (or written up in a way that suggests this). Many of the local evaluations did not offer explanations and/or nuanced insights into the Vanguard operation, and did not integrate with other data sources to explain or enhance the credibility of the findings. However, there were difficulties in gaining access to and engaging professionals and service users as research participants which may have limited the depth of analysis.

Recommendation 4: evaluations using both qualitative and quantitative methods should integrate findings from both approaches in a more effective way.

3.3.3.5. Reporting in general

Extracting relevant information from local reports was difficult when synthesizing findings. It was particularly difficult to ascertain what type of interventions were evaluated. However, interviews with evaluation leads revealed that the Vanguard process also lacked clarity on what was a new initiative (i.e. what exactly should be evaluated).

Recommendation 5: National programmes may benefit from requesting local evaluators to use structured reporting frameworks (www.equator-network.org), which may also assist in defining Vanguard initiatives for evaluation purposes at an earlier stage

3.4. Local implementation – process evaluation

This section reproduces a summary of our report on our qualitative case studies (see appendix p133).

3.4.1. Introduction and background

This report forms part of a wider evaluation of the National Vanguard programme, funded by the NIHR Policy Research Programme and taking place between 2017 and 2021. The aim of this national evaluation is to explore the implementation and impact of the Vanguard New Care Models programme. This study forms part of a wide-ranging

evaluation for the programme, which incorporated internal evaluation by the NHS England Operational Research and Evaluation team, locally commissioned evaluations of each Vanguard as well as this independent evaluation. Our study was conceived as an evaluation of the programme as a whole – i.e. it was our intention to not only explore how local areas made changes, but also to understand in depth how the programme as a whole operated, including the national support programme which ran from April 2016-March 2018. We have focused throughout on understanding how national policy initiatives and local contextual conditions intersect, in order to explore more widely how national policy is interpreted and implemented locally and the factors that affect this. The focus was on the evaluation of the Vanguard programme as a whole, set against the original aims, not the individual interventions being introduced locally. Our study is underpinned by an understanding of the policy literature, notably: the importance of history in determining how national policy is interpreted and implemented locally (Pope, Robert et al. 2006, Coleman, Checkland et al. 2010); the interplay between ‘bottom up’ and ‘top down’ approaches to policy implementation (Barrett and Fudge 1982, Matland 1995); and the complexity in determining what constitutes policy ‘success’ in any given situation (Marsh and McConnell 2010, McConnell 2010).

Our national evaluation consists of four main phases. In the first phase of the project, we explored the operation of the national support programme; the role of Vanguards within local health economies; and the operation of the programme of locally commissioned evaluations. Our findings to date have been published (Checkland et al 2019, Laverty et al 2019 and Wilson et al 2019).

The second phase of the study comprised of a quantitative analysis of outcomes associated with Vanguards. This has been reported separately.

It is the third phase of the study we are reporting here. We have used qualitative case study methods in order to explore in depth the factors that affect whether and how local initiatives are implemented in response to national policy. We adopted a theoretical framework (the Strategic Action Field [SAF] framework, designed to interrogate the factors affecting policy implementation at macro (national), meso (regional) and micro (local) levels.

3.4.2. *Study aims, objectives and research questions*

In our original project proposal we posed three general research questions for the case study phase of the research. These were based upon our initial understanding of the programme and of the literature on major system change. The Strategic Action Field framework (SAF) was a good fit with our over-arching approach, and we therefore developed an expanded set of research questions based upon insights from the SAF, which guided our case study site data collection:

- **RQ1:** What is the programme of change in this case study site?
 - What has the local Vanguard programme involved, and what is the underlying causal logic assumed?
 - What methods of co-ordination have been developed and used to support the change programme at both frontline and organisational level?
 - What has changed so far in service operation and delivery, and what further changes are planned?
 - To what extent do local actors believe that new ways of doing things have been normalised?
 - What outcomes are claimed?
- **RQ2:** What have been the drivers of change in this case study site?
 - What sources of authority (including national, regional and local levels) have been successfully mobilised, by whom and under what conditions?
 - What social skills have been used to support change, by whom, at which levels and under what conditions?
 - What has been the impact of exogenous factors originating at local, regional and national level?
- **RQ3:** Looking across the case study sites, what are the common factors at local, regional and national levels (including sources of authority, social skills and exogenous factors) underpinning (perceived)

successful implementation of Vanguard change programmes, and what factors have prevented or hindered progress?

- **RQ4:** To what extent can particular claimed beneficial changes in outcomes be related to these factors?

3.4.3. *Theoretical framework*

The Strategic Action Field (SAF) framework (Moulton and Sandfort 2017) is a useful way of thinking about policy implementation, which takes account of the multiple levels which influence how a particular policy is implemented. The key assumption in this framework is that the same initiative implemented in two different places will vary according to the local SAF framework, because the change will be interpreted differently by those involved, suggesting a uniqueness in local conditions and implementation. The SAF framework assumes three broad scales as being relevant – national policy, inter-organisational, including the interaction with other policies across an area, and front-line enactment. Finally, the framework identifies three categories of factors which are called ‘drivers of change or stability’. These are:

- Sources of authority – political, economic, norms, beliefs and values;
- Social skills – interpreting, framing, brokering and bridging;
- Exogenous shocks – funding, legislation, policy change and changes in actors.

The SAF allows us to move beyond the need for ‘good leadership’ to explore, exactly what is done by whom in making change happen.

However, the framework as devised by Moulton and Sandfort focuses upon the implementation of defined interventions. The Vanguard programme, by contrast, comprised a suite of ill-defined interventions, different across the different Vanguard ‘model’ types (MCP, PACS, EHCH) We will therefore apply the SAF framework to our Vanguard case study sites, and then reflect upon if and how it might need to be modified to understand policy-driven system change where interventions are not necessarily well defined. In our final discussion we will consider the SAF framework in the light of the broader literature relating to major system change, and consider how insights from the framework might align with or further elucidate the ‘rules’ for major system change proposed by Best et al (Best, Greenhalgh et al. 2012) and Turner et al (Turner, Ramsay et al. 2016).

3.4.4. *Methods*

For this phase of the project, a qualitative case study approach was adopted to explore, in depth, the processes and experiences of participants directly involved in implementing and operating the Vanguard programme (2015-2018) at the local level. During the summer 2018, we selected six case-study sites, from the 50 New Care Models Vanguards that operated in England from 2015-2018, to study in depth and gain an understanding of their journey to devise and implement new models of care: two Multi-specialty Community Providers (MCP) Vanguards, two Integrated Primary and Acute Care Systems (PACS) Vanguards and two Enhanced Health in Care Homes (EHCH) Vanguards. We focused on these 3 model types to allow wider conclusions to be explored about the opportunities and challenges around the 3 approaches and to try to meaningfully inform the wider roll out of the Vanguard models. Choosing two case studies from each of these three Vanguard types gave us the best opportunity to explore different approaches whilst maintaining sufficient depth to provide meaningful explanations for what we saw. We made sure we have a reasonable geographical spread of Vanguards around England (2 North, 2 Midlands and 2 South), looked at progress to date and issues the Vanguards were trying to solve (informed by logic models and local evaluations).

Between October 2018 and July 2019, the research team carried out a series of focus groups and interviews with a variety of respondents at six case study sites. Interviews were a mix of face-to-face or telephone. Focus groups were conducted face-to-face and facilitated by at least one researcher. A total of 80 respondents participated at these Vanguard sites, including current and past representatives from Clinical Commissioning Groups (CCG) provider organisations, local authorities, voluntary sector organisations, Vanguard programme leads, frontline staff and patient/public contributors.

3.4.5. Findings

Our findings address our research questions in turn. The first two sections address RQ 1 and 2, with the final section answering RQs 3 and 4.

3.4.5.1. Programme of change

Our first research question focused upon what had been implemented in each site.

- We found no clear pattern of differences between the three types of Vanguard. Whilst EHCH Vanguards differed slightly in their scope (focusing upon care home populations rather than the population at large) the types of initiative implemented in EHCHs were very similar to those introduced in the other types of Vanguard. Importantly, we found that, rather than implementing any clearly defined 'models' of care, our case study Vanguards in practice consisted of a variety of individual service innovations. The most common of these was the implementation of Multidisciplinary Teams to manage care for patients with complex needs, but also involved a variety of social prescribing initiatives, community pharmacist initiatives and various approaches to health and social care co-ordination. These are set out in Table 8

Table 8: Vanguard initiatives by site

	Site 1 MCP	Site 2 MCP	Site 3 EHCH	Site 4 EHCH	Site 5 PACS	Site 6 PACS
Multidisciplinary Team	•	•	•	•	•	•
Musculoskeletal pathway					•	•
Social Prescribing	•	•		•		•
H&SC coordination	•	•	•	•	•	•
New clinical services	•	•		•	•	•
Dementia support	•		•			
End-of-life pathway		•	•		•	
Community paramedics	•				•	
Community pharmacists	•	•	•			•
Smartphone apps/tEHCH	•	•	•		•	•
Social cafe			•	•		•
Community consultants	•		•		•	•
Community therapies	•		•		•	•
Hospital transfer pathway		•	•	•	•	•
Extended access	•				•	•
Policies as interventions			•	•		
Administrative changes		•	•		•	•
Specialist staff training	•	•	•	•		•

- Whilst a number of sites had a compelling over-arching narrative about what they were trying to achieve and the way in which they intended to achieve it, it is hard to distil from these anything which might, in the longer term, develop into a 'new model' of care which could be straightforwardly codified and implemented elsewhere. Each of the approaches developed in our sites were locally specific and built upon existing initiatives.
- The Vanguard programme was generally perceived as providing an opportunity to obtain additional funding to support and build upon local initiatives which were seen as having potential. Better integration of all kinds (between primary, community and secondary care, between statutory and voluntary services, and between health and social care services) was, in all of our areas, seen as an obvious and desirable objective and the Vanguard programme was an opportunity to pursue this.

- Finally, all of our sites followed a similar trajectory, with the short-term nature of the programme perceived as problematic. In the initial stages, the substantial additional funding provided was welcome and used to support a wide variety of initiatives. However, as we documented in our interim report (Checkland et al 2019), funding was not secure, with some sites not receiving funding for year two or year three, based upon performance metrics which had not been stated at the start. Moreover, whilst many of the initiatives were locally perceived as having been successful, few (if any) were cash-releasing, meaning that many had to be scaled back or stopped when the additional funding ended. Staff were appointed or seconded to support Vanguard initiatives, but once the funding ended many of these roles disappeared. Some initiatives were absorbed into 'business as usual', but many were not.

3.4.5.2. Perceptions of Vanguard outcomes and success

Respondents from all of our case study sites were able to point to valuable effects perceived to be associated with their Vanguard.

- These largely centred on the benefits of working together across boundaries, with frequent references to increased trust.
- The processes associated with the Vanguard, particularly in the early stages, engendered a feeling of exceptionalism, in turn generating enthusiasm and engagement.
- The additional funding associated with Vanguards was very important, and this is particularly evidenced by the post-Vanguard trajectory in which many initiatives were abandoned and downgraded as the additional funding ended.
- Most initiatives represented incremental improvements in local procedures and approaches to care rather than anything which might be identified as a 'model' of care.
- We found very limited evidence of scaling or spreading of Vanguard initiatives. Where this did happen, it was usually either limited individual schemes (such as the care home initiative designed to facilitate communication between hospitals and care homes) or regional spread of a service or service model (e.g. MSK services, MDTs). This type of spread was supported by the transfer of relevant staff to posts within STPs/ICs, and was hampered by the lack of additional funding.
- This limited evidence of spread of Vanguard initiatives contrasts sharply with the programme goals and with the ambitions set out in each areas' initial 'value propositions'.
- The exception to this rather limited picture of impact is the EHCH model, elements of which are to be rolled out via Primary Care networks². This largely reflects the much more limited scope of the EHCH model, and the fact that care homes were relatively neglected in terms of health care initiatives prior to the Vanguard programme. However, it is important to note that even in our care home sites some of their initiatives were downgraded or ceased following the end of the Vanguard programme due to lack of funding. Additional funding is likely to be an important determinant of whether or not this initiative endures.

3.4.5.3. Drivers and enablers of change in case study sites

We used the Strategic Action Field framework as a theoretical framework to interrogate our data in order to understand the factors, which had initiated and supported change.

Sources of authority

We have identified the use of a wide range of sources of authority across our sites to mobilise local actors around a change programme.

- Whilst the exact pattern of particular sources mobilised differed between our sites, all regarded the 'badge' of belonging to the national Vanguard programme as an important source of political authority, at least initially.

²https://www.engage.england.nhs.uk/survey/primary-care-networks-service-specifications/supporting_documents/Draft%20PCN%20Service%20Specifications%20December%202019.pdf

- All sites used an initial narrative focusing upon an economic crisis (often verbalised as a ‘burning platform’) as a source of authority to justify significant changes in local services, whilst additional funding was important both for its own sake and as a marker of esteem.
- The values underpinning the programme as a whole – including support for local innovation, focus on collaboration and emphasis on providing value to local populations – chimed clearly with the public service ethos present in all of our sites, and in all sites the programme carried a strong moral tone.
- New norms of collaboration were prominent as mobilised sources of authority, often contrasted against the ‘bad old’ norm of competition. However, existing NHS legislation could be problematic in this context, with procurement rules, for example, militating against collaboration at times.
- The use of data and data analysis as a source of authority was not necessarily expected, and carries with it an important ambiguity and tension between robust evaluation of actual impact versus demonstration of impact for local and national political purposes.
- What runs through all of our sources of authority was the local creation of a compelling story, containing many of these elements: the establishment of a sense of crisis and pressing need for change; a narrative about why this particular area had been singled out or was recognised as being ‘special’; a moral case for why this particular change was required; and a road map or vision as to what was going to be done.

Social skills

The SAF framework focuses upon the social skills used in order to initiate and maintain policy-driven change programmes in public sector settings. We explored with individuals and groups the factors which they felt had supported their programme, and the things which had made their task more difficult. Our analysis then looked across the cases for common examples of particular social skills. What we found was somewhat more complicated than this.

- We found a complex interplay between particular contextual conditions, individual use of social skills and surrounding support functions. It appeared that beneficial or other outcomes were driven by the particular configuration of these elements at any given point in time. None were sufficient alone, but together they combined to facilitate and enable change. Not all were necessary in all cases, and the exact combination depended upon the complex social situation involved.
- At all levels throughout the system – Vanguard, STP/ICS, regional and national - in a given context, actors utilised social skills (vision, framing, leveraging position, seizing opportunities, positive risk taking, using flexibility of roles and brokering) facilitated by functions such as communication and engagement in order to ‘sell’ to others the theory behind the changes proposed, work through how to best make changes locally and implement them to benefit of those delivering and receiving the health and care services.
- Which skills were available at any time was dependant on individuals and groups of people working across the local system who had hierarchical or individual standing. Particular characteristics such as occupational credibility, length of service and ability to work across traditional organisational boundaries were important in establishing this standing.

Exogenous shocks

As predicted, exogenous shocks had potentially significant impacts. Whilst some exogenous shocks affected all Vanguards, others were locally specific, and each Vanguard reacted somewhat differently to each shock depending on their local contextual conditions and social actors. Important shocks included:

- an unpredictable annual funding round;
- the increasing reliance by NHS England upon specific performance metrics, which were not necessarily the focus of individual Vanguards’ initiatives;
- the loss of key staff.

Whilst the end date of the programme was clear from the outset, the cessation of the programme and cessation of funding were experienced as shocks by our case study sites, in part, perhaps, because they anticipated that there would be some sort of follow on initiative. However, after the end of the programme the focus shifted to Integrated Care Systems, and there was no systematic attempt by NHS England to link ex-Vanguards into the ICS programme.

3.4.6. Discussion and Conclusions

Our case study sites were very diverse in their aspirations, approaches and particular configurations of local contextual conditions. All were successful in establishing some new services and approaches, and all were generally enthusiastic about the opportunity and encouragement to work together differently. The Vanguard programme clearly chimed with their local aspirations and desired direction of travel; and to some extent, by design, built upon existing local initiatives. Those we interviewed were frank in their discussion of their local experiences and happy to discuss things which had gone less well. All agreed that the termination of the programme, and a perceived failure by NHS England to make forward links with the new evolving policy of STPs and ICSs had been difficult for them. However, they also highlighted the value of the trusting relationships that they had built locally.

Making specific links between particular contextual conditions, skilled behaviours and achieved outcomes is difficult, not least because desired outcomes shifted and changed through the trajectory of the programme. It is perhaps easiest to identify the factors supporting the initiation of change programme pilots such as this, and in this regard, we would highlight:

- a flexible programme which chimed with local aspirations and the strong public service ethos running through our sites;
- a national 'badge' which was seen to be both prestigious and affirming of previous local achievements;
- funding, although this was a double-edged sword and brought with it considerable problems, not least those associated with an annual round of funding allocations;
- a sense of crisis, by which 'business as usual' was seen by all to be unsustainable;
- the establishment of a new 'norm' of collaboration, replacing the focus on competition upon which the Health and Social Care Act 2012 had been built.

At local level individual positionality amongst those driving change was vitally important, and success seemed to be linked to:

- the involvement of those in hierarchical positions who had decision making power;
- the involvement of individuals, at operational level, who were perceived to have credibility as a result of their personal attributes (with front-line clinical experience the most important) and their longevity in a local area;
- Having a local history and extensive local knowledge, and being seen to be committed to a local area, were powerful generators of credibility and esteem.

The expected social skills of brokering, framing, translating and active boundary spanning were important, but other skills such as the appetite and ability to take risks and willingness to act beyond role expectations were also necessary. However, this latter aspect could lead to an over-reliance upon specific individuals.

Finally, the individual exercise of social skills required support from external structures to enable communication, with the edifice associated with the national programme both facilitative and, at times, unhelpful due to its size and complexity.

Underlying all of these factors is the issue of trust. Time and again individuals told us that their achievements rested upon knowing and trusting one another, and that taking time and opportunities to build trust was the most important element in their success.

In terms of the ongoing success of the case study Vanguards beyond their establishment, much depended upon what they were trying to achieve, its consonance with other local priorities and the wider local context including funding, the retention of key individuals and their ability to respond positively to exogenous shocks. The most common longer term 'success' identified by our respondents was not the achievement of particular metrics, or the retention of particular initiatives, it was the development of a local sense of purpose and commonality of vision about what they were trying to achieve.

The Strategic Action Field framework was a useful framework within which to interrogate our data, but we found that the category of ‘social skills’ required further elucidation in order to consider who was acting, how and why, in any given situation. In addition, the category of ‘norms’ needs expanding to accommodate the context of integrated care, and political sources of authority were found to be more subtle than simply the expression of existing rules. Indeed, we found that political authority derived from the state of exception associated with being a Vanguard supported actions which were, to some extent, in defiance of existing rules (e.g. competition). We also found that data analytics and the fact of public consultation could be used effectively as sources of authority.

3.5. Understanding scale and spread of Vanguard initiatives

This section reproduces a summary of our report on the scale and spread of Vanguard initiatives (see appendix p133).

3.5.1. Introduction and research aims

The Vanguard New Care Models programme was established in 2015 to test out new approaches to providing more integrated care. It was intended that pilot sites across the NHS in England would test five ‘new care models’, and an associated support and learning programme would allow the distillation of core model components which could be developed into ‘products’ to support the national roll out of the models (NHS England 2015). In practice, only one of the models (that providing additional care in residential Care Homes, known as the Enhanced Care in Care Homes model, EHCH) generated a clearly defined care model. This has subsequently been spread as a new Enhanced Health in Care Homes (EHCH) service via a national contract, the Primary Care Network Directed Enhanced Service (NHS England and BMA 2019). In this final phase of our national evaluation of the overall Vanguard programme we explored the scaling up and spreading of the EHCH model, using a framework developed by Nolte (2018) to understand the factor supporting or inhibiting the process. We address the following research questions:

- How did the Vanguard pilots feed into the development of the EHCH service model?
- What factors have affected the spread and scale of the EHCH service model?
- What does this tell us more generally about the spread and scale of pilot initiatives?

The components of the EHCH model are set out in

Box 2

Box 2: The EHCH model

- Every care home aligned to a named Primary Care Network
- Every care home has a named clinical lead
- A weekly ‘home round’ or ‘check in’ with residents prioritised for a review based on care home advice and the MDT clinical judgement (this is not intended to be a weekly review for all residents)
- Within 7 days of re/admission to a care home, a resident should have a person-centred holistic health assessment of need (will include physical, psychological, functional, social and environmental needs of the person and can draw on existing assessments that have taken place outside of the home, as long as it reflects their goals)
- Within 7 days of re/admission to a care home, a resident should have in place personalised care and support plan(s), based upon their holistic assessment
- The Network Contract Directed Enhanced Service (DES): structured medication reviews (NHS England/NHS Improvement 2020) also has a contractual requirement to prioritise care home residents who would benefit from a Structured Medication Review (SMR)

Nolte’s (2018) criteria for the successful roll out of innovations include:

1. an **organizational structure** that is adaptive and flexible, with structures that support devolved decision making;

2. **leadership and management** at different tiers that are supportive of and committed to change, including the articulation of a **clear and compelling** vision;
3. early and widespread **stakeholder involvement**, including staff and service users;
4. **dedicated and ongoing resources**, including funding, staff, infrastructure and time;
5. Effective **communication** across the organization (and, where relevant, between organizations);
6. **adaptation** of the innovation to the local **context** and integration with existing programmes and policies;
7. ongoing **monitoring and timely feedback** about progress; and
8. **evaluation** and demonstration of (cost-)effectiveness of the innovation being introduced, including assessment of health benefits.

3.5.2. *Methods*

We undertook 26 interviews with local staff involved with the Vanguards in six case study sites (including three of the five Vanguard types), and 2 interviews with national programme leads. In addition, following ethics approval, we obtained data from an associated project exploring the development of Primary Care Networks, including data from 31 interviews in non-Vanguard sites. This allowed us to compare what happened in those sites which had previously been Vanguards with those that had not. We also examined documentation associated with EHCH roll out.

3.5.3. *Findings*

3.5.3.1. Relationship of the EHCH service to the EHCH Vanguard framework

Our national-level interviewees were clear that the EHCH service programme as eventually rolled out did derive from the Vanguard EHCH pilots. However, whilst it was agreed that the outcomes achieved by the pilots clearly justified their wider roll out, the large-scale evaluation programme had been unable to isolate or elucidate the causal mechanisms underlying that achievement. As a result, the EHCH service programme as rolled out was not accompanied by clear guidance as to how particular elements should be implemented, or by advice as to what should be prioritised. In the event, roll out coincided with the early stages of the global COVID-19 pandemic. This led to acceleration of some aspects of the roll out, although this was initially led by CCGs rather than PCNs as intended. There was a sense of emergency allowing potentially difficult issues around information governance or use of IT platforms to be ignored, at least in the short term. However, at the same time the pandemic prevented a more careful or staged implementation, with local areas implementing what they could as fast as possible.

3.5.3.2. Criterion 1: Structure that is adaptive and flexible, with structures that support devolved decision making.

We found that previous experience of working together as a Vanguard was generally perceived as being helpful in rolling out the EHCH service more widely. This was, in some places, enabled by the local structures which had been developed, but more generally was supported by the relationships engendered by collaborative working during the Vanguard programme. Moreover, the Vanguard experience, in which bottom-up activity and innovation was both encouraged and incentivised, had allowed the development of modes of working and cultural norms which supported rapid progress in both EHCH roll out and pandemic response. This 'Vanguard advantage' was present in all Vanguard sites, not just those which had previously been Care Home Vanguards. Respondents suggested to us that having been a Vanguard of any kind had allowed the development of the flexible structures and devolved decision making which Nolte suggests are important for successful scaling and spreading. However, it was clear from our interviews that structures and relationships are intertwined, with those who had worked together in the Vanguard programme telling us trusting relationships were vital in allowing the flexibility to respond to new demands. The need to rapidly mobilise support for Care Homes as the pandemic proceeded acted to further catalyse and support rapid action and decision making, getting rid of some things which had previously inhibited collaboration such as difficulties in sharing data. However, previous relationship difficulties could also cast a long shadow, with Care Homes wary in their interactions with organisations which had previously sat in judgement of their performance. Sites which had previously not been Vanguards nevertheless had instituted a variety of Care Home-related services, some of which required adaptation to 'fit' the new model. In these sites too, trusting relationships were seen as vitally important.

3.5.3.3. Criterion 2: Leadership and management at different tiers that are supportive of and committed to change, including the articulation of a clear and compelling vision

The EHCH service roll-out is taking place within a complex web of system, place and neighbourhood structures. Our findings suggest that leadership structures within the PCNs, in particular, are still evolving as the PCNs reach different levels of maturity. Consequently, levels of enthusiasm for change and engagement with the wider system are variable. Previous experience of Vanguard working, for some, offered opportunities to develop leadership roles and experience. Alongside leadership by both individuals and organisation, sites told us that flexible management processes were also important, and had been facilitated by the Vanguard experience. However, local organisational reconfigurations such as CCG mergers, created instability in terms of relationships, processes and the potential for staff turnover. A need for accountability across the system was also identified.

3.5.3.4. Criterion 3: Early and widespread stakeholder involvement, including staff and service users

Engagement of staff working at an operational level was key to the roll-out and seen as the most challenging aspect for many. An important legacy of the Vanguard was believed to be the establishment of partnership working alongside the development (and maintenance) of strong, trusted relationships. Where this did not exist, there was a need to 'incentivise' engagement through monetary payments. Related to this, was the need for continuity of staff – changes in key personnel, especially those in leadership or management roles was disruptive and decelerated the pace of change. Consistent with our findings from phase 2, 'champions' and 'boundary spanners' who moved from the Vanguard into key roles within the developing ICSs, PCNs or CCG were instrumental in facilitating effective scale and spread of EHCH initiatives. It was perhaps striking that engagement with users of services was not high on the agenda for any of our sites. It is likely that in part this was due to the restrictions associated with COVID-19 with Care Homes particularly badly affected. Many Care Homes severely restricted visitors for their residents, and engagement with this group would have been very difficult. However, it is also true that engagement with service users was not a particularly prominent element of the Vanguard programme. In the longer term, it will be important to explore to what extent and how users of services are engaged with further developments of services such as these.

3.5.3.5. Criterion 4: Dedicated and ongoing resources, including funding, staff, infrastructure and time

Comparisons were drawn between Vanguard funding and funding for the EHCH service roll out. In essence, it was not just the amount of funding but the stability and flexibility of that funding over time that was deemed important for both the Vanguard programme and the EHCH service roll-out. The money made available to the Vanguards, especially at the start of the programme, was a significant enabler. However, Vanguard funding was not without tensions, as it was contingent upon meeting nationally imposed targets set later in the programme. The uncertainty that this engendered affected staff recruitment and retention, for example. Moreover, as Vanguards were designated 'pilots', funding was time-limited and this experience may have created a reluctance to engage in further new initiatives such as the EHCH service. Importantly, the rules around the use of Vanguard funding were permissive, allowing sites to invest where they saw fit. PCN funding, by contrast, is specifically allocated to PCNs and is relatively inflexible in how it can be spent. For many, the resources available for the EHCH service roll-out were insufficient and compounded by the rapid pace of implementation. In many ways, the combination of circumstances created by COVID-19, national austerity and the shift to population based systems of care created a 'perfect storm' of funding challenges within which the EHCH roll out was taking place.

3.5.3.6. Criterion 5: Communication

Good communication between providers and commissioners of care was identified as vitally important, particularly in the circumstances arising out of the pandemic. National initiatives to ensure rapid communication, such as the mandated NHS capacity tracker for rapid assessment of care home vacancies, at times clashed with local work and could have a negative influence on local communication and trust. As CCGs were required to check care home compliance with the tracker despite technology issues with the tracker itself, some interviewees felt this set back existing local relationships and ongoing partnership building. Overall, whilst formal modes of communication were important, good local relationships between staff who knew each other well were also vital.

3.5.3.7. Criterion 6: Adaptation of the innovation to the local context and integration with existing programmes and policies

Overall, the EHCH service roll out is occurring in a shifting and volatile context. As predicted by Nolte (2018), the ability to adapt to that changing context is crucial in supporting the wider roll out of the previously piloted service. We have identified a number of features of our research sites that supported or facilitated such adaptation. These include many factors which we have previously identified as supporting collaboration more generally (Checkland, Coleman et al. 2021). In particular, we found that such adaptation was supported by: involvement of individuals with a strong local history and good understanding of local collaborative projects in positions which gave them opportunities to broker relationships and support local developments; the development of concrete collaborative mechanisms such as shared IT platforms and regular meetings; and opportunities for local flexibilities to adapt initiatives to fit alongside existing programmes of work and be culturally acceptable.

3.5.3.8. Criterion 7: Ongoing monitoring and timely feedback about progress

Whilst monitoring EHCH service progress was seen as important, how sites approached this, and how much monitoring was already taking place differed significantly across the case study sites. Some had monitoring systems for evaluation of EHCH service as part of wider monitoring policies. Others initially trialled monitoring with a small number of care homes, and scaled up this approach as a result of the pandemic. Some were yet to establish a monitoring approach, but were creating/extending quality assurance roles as a reaction to COVID-19. The pandemic has also influenced how much time sites had to plan and undertake monitoring, with focus placed on rapid rollout; this was illustrated by lack of documentation around EHCH service rollout, despite many new initiatives already in place. Nonetheless, all sites were keen to learn, reflect and assess, and had recently performed evaluation exercises or were setting out evaluation plans for the future. In some areas it was clear that their experience of being part of the Vanguard programme had embedded a philosophy and approach in which sharing of experiences and learning with a wider community was both expected and welcomed.

3.5.3.9. Criterion 8: Evaluation and demonstration of (cost-) effectiveness of the innovation being introduced, including assessment of health benefits.

There is some evidence that the EHCH Vanguard pilots were partially successful in reducing emergency hospital admissions, but there has been no robust assessment of their cost effectiveness. Nevertheless, the decision was made to roll the service out via PCNs. Monitoring of (cost) effectiveness of the innovations was yet to take full shape in the case study sites. There were, however, some notable examples of work to date. Site 2 highlighted achievements against national targets (e.g. admissions to hospitals) and claimed to be able to trace these achievements to having been involved with the Vanguard previously. Site 1 had evidence around small-scale implementation of some EHCH initiatives and used this to guide investment decisions around roll-out, and Site 4 was working at reviewing and eliminating overlap between interventions resulting from Vanguard, EHCH, COVID-19 and other initiatives.

3.5.4. Discussion

3.5.4.1. EHCH services as a legacy of the Vanguard programme

Our national level interviews suggested that the Vanguard EHCH pilots played an important role in developing the subsequent EHCH PCN service specification, with many of the elements in the specification similar to those trialled in the Vanguard pilots (Coleman, Croke et al. 2020). However, in keeping with findings from our study of the programme as a whole (Checkland, Coleman et al. 2021), the broader and more detailed learning from the Vanguard programme about how to implement change across sectors was not manifest in the roll out process. Thus, whilst the Vanguard programme was designed to both develop new models of care which could be rolled out AND to work out how such models could best be implemented (Checkland, Coleman et al. 2019), in practice, the only distinct model that was developed and rolled out included no guidance at all about mechanisms for implementation. The context within which this roll out occurred – in the early stages of the global COVID-19 pandemic- may have affected this, with

speed of roll out of certain elements prioritised in order to support the struggling care home sector, but it is notable nonetheless in the context of the espoused goals of the programme overall.

3.5.4.2. Scale and spread of pilot initiatives more generally

The rationale underlying a piloting approach is that testing initiatives in a small area will provide useful insights into whether the initiative works to achieve the intended outcomes, as well as how it can best be organised and implemented. It was the explicit aim of the Vanguard programme to develop a suite of so-called 'new service models' which would, via an extensive programme of support and evaluation, be codified in order to allow their wider implementation. The EHCH care model was the only one of the Vanguard models which was so codified, and our study of its roll out via PCNs has demonstrated some of the difficulties with this approach. In particular, we found that the use of a contractual approach to roll out, whilst effective in ensuring that every area implemented the model, created some difficulties in that it is a relatively inflexible approach which may not allow the kind of local adaptation required. It required areas which had developed their own approaches to change tack to fit with the specific requirements of the service, and the implementation via a single sector - primary care – failed in some areas to capitalise on the broader cross-sectoral relationships developed during the Vanguard programme. Prior experience as a Vanguard (or via other, previous collaborative initiatives) was helpful in generating the required trust and good working relationships, but mismatch between new and old initiatives could be problematic and demoralising. The lack of any strong evidence of cost-effectiveness did not seem to be detrimental to the roll out of the programme. Funding is very important, and our study suggests that, in complex health and care systems with limited resources, tensions between organisations competing for resources will always exist no matter what finding mechanism is chosen, with resulting negative impact on relationships.

Taken together, our findings suggest that, in testing and subsequently rolling out pilot initiatives, careful attention needs to be paid to the issues set out below in Table 9.

Table 9: Supporting the scale and spread of pilot initiatives

Factor	Detailed description	Areas of focus	Examples from our study
Initiative design	Pilot initiatives that are intended to be rolled out should be carefully assessed to understand what features of the design appear to be important in enabling successful implementation and success in achieving desired outcomes.	<ul style="list-style-type: none"> • What are the design elements crucial to any success which is seen in the pilots? • How can these elements might be replicated in a wider roll out? 	The EHCH service specification for PCNs arose fairly directly out of the Vanguard programme. However, in the event (and contrary to the original intentions) the Vanguard programme did not provide any systematic assessment of the design driving any success in the pilots. Even though each Vanguard procured an evaluation, there was no systematic learning generated from this process (Wilson, Billings et al. 2021). The flexible nature of the Vanguard EHCH service was seen as important, but this was not replicated in the new PCN service.
Roll out mechanisms	In general, pilot programmes will receive more support and attention than is available once wider roll out has been initiated. Learning from the pilots should therefore include consideration of which elements of support might be replicable on a larger scale	<ul style="list-style-type: none"> • Oversight – who is responsible & accountable in a local area for roll out? • Resource approaches – how will human and material resources be allocated? • What support processes can be resourced in local areas, and which types of support are most needed? • What monitoring is required? 	A contractual model was chosen for EHCH service roll out. This had the advantage of clarity, and its inclusion in a broader contract model ensured universal coverage, but it brought associated inflexibility. EHCH service support was provided by CCGs, but this support was compromised by the uncertainty associated with ongoing NHS reorganisation. The contractual approach means that monitoring tends to focus on the incentivised elements rather than any wider consideration of beneficial outcomes
Local adaptation	Nolte makes it clear that flexibility and local adaptation are key to successful roll out, but this can be difficult to replicate beyond pilots	<ul style="list-style-type: none"> • To what extent is local adaptation allowable and desirable? • What elements can be left flexible and which should be universal? • How can new initiatives be successfully layered upon and integrated with existing initiatives? 	The EHCH service roll out via contract allowed limited local adaptation, and this proved problematic for some areas. Ironically, previous EHCH Vanguards were to some extent disadvantaged as the new service differed from locally developed examples.
Trust and relationships	All of the elements on Nolte’s framework were supported and facilitated by the existence of local trusting relationships between individuals and organisations	<ul style="list-style-type: none"> • How can individuals be supported to have satisfying long term careers in local areas? • What policies might reduce staff turnover and support retention? • If large-scale reorganisation is considered, what are the projected benefits and will those outweigh the negative impact associated with organisational churn? 	Vanguard areas were advantaged by the trust and strong relationships built up during the programme. This applied to all Vanguard types. In all areas local trusted individuals were key to successful roll out. Impending major reorganisation problematic for both individuals and organisations.
Clarity over roles and responsibilities	Clarity is required over both individuals’ and organisations’ roles and responsibilities in the roll out process	<ul style="list-style-type: none"> • Which individuals locally will drive roll out? • Which organisations will provide support? • Who is accountable, for what? 	The shift from EHCH Vanguards to PCN-led EHCH service roll out entailed a shift in responsibilities from a shared model across a Vanguard footprint to a PCN (i.e. general practice)-led approach. Organisational churn resulted in some ambiguities.

3.5.4.3. Reflections on the use of Nolte's framework

Nolte (2018) developed her framework from the wider literature relating to the diffusion of innovations, and we found it to be a useful approach for structuring our findings. There were, however, a number of issues which arose in our sites that do not fall neatly into the categories as defined. In particular, roles, responsibilities and governance mechanisms, although implicit in Nolte's framework, needed to be explicitly considered. In addition, the framework takes as given the fact of a stable implementation context. Our context was in considerable turmoil (changing organisational context, COVID-19 pandemic etc.), and this was an important factor in what happened. Where initiatives cross-sectoral boundaries, meso-level co-ordination is important, but difficult to achieve if the meso-level organisations are themselves subject to change. Moreover, the need to engage multiple small private providers brings with it its own challenges.

In addition, we found that, in applying this approach specifically to scale up and roll out of pilot innovations, restructuring Nolte's factors around our two categories (local area characteristics and the design of the initiative) may be helpful. This draws attention to issues such as: the extent to which local adaptation is allowable; appropriate oversight mechanisms; and the totality of resources (funding, workforce etc.) available - those pre-existing and those associated with the initiative.

More generally, we found that Nolte's criteria are predicated upon the idea of a fixed and stable local health care environment, in which formal hierarchy and organisational relationships are the most important factors determining rational roll out of planned initiatives. In reality, health care contexts are considerably more complex than this, with each local health economy consisting of relationships and previous initiatives layered both in time and in place. The legacy of previous initiatives and the associated relationships structure responses to new initiatives in ways which are not necessarily predictable (Coleman, Checkland et al. 2010). Facilitating the scale and spread of pilots therefore requires not only an understanding of the contextual factors which affected the initial pilot, but also a deep understanding of the context to which spread is intended to occur, alongside enough flexibility to allow necessary adaptation to occur.

3.5.5. Conclusion

The EHCH service roll out represents a success for the Vanguard programme, as a framework developed via the programme has now been implemented across England. However, there were perhaps lost opportunities in using the wider learning from the programme about the detail of factors underpinning effective implementation to support the design of the service as it was rolled out. Vanguard sites highly valued the opportunity for local 'bottom up' input to service design allowed in the scheme (Checkland, Coleman et al. 2019), something which is not possible with the use of the relatively inflexible PCN contract as a vehicle for roll out. Whilst convenient and effective in ensuring universality, it is by no means certain that the beneficial effects seen in Vanguard EHCH sites will be replicated when the conditions of implementation are so different. The broader question as to whether it is possible to define and spread to other contexts the 'active ingredients' of apparently beneficial service changes remains unanswered. Notwithstanding this, the implementation of new services during the global pandemic is tribute to the hard work and commitment of those involved.

3.6. Summary: implementing the Vanguard programme and meeting its goals

The Vanguard programme was ambitious and fast moving. We have identified it in Matland's (1995) terms as a high ambiguity, low conflict programme, which suggests that locally-driven and context-sensitive implementation is required. The programme started with a clear intention to generate replicable care design frameworks which could be rapidly spread to other areas, and to use a combination of evaluation methods to support generalised learning about implementation. The programme was very successful in generating activity and enthusiasm, with local areas organising themselves rapidly to join the programme and successfully implementing new services. However, with the exception of the Enhanced Care in Care Homes framework, in spite of a very well-resourced support programme, no generalizable or replicable service models were developed. Changes were mostly local and incremental, and there were no examples of successful implementation of anything resembling the 'new models of care' incorporating new contractual models which were envisaged in the original policy documents. There was limited evidence of learning from implementation, with reports from the internal evaluation team not published outside NHS

England/internal NHS websites and no clear link between syntheses of Vanguard experiences and subsequent policies. Local evaluations were procured at significant cost. These were valued by local areas, but our synthesis demonstrated considerable challenges, and reports were of variable quality. We suggest that the role of local evaluations in future programmes needs to be more clearly identified; formative feedback may be of more value than attempts to generate generalisable findings. NHS England did not respond to the National Audit Office's call for the publication of a full assessment of the learning from the programme (National Audit Office 2018, p13), which we would suggest was a missed opportunity.

In terms of the factors supporting the successful initiation of change in Vanguard sites, we found that pre-existing trusting relationships were key, supporting both initial response to the call for volunteer sites and the rapid initiation of projects locally. Stability of employment of middle managers and senior clinicians is particularly important, both in initiating and maintaining change programmes, and this is something that can and should be prioritised if successful long-term change in services is to be achieved. The high-profile nature of the programme and the kudos associated with being labelled as a Vanguard were helpful, and the bottom-up ethos of the programme, enabling local development of services was valued. However, this latter factor also was instrumental in the failure to develop standardised 'care models', as generating coherent learning and design principles from disparate local initiatives is very difficult. The initial funding was crucial, but the belief that pilots could become self-sustaining (as set out in pilot sites' initial 'value propositions') within three years was overly optimistic. This meant that when the 3 years of funding ended, many initiatives were finished or scaled back. Moreover, a shift halfway through the programme from a permissive, bottom-up ethos to one in which funding was conditional upon meeting a small number of standard performance targets caused problems for Vanguards. There was a tension within the programme between a rational attempt to determine benefits from a specific perspective (reduction in acute activity in secondary care, tied to future funding) and the widespread use within the support programme of anecdotal 'success stories', designed to demonstrate beneficial change associated with Vanguards in order to continue to generate 'bottom-up' enthusiasm for change.

The only element of the programme which was explicitly drawn together into a framework and spread more widely was the Enhanced Care in Care Homes service model, which was subsequently implemented via Primary Care Networks, using a contractual approach. Our research suggests that this occurred in part because services in Care Homes had been historically neglected, leaving significant room for improvement in a small-scale care sector in which it was relatively easy to identify targets for improvement. The top-down contractual model chosen for this roll-out generated some issues, in particular the fact that previous Vanguard sites which had developed locally specific approaches were required to change what they were doing, in ways which some felt represented a downgrading of services. At the same time, the strong relationships developed during the Vanguard process were found to be helpful. We found that the roll out of the EHCH framework was not accompanied by any specific support based on evidence derived from the Vanguard experiences or from learning across the programme. Beyond the EHCH framework we found limited evidence of 'scaling and spreading' of Vanguard services. Where this had occurred it usually entailed some specific service, such as a multidisciplinary team approach across neighbourhoods, and the relationship to the Vanguard programme was often unclear.

Drawing together these findings, we found that, notwithstanding that fact that local areas were enthusiastic about their involvement, the short-term nature of the Vanguard programme was problematic. Halfway through the programme national attention shifted to Sustainability and Transformation Partnerships and subsequently Accountable Care/Integrated Care Systems (ACS/ICS) (see Figure 3 p21). This shift was associated with an apparent shift in attention away from attempts to learn lessons from the Vanguard programme. This meant that subsequent policy such as the roll out of the EHCH framework and the development of ICSs has not been accompanied by any detailed implementation guidance drawing upon Vanguard experiences. Our study found that long-term relationships and trust within local areas is crucial for successful change programmes, and would suggest that policy

could usefully consider ways to foster such relationships. The Vanguard programme was underpinned by an assumption that pilots, accompanied by an extensive programme of evaluation and support, could test new service models, subsequently identifying and then spreading 'active ingredients' (see

Figure 2 p17). This was only achieved in the very limited sense that the EHCH framework was rolled out via Primary Care Networks; well short of the ambitions set out in the Five Year Forward View of wholesale service redesign across health economies. We will return to this question in our discussion, but this chapter suggests that: the goals of the programme were probably over-ambitious; such change takes a long time to develop and requires long term investment; and that the ambition to learn lessons from local pilots requires long term attention to detail and painstaking efforts to synthesise experiences and learn from local outcomes.

CHAPTER 4: The place of Vanguards in Local Health Economies

4.1. Introduction

The Vanguard programme took place in a complex landscape of other initiatives. In particular, prior to the Vanguard programme a number of areas of England had been designated as 'Integration Pioneers' (launched in 2013), charged with accelerating integration between services and sectors in their areas. Some of these also went on to become Vanguards. Furthermore, both of these initiatives built upon previous attempts to integrate services, such as the Integrated Care Pilots initiated in 2008. At the same time, halfway through the Vanguard programme, wider-scale Sustainability and Transformation Partnerships (STPs) were established, intended to support integration across sectors and build upon progress made by Vanguards.

In order to explore this complexity and understand its impact on the Vanguard programme, our second research question was:

How do Vanguards interact with other policy initiatives such as Integration Pioneers and Sustainability and Transformation Plans (STPs)?

We addressed this question in three ways:

- Asking qualitative interviewees about any interactions with other initiatives in their local area and with STPs/ICSs
- Interviewing STP leads across England
- Working with the Integration Pioneers evaluation team on a combined analysis of the impact of the two programmes

In the rest of this chapter we reproduce some text from our qualitative case study report and a standalone report of interviews with STP leads. The findings from our work with the Pioneers programme evaluators is described in Section 5.3 p715.3.

4.2. Interactions with other integration initiatives

In the initial stages of our study we spent some time trying to understand the wide variety of initiatives established as part of the Vanguard programme. It was clear that a history of previously working together under a previous initiative was important both in being able to rapidly put together an application to join the programme and in facilitating change locally. Individuals from different organisations who had worked together as part of previous initiatives told us that the trust and confidence developed was invaluable in the process of implementing their local Vanguard. There was thus a built in advantage for sites which had previously worked together. There were some attempts by NHS England to make links between the Integration Pioneer Programme and the Vanguards, via joint meetings and links made by local NHSE Account Managers, the two programmes remained distinct, not least because the Vanguards received much greater funding.

We also explored the extent to which local Vanguards felt that their initiatives and experiences had influenced later initiatives such as STPs/ICSs. Apart from a few notable exceptions, there were not many concrete examples of the extent to which Vanguard activity had had a direct impact on the integration initiative occurring across wider footprints, known as Sustainability and Transformation Partnerships (STPs) or Integrated Care Systems (ICSs). Most respondents reported the potential for 'influence' rather than actual effects. Positive examples however emanated from two sites, where the transfer of roles and posts from the Vanguard to the STP/ICS provided distinct and solid opportunities for scale and spread.

In site 1 for example, there appeared to be a range of encouraging examples of how the Vanguard activity had impacted at the STP level, felt largely due to key Vanguard personnel either now working for the STP or appointed in advisory roles:

Two of us have come over, so [name] and I were both in [the Vanguard] and now in the STP, in the local care team. We've got two main objectives for local care for this year. One is setting up of MDTs, the other is care navigation. So setting up MDTs, this is bread and butter for us isn't it? (S1R04)

When I knew I was coming to the STP, I asked if I could bring all that we'd built up in the Vanguard, which was a lot, over to the STP so that the ceiling became the floor for the STP. (S1R03)

As a consequence, the STP was reported to have adopted the particular MDT model with its associated learning from the Vanguard. For example, data sharing agreements have been directly imported into the STP; case studies of the MDTs and social prescribing are now part of resource packs being used by the STP; and the local evaluation report is being used by the STP to guide implementation. In addition, the STP were developing a carer's app which will be linked to the Vanguard directory of services for social prescribing. The ambition is for this Vanguard influence to be incorporated into a third wave ICS.

This STP/ICS involvement was also felt by some in site 5 to be useful, enabling them to champion and further good practice that had been developed at the local level:

I think that the key leaders in terms of [named], who was chair of the [Site 5] Vanguard board at the time and is now chair of the ICS, so he's added that continuity and is absolutely key to taking a number of what we're trying to do forward and is really passionate about ensuring that we do act as an integrated care system with all the learning from the Vanguard. (S5R08)

Others argued that the Vanguard programme had had a more diffuse influence, in particular relating to Care Homes, which had been given added prominence by their inclusion in the Vanguard programme:

I get a sense that people are...instead of such a kind of looking down on care homes, there's a bit more of a working with them. (S3R01)

More generally, we saw some evidence of initiatives started under Vanguards being passed over to the STP for further development. The timely ability of the STPs/ICSs in 'taking the baton' for the further development, scale and spread of Vanguard initiatives is important, given the recognised delays in establishing initiative maturity within the Vanguards themselves (Checkland et al 2019).

A number of sites however did recognise that the emerging ICSs are focusing on larger scale population change and prevention related to cancer, heart disease and stroke for example. This was seen to have both positive and negative consequences in relation to the influence Vanguards could have on ICS activity. For example, in site 6, the main focus of the STP/ICS was on broader priorities, such as linking mental and physical health, investing in out of hospital care, and joining up health and social care. However, respondents reported that the geographical MDT initiative blended

well with these priorities, being population focused and intrinsically geared towards service integration, and hence was reported to be rolling out across the area.

4.3. The perspective from STP leads

4.3.1. Introduction

Each Vanguard is situated within a complex local landscape of health and social care organisations and plans. The objective of one of our work packages (WP1c) was to establish the position of Vanguards within their local health economies, addressing the question:

‘How do Vanguards interact with other policy initiatives such as Integration Pioneers and Sustainability and Transformation Partnerships / Plans?’

This is important because Vanguards exist in a complex landscape of initiatives, including Integration Pioneers, primary care Federations, non-Vanguard new care models (e.g. Accountable Care Organisations, Integrated Care Systems) and Sustainability and Transformation partnerships / plans (STPs) (NHS England web ref). This short report sets out the results of one part of the research, a survey of Strategic Transformation Partnership (STP) Leads, to examine how the Vanguard programme has been understood and managed at the meso level.

4.3.2. What we did

Between February – April 2018 we undertook a survey (by phone) of a sample of STP leads in senior management roles who had one or more Vanguard sites in their area to gauge how the Vanguards fitted into their local health economy and how they were perceived by those driving the developing STPs. This resulted in us speaking to 12 leaders, geographically spread across England, covering different Vanguard model types.

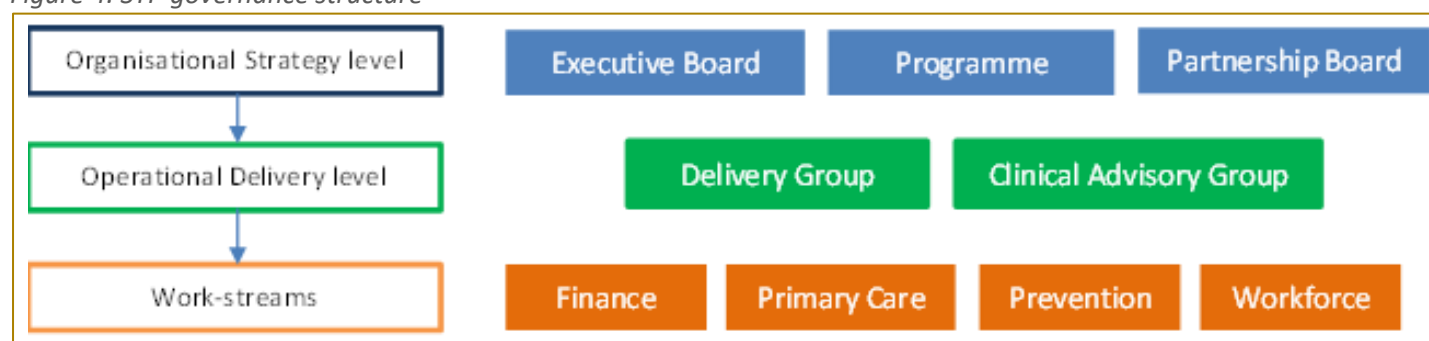
We have also linked up with the National Audit Office to gain the views of Vanguard leads across England (National Audit Office 2018) – this is reported separately.

4.3.3. What we found

4.3.3.1. The role and governance of the STP and Vanguards

STPs have no formal statutory form, and no legal powers. Notwithstanding this, each STP has developed a governance structure in order to support its work. These structure largely followed the same template, which is illustrated in Figure 4. At the top tier are organisational and strategy boards, largely attended by the chief executives and leaders of all partner organisations, which focus on wider structural issues. Below this are delivery boards, often represented by senior clinical leads, focussing on operational issues and supporting these are work-streams focusing on particular services or topics areas.

Figure 4: STP governance structure



A number of leads suggested that the idea of STPs has become reified. They view STPs as partnerships, not as organisations, and as such, there is only informal governance that is dependent on the cooperation of partner organisations. For example, STP Lead H describes the partnership as ‘the coalition of the willing’.

Vanguards are represented in a variety of ways in the STP governance structure. In two STPs, particular individuals’ roles meant that the Vanguards were represented at the organisational and strategy level on appropriate boards. In three STPs, Vanguard representatives attended boards at the operational delivery level, while in another three STP areas Vanguards were represented in appropriate work-streams. Four STP leads explicitly stated that Vanguards were not represented independently from other organisations and had been subsumed within wider STP strategies around population needs.

All of the STP leads anticipated undergoing change at the organisation level over the next 12 months with most citing significant system reform which would involve new structures and governance as existing organisations (e.g. Clinical Commissioning Groups (CCGs)) and partnerships merge. This was described as an ‘evolving process’ (STP B) or ‘moving beast’ (STP E). Some STP leads expressed concerns about taking on a more regulatory role within the current STP system in which providers are stakeholders. Part of the anticipated change also related to a move towards Integrated Care Organisations and Systems (ICO/Ss) and waiting for national guidance about regulatory and legal frameworks. The majority of STP leads were committed to (6 participants) or cautiously optimistic (4 participants) about a move to an Integrated Care Organisation/Systems (ICO/S) in the future. Whilst some of these participants regarded ICO/S as inevitable, others expressed concerns about the semantics of these changes. A few STP leads expressed concerns about the political implications of having an ICO/S in their name.

4.3.3.2. How the Vanguards fit within the aims of the STP

The leads were asked to outline the main goals of their STP. All but one participant stated financial security as a key goal, followed by improving population health by better responding to local needs (9 participants) and more efficiency (5 participants) through collaborative working (4 participants). Two explicitly stated that their STP goals were aligned to national and FYFV (NHS England 2014) priorities. The understanding of core Vanguard aims and objectives were seen as closely aligned to wider STP goals (4 participants stated this explicitly), with a focus on improving efficiency (through improving sustainability, reducing variation in quality of care), integrating care (6 participants), and improved patient outcomes through better responding to population needs (4 participants). Individual aims and objectives related to the particular model of Vanguard were also reported within the broad goals.

Within the local health economy, Vanguards were seen as initiating developments that were in the general future direction of travel for the STP. Vanguards were seen as able to demonstrate how things might work and identify components that work/don’t work within an area and service. Four STP leads reported creating new initiatives based on Vanguard learning (from local or national sites) to implement change. A number of STP leads saw Vanguards as starting out as pilots and gradually moving to exemplars as they improved and produced positive outcomes through the process. As such, over half of the participants saw the Vanguards’ contribution to wider STP goals as integral (7 participants). A further 5 regarded Vanguards as contributors towards STP goals. Where participants did not see the Vanguards as integral or contributors this was down to systems having changed or the Vanguards focussing on specific limited services.

For STP areas with more than one type of Vanguard, leads were asked about the different levels of success and integration between them. On the whole, participants found it difficult to compare between different models due to different priorities and outcomes, and the different levels of complexities facing some Vanguards due to their diverse starting points (areas with pre-existing relationships compared to areas starting from scratch) and services

they were engaged with. Success was relatively hard to discern with no one system seen as able to show definitive outcomes. Instead, it was components of a model rather than the model itself that was seen as a success or failure.

Five STPs were involved in the allocation of final year funding to the Vanguards, whilst two STP reported that the decision remained within the relevant CCG. Five participants reported that funding was decided by the national NCM team. For the STPs that were involved in funding decisions, hard and soft metrics were considered alongside efficiency and scale of delivery. NHS England and NHS Improvement provided oversight of the Vanguard programme at various levels, such as monitoring performance indicators. This support and oversight came primarily from the NHS England team. Participants were unanimous in stating that there was no change in oversight or inspections from the Care Quality Commission who remained focussed on individual organisations.

There were large amounts of variance in how different Vanguards were integrated into their STP. Whilst the majority of participants reported that the findings and learning would be used to inform the wider STP system, others thought that some but not all Vanguard models would be integrated into the STP going forward. In turn, there was uncertainty about the sustainability of the Vanguards within the STPs. Three STP leads reported that they were providing funding for the Vanguard to continue. A further three participants thought funding may be provided if senior management could be persuaded. In other areas, the learning and successful components of Vanguards were seen as likely to continue to be taken forward, whilst two STP leads stated that the Vanguards had been subsumed into the wider STP programme and would not continue to receive independent funding.

4.3.3.3. Facilitators and hindrances to Vanguard understanding and integration within the STP

The key facilitator described was individual relationships. Seven leads had direct involvement in a Vanguard through their multiple roles such as membership on the board or as the AO responsible for signing off funding, helping to facilitate communication and networks. Where a lack of engagement was identified, relationships were created. For example, STP lead B employed a member of the Vanguard staff within the STP in order to provide a direct link. This was limited, however, when there were multiple Vanguards within an area. Four STP leads described having a reporting and monitoring role of Vanguards whilst others referred to their involvement in more vague terms: as integrated into the daily work of the STP or using learning from the Vanguard.

The biggest hindrance to STPs' understanding of the Vanguards was the timing and sequencing of both programmes. Although both STPs and Vanguards were created to drive forward the priorities of the FYFV, the Vanguard selection process occurred in early 2015 whilst STPs came afterwards and plans were not formally submitted until September 2016. This created difficulty in matching aims and objectives. Two further related hindrances were the knock-on effect of Vanguards on existing initiatives and resentment as a result of Vanguard funding, branding and additional support. A small number of leads stated that the branding and focus on Vanguards was not helpful and led to other initiatives and projects being dropped or forgotten.

Finally, STP leads were asked to think about their overall view of the FYFV and the Vanguard programme in meeting the goals of the STP. The majority of participants found the FYFV and updated documents useful in providing a direction for the future and a way for the NHS to remain sustainable. How easy it is to implement, however, was not as certain. The majority of STP leads described the Vanguard programme as helpful (8 participants) or vital (6 participants) to help deliver FYFV goals. They were also seen as helpful to kick-start change, and provide the funding and resources to test out new ways of working.

4.3.3.4. What this means

It was seen that at this meso level (local health economy / STP) Vanguards were perceived in different ways dependant on local context, models of Vanguard and existing history (e.g. longer term relationships). Despite

Vanguards and STPs both being established to help deliver the FYFV, due to the uncoordinated sequencing of their introduction, aligning developments has been a challenge in many areas.

Many of the STP leads saw Vanguards as helpful in testing new ways of working, adding additional funding to the local health economy, and kick starting change. Vanguards were represented at the different levels of the STPs evolving governance structures which helped to facilitate coordinated developments going forward and build relationships between the different organisations and partnerships involved.

The focus nationally has moved away from Vanguards towards larger-scale Integrated Care Organisations/Systems. Our survey suggests that, in some areas, local relationships and structures will offer an opportunity for the learning gained from Vanguards to be incorporated into the new developments. However, it is by no means inevitable that this will happen, and there is a risk that the shift in focus to larger populations and changes in personnel will mean that learning from the Vanguards will be lost.

There was some concern over future funding, integration and sustainability of Vanguard initiatives, with some lack of clarity as to whether Vanguards will continue to receive the additional funding that they need. We also found some apprehension about the potential monitoring roles of STPs in local health economies, and the potential for overlap with other regulatory mechanisms (NHS England, NHS Improvement, Care Quality Commission).

4.4. Summary

Vanguards were established in a complex landscape of repeated initiatives. Many groups applying to join the programme were able to do so because they already had a history of working together under previous integration/innovation initiative. The relationships and trust engendered by these previous experiences were vital in allowing local areas to work together effectively to establish themselves. However, once Vanguards were established there was little interaction with other initiatives that were happening simultaneously, such as Integration Pioneers. The establishment of Sustainability and Transformation Partnerships (later becoming Integrated Care Systems) occurred early in the Vanguard programme, and there was no clear mechanism for linking the two, with no systematic mechanism by which STPs/ICSs could learn from the experiences of local Vanguards; the extent to which this happened was generally determined by serendipitous factors such as the employment by STPs of ex-Vanguard staff, and the personal relationships or activities of those involved. Indeed, although STPs and ICSs have been presented publicly as 'learning from the Vanguards' (NHS England 2019), in practice there is little evidence as to whether and how this has occurred.

Chapter 5: Vanguard outcomes

5.1. Introduction

Our quantitative work packages were designed to answer the following research question:

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

As set out in section 2.3 p23, our initial intention was to do some initial economic modelling in order to project how Vanguard sites might achieve the beneficial change in outcomes to which they aspired, using the published 'logic models' to identify relevant activities and causal pathways. However, when we explored Vanguard logic models and 'value propositions' (their statement of their plans and expected outcomes) we found that they were generally diffuse and lacking in the specificity required to do any economic modelling. In discussion with our advisory group we therefore did not undertake this initial modelling. Instead we worked closely with the NHS England internal evaluation team to undertake an analysis of outcomes data associated with the Vanguards. This was published as an academic paper (see appendix p133). We include here the abstract and discussion section from that paper. In addition, our quantitative exploration of outcomes includes:

- A comparison of Vanguards with Integration Pioneers – published paper included as an appendix, abstract and discussion included here;
- A new analysis of longer term outcomes associated with Vanguard status;
- A new individual patient-level analysis of the impact of the Vanguard programme
- A new analysis of the impact of Vanguards on variation of hospital activities across localities before/during/after the Vanguard programme
- A new analysis of the impact of Vanguard status on individual level social-care related outcomes.

5.2. Early Vanguard outcomes

5.2.1. Introduction

We undertook an early analysis which explored the impact of three types of Vanguards (MCPs, PACS and EHCH) on both emergency admissions and hospital bed days. This analysis was published as an academic paper in the journal *Health Policy* (Morciano, Checkland et al. 2020). The full paper, including a detailed explanation of the methods used is available online (see appendix p133). We reproduce here the abstract from the paper and the discussion.

5.2.2. Paper abstract (Morciano, Checkland et al. 2020):

Closer integration of health and social care services has become a cornerstone policy in many developed countries, but there is still debate over what the appropriate population and service level to target. In England, the Long Term Plan for the National Health Service (2019) announced the commitment to spread the integration prototypes piloted under the Vanguard 'New Care Models' programme. The programme, running from 2015-2018, was one of the largest pilots in English history, covering around 9% of the population. It was largely intended to design prototypes aimed at reducing hospital utilisation by moving specialist care out of hospital into the community and by fostering coordination of health, care and rehabilitation services for (i) the whole population ('population-based sites'), or (ii) care home residents ('care home sites').

In this paper, we evaluate and compare the efficacy of the population-based and care home site integrated care models in reducing hospital utilisation. We use area-level monthly counts of emergency admissions and bed-days obtained from administrative data using a quasi-experimental difference-in-differences setup.

We found that Vanguard sites had higher hospital utilisation than non-participants in the pre-intervention period. In the post-intervention period, there is clear evidence of a substantial increase in emergency admissions among non-

Vanguard sites. The Vanguard integrated care programme slowed the rise in emergency admissions, especially in care home sites and in the third and final year. There was no significant reduction in bed-days.

In conclusion, integrated care policies should not be relied upon to make large reductions in hospital activity in the short-run, especially for population-based models.

5.2.3. Discussion

The main components of the Vanguard 'New Care Models' programme for the three prototypes we focussed on (MCP/PACS and EHCH) were largely intended to reduce hospital utilisation by moving specialist care out of hospital into the community and by fostering coordination of health, care and rehabilitation services for care home residents.

5.2.3.1. Principal findings

Vanguard sites experienced higher emergency admissions and total bed-days rates than non-Vanguard sites in the two years prior to their introduction. After their introduction, non-Vanguard sites experienced a sharp increase in emergency admissions, especially since 2017. Over the three years of the programme, a significant relative net reduction of -4.2% in emergency admission rates was found only in the care home sites, with the bulk of the effect occurring among the adult and older population. The magnitude of the net reduction in the emergency admission rates in care home sites increased over time and became statistically significant in the third year after implementation. In that year, a significant reduction in emergency admission rates of -3.1% also emerged for the population-based sites. However, the introduction of the Vanguard prototypes was not associated with an overall reduction in total bed-days.

5.2.3.2. Limitations

Our study has four main limitations. Firstly, our estimates are valid under the assumption that the outcomes would have followed the same trend in the Vanguard and non-Vanguard groups in the absence of the programme. Under that assumption, the (adjusted) difference we observe in the evolution of the outcome between those groups is attributable to the Vanguard integrated care programme. We found evidence of parallel trends prior to implementation in the Vanguard and non-Vanguard groups. We also undertook a series of analyses to assess the robustness of our findings to the treatment of missing values, the length of the pre-intervention period used and the definition of the control group. While the estimated net effects were only marginally influenced, the goodness-of-fit statistics worsened compared to our main analysis. Nonetheless we cannot rule out the possibility that confounding events, unrelated to the programme implementation, have affected one group more than the other in the post-implementation period. For example, other coincident innovation programmes (e.g. the "Pioneer" wave 2) might have influenced our results. Further analysis on the overlapping of innovation programmes are therefore required (see section 5.3)

Secondly, residual confounding may still occur should historic differences not fully identify whether the intervention sites are more or less likely to embrace the intervention. There were in excess of 260 (NHS England 2017, National Audit Office 2018) expressions of interest for becoming a Vanguard prototype, and only 50 were successful. Including unsuccessful applicants in the control group might have introduced bias in the analysis but information no longer existed on the unsuccessful Vanguard applicants. Unmeasured factors might therefore have biased our estimated effects.

Thirdly, our focus was on two outcomes: emergency admissions and total bed-days rates. These outcomes were chosen because the types of Vanguards analysed were typically expected to involve an emphasis on prevention and hospital admissions avoidance, and emergency admission and bed-days rates became the main outcome measures assessed by the programme in the second and third years (National Audit Office 2018, Checkland, Coleman et al. 2019). We recognise that Vanguards, like other integration initiatives, were initially set up with a much broader

range of objectives, but it has not proved possible to robustly evaluate Vanguards against these as the data are not available and local objectives were rarely set in such a way as to be evaluable (Wilson, Billings et al. 2021).

Finally, leading on from this, our analysis aimed at assessing whether the programme as a whole had a measurable impact on service use (i.e. hospital utilisation). We were not able to link the outcomes to specific initiatives within the Vanguards because the initiatives implemented were heterogeneous and poorly defined (Checkland, Coleman et al. 2019). It is therefore difficult to know what the drivers of the improvements in outcomes that we have shown might be. For example, the effect of NHS England directly linked continued payment to improvements in specific measures in the third year. Because funding for the final year of the Vanguard programme was only available if progress could be shown against measures of emergency admissions, this may have driven improvements in coding alongside efforts to reduce admissions. Our qualitative work has shown that this linkage did lead some Vanguards to discard some of their initiatives which were not directly focused upon admissions (Checkland, Coleman et al. 2021), and it may be that this sharper focus drove improvements. Further research is required in order to explore in more depth whether improvements in outcomes derive from specific service innovations or whether they are driven by a more general improvement in collaboration and communication between sectors consequent upon engagement in a pilot such as this (Goodwin 2019).

5.2.3.3. Strengths in relation to other studies

The 2019 NHS Long Term Plan announced that “[f]ollowing three years of testing alternative models in the Five Year Forward View through integrated care ‘Vanguards’ [...], we now know enough to commit to a series of community service redesigns everywhere” (p.13) (NHS England 2019). Evidence of reduced emergency admissions attributable to the population-based (PACS and MCP) programmes underpinning this statement were gathered from an internal NHS national evaluation. We have used a dataset that is very similar to that used by the NHS national evaluation team. In supplementary Appendix 3, we replicated closely their results, by computing analogous rolling 12-months moving averages on raw outcomes indexed to the month of intervention. However, we conducted a more extensive statistical analysis that additionally includes an evaluation for the care home (EHCH) scheme, showing these to be most effective on the emergency admissions measure over the first three years.

In addition to these national studies there have been evaluations of individual Vanguards. A study conducted as part of the national new care models evaluation included an evidence synthesis of locally-commissioned evaluations (Wilson, Billings et al. 2021). The synthesis summarised a significant grey literature of 108 local evaluation reports. It concluded that many local areas struggled to design and carry out robust evaluation designs, with particular problems in collecting relevant data (National Audit Office 2018, Wilson, Billings et al. 2021). Robust evaluations of some individual Vanguards have been undertaken by The Improvement Analytics Unit (a partnership between NHS England and The Health Foundation) and have found mixed results (Wolters, Santos et al. 2019). Their evaluation of four specific care home sites has shown significant reductions of emergency admission from care home residents in three sites (Rushcliffe, Wakefield and Nottingham City) but inconclusive results for the other site (Sutton) (Smith, Sherlaw-Johnson et al. 2015). Our overall evaluation of all care home sites shows that on average there is a relative net reduction in hospital admissions for this model of integration, more beneficial than a population-based model over the three years follow-up.

5.2.3.4. Meaning of the study

Providing more integrated care for patients is not straightforward. In this paper we have tested the NHS England Vanguard pilots (PACS/MCP and EHCH) against their official objective (reducing hospital usage) and shown that, whilst there were modest reductions in emergency admissions in Vanguard sites, these were seen mostly in the pilots which targeted elderly people living in care homes. The results suggest that focused interventions on a concentrated population of care home residents who are vulnerable to high levels of emergency admissions are likely to be most effective in keeping people out of hospital over the time period analysed (Lemoyne, Herbots et al.

2019). Moreover, our results clearly show no net changes in the first year and net reductions in emergency admissions only became significant after three years. This suggests that, even in a relatively straightforward organisational context where initiatives can be applied to a whole resident population, achieving desired results takes time. In addition, absolute emergency admissions were not reduced in the Vanguard sites, with the effect driven by the large increase in emergency admissions in the non-Vanguard sites. Finally, the modest net reduction in emergency admissions which we have shown was achieved with the help of considerable additional funding and a dedicated support programme for Vanguard sites. Our results do not assess the cost-effectiveness of this approach to integrating care.

5.2.3.5. Policy implications & future research

The recent NHS Long Term Plan announced the “commit[ment] to a series of community service redesigns everywhere” (p. 13) (NHS England 2019), spreading the innovative practices piloted with the Vanguard initiative. The way in which the spread will be operationalised is still far from clear and not well understood. Our research sheds lights on the effects of such initiatives on those sites involved in the programme. It cautions that the effect is likely to be heterogeneous among sites and initiatives and unlikely to be detectable in the short-term. This suggests that those seeking to introduce similar initiatives in other policy contexts should take a longer-term view and refrain from judging policy success too soon. It also suggests that the approach taken by the Vanguard programme – of making funding contingent upon the achievement of measurable impact against a narrow range of prescribed metrics within two years – was probably flawed. Vanguard sites received national support and considerable additional funding, and it remains to be seen if any beneficial impacts can be replicated without this funding and the associated support. We address this in section 5.6.

5.3. Comparing Vanguards with other integration initiatives

5.3.1. Introduction

As discussed in Chapter 0 (p36), sites which successfully applied to become Vanguards were often able to do so because they had a history of working collaboratively under one or more previous policy initiative. We therefore identified that it would be valuable to consider whether or not the modest and variable impacts of the Vanguard initiatives that we found in our early analysis could be explained by the co-occurrence of other initiatives. We worked with the Integration Pioneer evaluation team on an analysis which was published as an academic paper (Morciano, Checkland et al. 2021). The full paper is available online (see appendix p133) including a detailed presentation of the methods and results. We reproduce here the abstract and the discussion.

5.3.2. Abstract

Background: Policy-makers expect that integration of health and social care will improve user and carer experience and reduce avoidable hospital use.

Objective: To evaluate the impact on emergency hospital admissions of two large nationally-initiated service integration programmes in England: the Pioneer (November 2013 to March 2018) and Vanguard (January 2015 to March 2018) programmes. The latter had far greater financial and expert support from central agencies.

Methods: Of the 206 Clinical Commissioning Groups (CCGs) in England, 51(25%) were involved in the Pioneer programme only, 22(11%) were involved in the Vanguard programme only and 13(6%) were involved in both programmes. We used quasi-experimental methods to compare monthly counts of emergency admissions between four groups of CCGs, before and after the introduction of the two programmes.

Results: CCGs involved in the programmes had higher monthly hospital emergency admission rates than non-participants prior to their introduction [7.9 (95% CI:7.8-8.1) versus 7.5 (CI: 7.4-7.6) per 1000 population]. From 2013 to 2018, there was a 12% (95% CI:9.5%-13.6%) increase in emergency admissions in CCGs not involved in either

programme while emergency admissions in CCGs in the Pioneer and Vanguard programmes increased by 6.4% (95% CI: 3.8%-9.0%) and 8.8% (95% CI:4.5%-13.1%), respectively. CCGs involved in both initiatives experienced a smaller increase of 3.5% (95% CI:-0.3%-7.2%). The slowdown largely occurred in the final year of both programmes.

Conclusions: Health and social care integration programmes can mitigate but not prevent rises in emergency admissions over the longer-term. Greater financial and expert support from national agencies and involvement in multiple integration initiatives can have cumulative effects.

5.3.3. Discussion

Integrated care initiatives are seen internationally as an important mechanism in managing healthcare for an aging population (Rosen, Mountford et al. 2011, Busse and Stahl 2014, Cash-Gibson and Rosenmoller 2014). It is commonly claimed in the UK and elsewhere that improving integration will lead to the more effective care of people in the community, thus reducing the use of expensive hospital care and improving system efficiency. However, despite the widespread support and considerable energy devoted by policymakers and care professionals to better integration of health and social care, there is little evidence that these initiatives are successful in reducing the rise in emergency hospital admissions. This is partly due to the heterogeneity of these integration initiatives and partly due to their overlapping introduction. We took advantage of national data and the phased nature of two major national integration programmes in England to investigate whether these programmes impacted on emergency hospital admission rates.

Compared with the areas that did not participate in either programme, CCGs that took part only in the Pioneer programme experienced a stabilisation of emergency admission rates after the announcement of the programme in November 2013, before rates rose again from 2015 in almost exactly the same manner as rates in the CCGs that took part in neither programme. Emergency admission rates grew less in CCGs involved in the Vanguard programme when this programme was introduced, but the rates remained higher than other CCGs. However, emergency admission rates grew less over time in the CCGs involved in both integration programmes. Their emergency admission rates declined from the end of the second year of the programmes, moving towards the levels seen in the other CCGs.

Previous separate analyses of the two integration programmes appeared to show a limited and temporary association between first wave Pioneer status and a lower rate of increase in emergency hospital admissions (Keeble, Bardsley et al. 2019) and a modest reduction in the rate of increase of emergency admissions among Vanguards compared to non-Vanguards. The latter took time to develop, being seen mainly in the last year of the programme (Morciano, Checkland et al. 2020). The Vanguard analysis also highlighted the variation in changes in admission rates among Vanguards. It is not clear why some sites succeeded in reducing the rate of increase of emergency admissions and others did not.

The findings of the current analysis shed further light on these previous findings. The current analysis shows that the overall rise in the rate of emergency admissions observed in England, especially in 2017/2018, was partially offset by reductions in sites involved in both Vanguard and Pioneer initiatives. These reductions occurred mainly in the three CCGs that were wave one Pioneers and also later took part in the Vanguard programme (Canterbury and Coastal, Tower Hamlets and West Cheshire CCGs) and in two CCGs involved in the concomitant Vanguard and wave two Pioneer programmes (Nottingham City and Wakefield CCGs). Of particular interest are the two sites that were involved in both the enhanced care in care home Vanguard initiative (NHS England 2020) and wave two of the Pioneers. The enhanced medical care to care homes initiative is a very specific intervention with a plausible direct mechanism of action to reduce emergency use of hospitals. This initiative did not figure in the Pioneer programme. Continuous involvement over time in successive national integration initiatives with some focus on reducing hospital admissions appears to have strengthened the ability of these CCGs to prevent the rise in emergency admissions

observed across other parts of England, especially in 2017/2018. Overall, this suggests that integration initiatives may be additive – i.e. that reducing unplanned emergency admissions to hospital takes sustained effort across a health and care system over a prolonged period of time. In addition, it seems that such effects are likely to be enhanced by interventions such as enhanced medical care in care homes which are very directly targeted at people who are at high risk of hospitalisation.

Whilst the Vanguard and Pioneer programmes both had similar aims – to improve the integration of care between health and social care and to improve care in the community so as to reduce unplanned admissions to hospital – there were significant differences between the programmes. Most notably, the Vanguard programme was better supported both financially and in terms of investment in support functions at national level. As such, it might have been expected that Vanguard outcomes would have been significantly better than those associated with Pioneers. Our analysis shows a modest advantage for Vanguard sites in that their reduction in the growth in emergency admissions was better sustained. However, the costs associated with the Vanguard programme were much greater. In addition, the Pioneer programme was more permissive, in that local areas were encouraged to design solutions fitted to their local context, whereas the Vanguard programme required applicants to define their approach according to a set of broad system models. Our analysis does not clearly show any advantage associated with either a bottom-up or a more structured, top-down initiative design, probably because in practise, the Vanguard ‘new models’ were too broad as to be particularly helpful in directing activity.

This analysis has important limitations. First, we were not able to account for local contextual factors which might have affected the adoption and implementation of integration processes. Moreover, implemented initiatives were heterogeneous across sites and difficult to describe in detail using interviews and documentary analysis (Erens, Wistow et al. 2017, Checkland, Coleman et al. 2019, Keeble, Bardsley et al. 2019, Coleman, Billings et al. 2020, Maniatopoulos, Hunter et al. 2020, Morciano, Checkland et al. 2020). A recent evidence synthesis of 115 local Vanguard evaluation reports concluded that none of the reports offered “explanations and/or nuanced insights into the Vanguard operation” (Wilson, Billings et al. 2021), making cross-initiatives comparisons difficult. Second, our method does not rule out the possibility that confounding events, unrelated to the integration processes, may have differentially affected the different groups of CCGs being compared in the post-implementation period. These are hard to account for without a difference-in-difference analysis with multiple groups. However, such an approach relies upon the ‘parallel trends’ assumption which is clearly not satisfied by the graphical inspection of the pre-Pioneer and pre-Vanguard trends in admission rates plotted in Figure 1. Since there was a tendency for CCGs involved in the two programmes to have higher starting emergency admission rates, there is always a possibility that the analysis is vulnerable to the problem of ‘regression to the mean’ (Healy and Goldstein 1978) and that changes observed are not all the direct result of integration initiatives. Third, our analysis defines periods (of unbalanced length) in relation to the official inception dates of programmes. This may not represent the precise ‘start’ of each programme, given that the localities were almost certainly attempting to make their care more integrated before entering the programmes and did not necessarily begin their new integration schemes precisely when the programmes were officially announced. Indeed, it seems likely that there was a variable, hard-to-discern lag between the two events. Finally, our analysis assesses differences in admission rates at the level of CCGs. However, the functional and geographical borders of the sites involved in the Pioneers and Vanguard programmes did not map precisely onto individual CCGs in all cases. This is because the Pioneer programme geographies were defined predominantly by local authority areas whereas the Vanguards were organised by CCG. This means that we might have underestimated the effect of on hospital admissions where the Pioneers and Vanguard initiatives did not fully align with the CCG boundaries.

Despite these limitations, a strength of the current analysis is the ability to look at the cumulative effect of participation in successive high profile national integration programmes in England, given that it is often argued that

such programmes are not implemented for long enough to demonstrate impacts. To our knowledge this is the first such analysis in England.

5.3.4. Conclusion

Over the past decade, there has been international interest in health and care integration policies aimed at the simultaneous improvement of patient experience and health status while reducing the cost of health care (Nolte and Pitchforth 2014). This paper provides an original, longer term, analysis of the impact of the two largest national integrated care initiatives in England on emergency hospital admissions. While it is neither possible to attribute causality to the relationships identified, nor to identify the precise drivers within sites of the trends observed, the findings do suggest that integration initiatives at the system level need to be sustained over time to have any chance of changing use of hospital care. By contrast, nationally led policy initiatives in the NHS tend to take place in rapid succession and over short periods of time (Smith, Walshe et al. 2001, Hunter, Erskine et al. 2015). The Vanguard programme, for example, was limited to three years of funding, with funding for the second and third years contingent upon success in improving a number of metrics, including those for emergency admissions (Checkland, Coleman et al. 2019). The Pioneer programme was unusual in having a just over four year lifespan, at least for wave one sites, though it was rapidly 'overtaken' by the far better resourced Vanguard programme. The current analysis suggests that expecting programmes to deliver major systemic change over such short timescales is probably unrealistic. Improving health system performance by improving integration between the health and long term care sectors is an extended project, in which progress is likely to be incremental rather than 'transformational' (NHS England 2014). This has significant implications for future support and guidance for integration projects, suggesting, for example, that support may need to be sustained over longer periods of time. This will be tested further in an ongoing analysis of changes in outcomes following the termination of the Vanguard programme.

Finally, the findings indicate that it would be worthwhile to undertake more detailed qualitative research in the small number of seemingly successful areas in both the Vanguard and Pioneer programmes to identify how they achieved their changes in emergency hospital use. Such research could attempt to tease out from interviews with frontline and managerial staff the precise range and nature of the organisational and service changes that had been put in place in these local health and care systems and the time frames over which they had been implemented, along with information about the populations targeted by specific integration initiatives, together with an indication of the quality of local leadership, human and technical resources and local participants' own explanations of how these changes were able to change patterns of emergency hospital use.

5.4. Individual patient-level analysis of Vanguard impact

5.4.1. Introduction

The quantitative analyses in sections 5.2 and 5.3 used Secondary Uses Service (SUS) aggregated administrative data to explore the impact of the Vanguard programme. In this data set only aggregated hospital admissions and hospital stays are recorded. This does not allow analysis of the causes of those admissions. In this section, therefore, we replicate the previous analysis using individual patient data from Hospital Episode Statistics (HES) data. This allows us to examine whether the Vanguard initiatives had differentiated effects among different types of admissions. It would help to understand what has changed in hospital services to create the apparent contradiction between reduced emergency admissions but unchanged total bed-days found by Morciano et al (2020).

5.4.2. Vanguard-type classification & Data

Previous quantitative analysis used aggregated data of counts of emergency admissions and bed-days, provided by NHS England, for the patients registered in GP practices that are part of a Vanguard site and those who were not. However, the list of GP practices involved in the Vanguard initiatives was not available to us. Therefore, the HES data analysis can be performed only at the level of the NHS Clinical Commissioning Groups (CCGs), by identifying CCGs

which took part (or not) to the Vanguard programme. There were 36 CCGs in total involved with the 23 population-based Vanguard sites and 6 care home Vanguard sites. However, for most of these CCGs, it was not the entire CCG but only a set of practices within that were part of a Vanguard site. Depending on the average proportion of population within each CCG that are registered with each type of Vanguard sites (details available upon request), we classify 20 CCGs which had a *predominant proportion* of its population registered with GPs involved in population-based sites as population-based Vanguard CCGs and six CCGs which had the predominant proportion of population registered with care home sites as care home Vanguard CCGs. The remaining 175 CCGs were classified as non-Vanguard CCGs.

We used anonymised data of all inpatient admissions to English hospitals stored in the HES dataset. The admission data are based on the unit of a Finished Consultant Episode, a period under the care of a single consultant in one hospital. Within each episode, a rich set of information is recorded including patient demographic data (e.g. age, gender, area deprivation), clinical information (e.g. one primary and up to 19 secondary diagnoses fields) and details of the trust where the patient received treatment, patient's GP practice and the Clinical Commissioning Group (CCG) of which the patient's GP practice is a registered member.

We restricted our sample to all emergency and elective admissions³, identified based on the method of admission to hospital provider spells following the NHS Digital⁴, of all adult patients aged 19 and over. The study period spans over five financial years from April 2013 to March 2018, covering 24 months before and the 36 months of the Vanguard programme implementation. We constructed continuous provider spells by linking uninterrupted inpatient stay for a given patient in the same hospital (including those spanning across years). With a unique identifier assigned for each patient and CCG where the patient's GP practice is registered in the HES data, we classified each patient as belonging to the Vanguard-type CCG groups used in previous analysis (PACS and MCP as population-based Vanguard CCGs; EHCH as care home Vanguard CCGs). We then calculated hospital use by each patient in terms of total admissions, same day discharges and bed-days of overnights stays for both emergency and elective admissions. In doing so, we have defined same day discharges as spells that were completed within the same day and bed days as each bed day the patient stays overnight in the hospital. Furthermore, we have linked the HES records with the Office of National Statistics' (ONS) mortality data to identify the year of death. Finally, we aggregated the spell-level data by CCG and month to calculate volume of hospital use by patients registered with each CCG at each month.

5.4.3. Outcome variables

We constructed four outcome variables:

- a) emergency admission rates;
- b) emergency bed-days (for overnight stays);
- c) elective admission rates;
- d) elective bed-days (for overnight stays).

These outcome variables account for variations in population size⁵. We additionally constructed outcome variables specifically for patients aged 65 and over because many initiatives, most notably the multidisciplinary teams, predominately supported older people. All outcomes were transformed using the inverse hyperbolic sine transformation to account for the skewness of the rates.

³ Emergency admissions occur when patients are admitted to hospital unexpectedly due to urgent clinical reasons, while elective admissions, also called planned admissions, are those have been arranged in advance for patients to receive a planned procedure or treatment.

⁴ https://datadictionary.nhs.uk/attributes/admission_method.html.

⁵ The admission and bed-day rates are calculated using data of general practices' registered population provided by NHS Digital for all patients and patients aged 60 and over.

5.4.4. Sample selections and Sample sizes

We obtained a full extract of patients aged 19 and over admitted to all English hospitals from April 2013 to March 2018, including 24,008,599 emergency admissions and 38,877,613 elective admissions. We excluded 1,019,811 admissions (1.6%) that were recorded with an un-mappable or unknown GP practice and CCG (list available upon request). We additionally excluded Sunderland CCG because with the unreliable GP population registration data we cannot adjust volume of hospital services by population size. There are three CCGs that consist of a complex mixture of different Vanguard sites⁶. We excluded the Corby CCG and Wakefield CCG because they saw dramatic changes in hospital use, especially emergency admission rates and elective bed-days rates. Within the Corby CCG, population registered with non-vanguard sites increased gradually since 2015 while the size of population registered with population-based Vanguard sites has not gone up proportionally. The Wakefield CCG consisted of almost equal size of population registered with population-based and care home Vanguard sites, so impacts of the two Vanguard types may be contaminated. During the study period, there were two CCG mergers and five boundary changes (further information available upon request). We combined the CCGs that merged into one or that changed the boundaries in-between into six artificial “CCGs”. Checking the time series of each of these CCG (further information available upon request), we excluded two CCGs – Lancashire North CCG, Cumbria CCG & Greater Preston CCG (move of two LSOAs in April 2015 and transfer of 34 GP practices in April 2017) and Bradford Districts CCG & Bradford City CCG (transfer of one GP practices), which saw dramatic change in volume of admissions after the boundary changes.

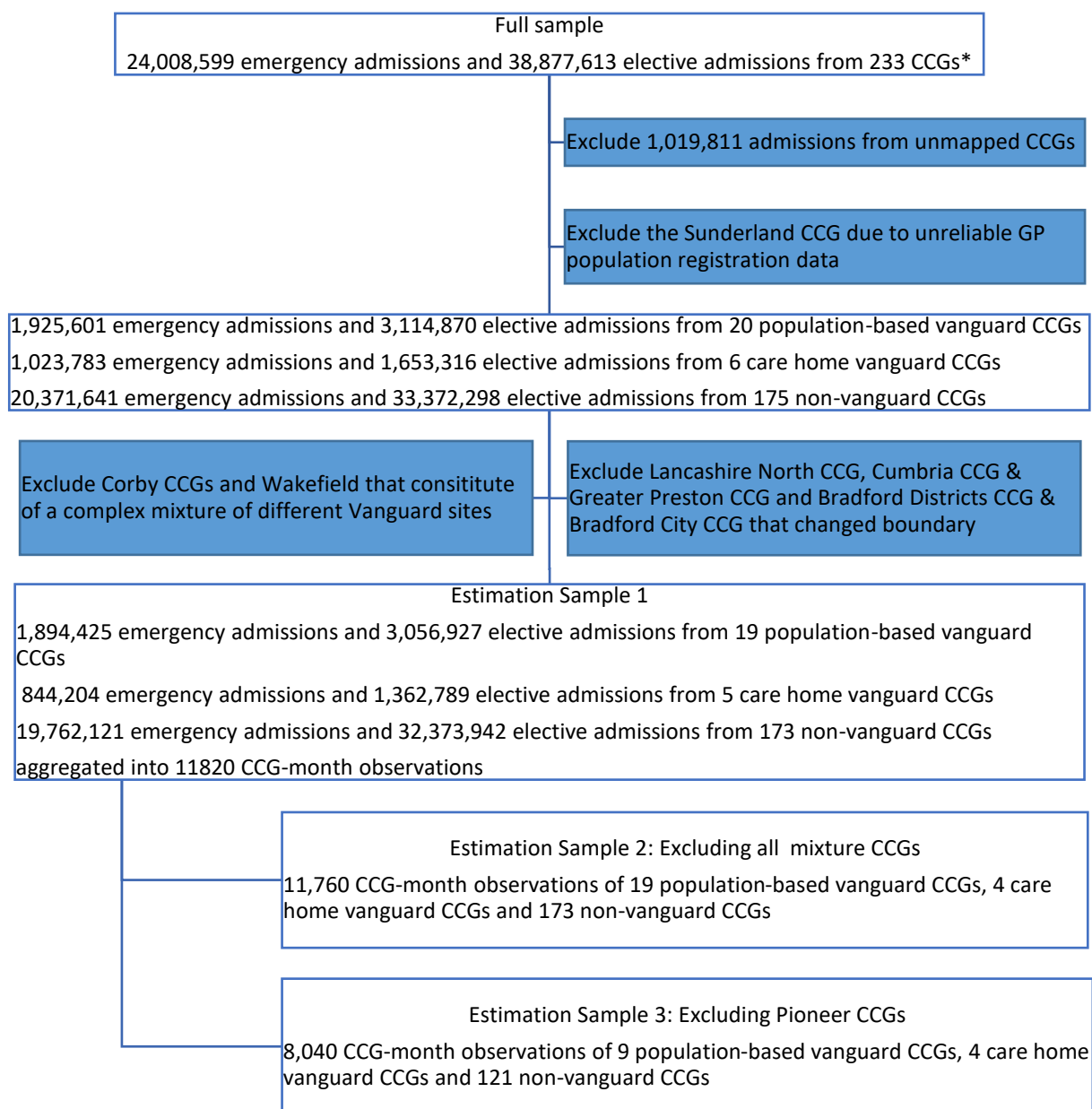
The main estimation sample contains 1,894,425 emergency admissions and 3,056,927 elective admissions from 19 population-based vanguard CCGs, 844,204 emergency admissions and 1,362,789 elective admissions from five care home vanguard CCGs, and 19,762,121 emergency admissions and 32,373,942 elective admissions from 173 non-vanguard CCGs, altogether aggregated into 11,820 CCG-month observations.

We generated two additional estimation samples to check the robustness of results. One excludes the third mixture CCG, Newcastle Gateshead, to assess whether the estimated Vanguard effects change when we only include CCGs that were predominantly involved with a single type of Vanguard sites. The other excludes Pioneer CCGs to assess whether the estimated Vanguard effects are partially attributed by the Pioneer programme. Figure 5: Flow chart of sample generation for the CCG level analysis

summarises the process we defined the three estimation samples used for the analysis.

⁶ Over five years, Corby on average had 64.2% of population registered with population-based sites and 35.8% with non-vanguard sites. Wakefield on average had 45.0% of population registered with population-based sites, 45.9% with care home sites and 9.1% with non-Vanguard sites. Newcastle Gateshead on average had 53.0% of population registered with care home sites and 47.0% with non-Vanguard sites.

Figure 5: Flow chart of sample generation for the CCG level analysis



* Note these CCGs include six artificial “CCGs” that we constructed by grouping the CCGs that merged or changed boundaries in-between together.

5.4.5. Results

Plotting time series of average log-transformed outcomes for the three CCG groups (**Error! Reference source not found.**), we see some changes in hospital use by patients registered with Vanguard CCGs, especially those with care home CCGs, in the three months after the Vanguard call⁷. The pre-intervention period is defined as between April 2013 and December 2014 and the rollout period is defined as between January and March 2015. The Vanguard

⁷ The NHS invited individual organisations and partnerships to apply to become Vanguard in January 2015 and selected population-based and care home experimental sites (Vanguards) in March 2015.

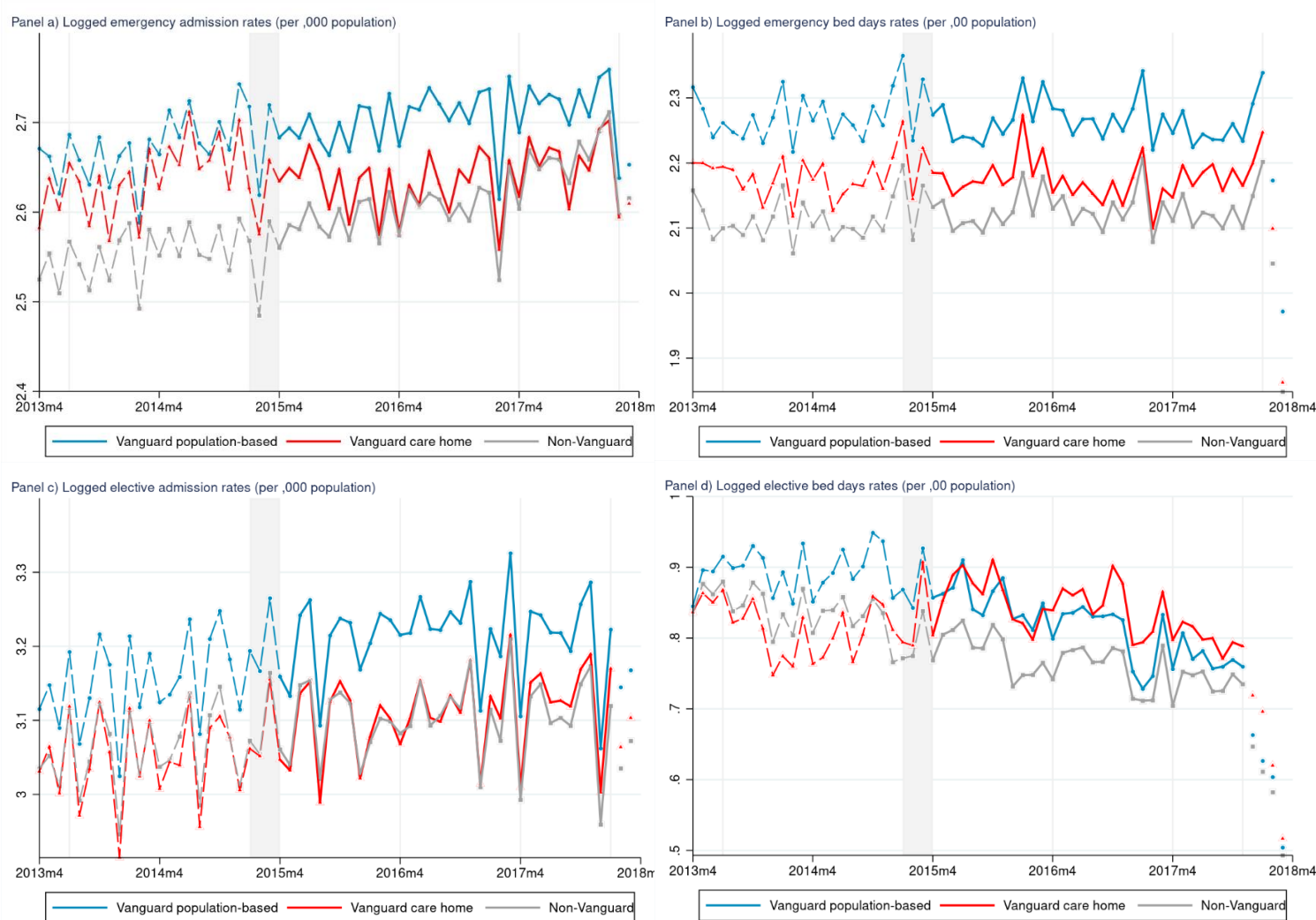
population-based and care home CCGs followed a similar pre-intervention trend to the non-Vanguard control CCGs across all four log-transformed outcomes (**Error! Reference source not found.**).⁸

In the pre-intervention period, emergency admission and emergency bed-days rates were higher in the two treated groups than in the control group. There is clear evidence of an increasing trend in emergency admission rates among non-Vanguard CCGs, especially in the third year of the Vanguard programme when the rates became slightly higher than those observed in care home CCGs. Emergency bed-days, on the other hand, remained almost unchanged among the three CCG groups. The changes in emergency admission rates look similar to those reported in Morciano *et. al.* (2020) using the SUS data. However, HES data documented slightly higher emergency admission rates in population-based CCGs than in care home CCGs. This is due to the exclusion of the two mixture CCGs and the two CCGs with changed boundaries during the study period.

Elective admission and elective bed-rates among the non-Vanguard control CCGs were lower than in the population-based CCG group but slightly higher than in the care home CCG groups in the pre-intervention period. There was a decreasing trend in elective bed-days rates among population-based and non-Vanguard CCGs throughout the study period. Care home CCGs, on the other hand, were experiencing significantly higher elective bed-days rates in the post-intervention period, even exceeding those observed in population-based CCGs since the second year of the Vanguard programme. Elective admission rates remained almost unchanged among the three CCG groups, except that the rates for care home CCGs became slightly higher than those observed for the non-Vanguard CCGs in the third year.

⁸ While there is some evidence that the care home CCGs were experiencing higher elective bed-days rates just before the Vanguard call (November–December 2014), the null hypothesis of parallel trends was not rejected at conventional statistical levels for the Vanguard population-based (p-value = 0.765 (a), 0.689 (b), 0.715 (c) and 0.116 (d)) and care home CCGs (p-value = 0.175 (a), 0.966 (b), 0.701 (c) and 0.623 (d)). The null hypothesis of parallel trends was rejected if we excluded the first three months of observation (April–June 2013) or included the three months after the Vanguard call (January–March 2015).

Figure 6: Descriptive statistics using the HES data



Notes: Own elaborations on HES data (estimation sample 1). We formally assessed the impact of the Vanguard programmes on population-weighted monthly outcomes using Difference-in-Differences (DiD) analysis, where we compare population-based Vanguard CCGs and care home CCGs (two treated groups) with non-Vanguard CCGs (the control group), before and after the introduction of the Vanguard programmes.⁹

Note there was a sharp drop in all outcomes at the end of the study period (see the dots in **Error! Reference source not found.**). This is likely because the HES data set does not include unfinished episodes in calendar year 2017/18 (i.e. patients who were admitted but not discharged at midnight on 31 March 2018 cannot be included in the counts). To avoid spurious results induced by the data, we run the econometric analysis by choosing different post-intervention periods for different outcomes based on the time series observed in **Error! Reference source not found.** That is, 35 months (April 2015 – February 2018) for emergency admission rates, 34 months for emergency

⁹ We follow the econometric approach used in Morciano et al. (2020). We allow for time (month) fixed effects to account for factors changing over time that are common across CCGs, and CCG fixed effects to account for time-invariant unobserved heterogeneity in CCGs that might be related to differences observed in outcomes between the Vanguard and non-Vanguard groups. We control for area-level population structures using the monthly proportion of population by age-groups (0-24, 25-64, 65 and older). We used robust variance estimators to account for clustering of outcomes within CCG.

bed-days rates and elective admissions rates (April 2015 – January 2018) and 32 months for elective bed-days rates (April 2015 – November 2017). We estimate the average effect over the entire post-intervention period and then separate effects for each post-intervention year to allow for heterogeneous effects varying over time.

Figure 7 graphs the difference-in-differences estimates of net impact on the four outcomes.¹⁰ Over the three-year period of the Vanguard programme, population-based and care home Vanguard CCGs experienced an overall significant relative net reduction in emergency admissions of about 3.0%**¹¹ and 5.5%***, respectively. The significant net reduction was found only in the last year among population-based CCGs (-6.0%***), but immediately after implementation in care home CCGs (-3.6% year 1, -5.4% in year 2 and -7.8% in year 3).¹² As for bed-days of overnight emergency admissions, we found significant net reduction of 2.5%* in the first year and 3.9%* in the third year among population-based CCGs, making an average of 3.0%* net reduction over the three years. We found no significant net effect attributable to the care home CCGs.

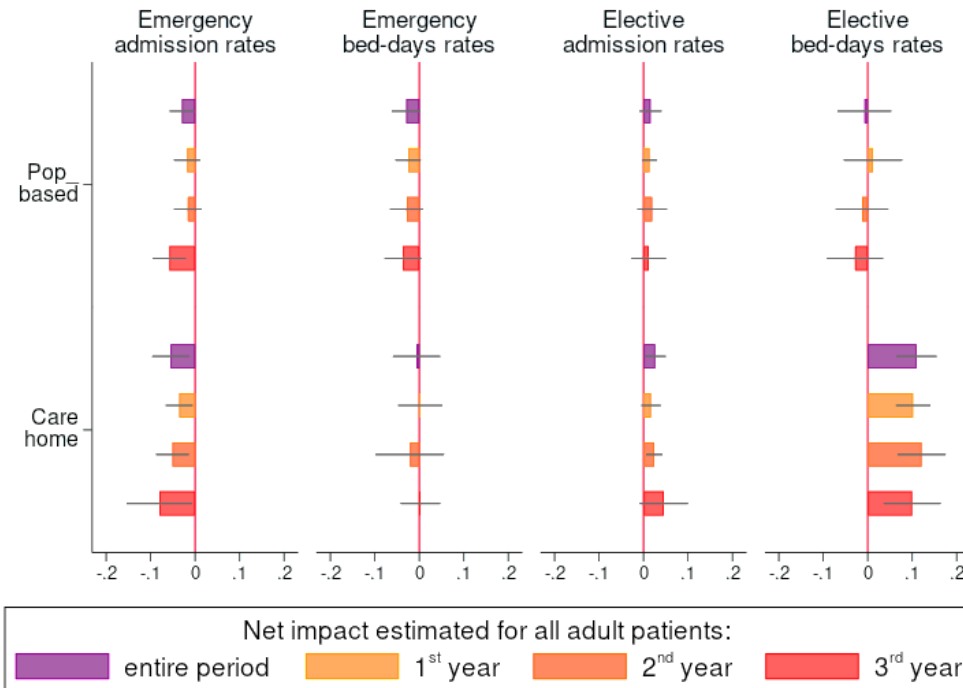
For the elective admissions, on the other hand, care home CCGs experienced a significant overall relative net increase of 2.6%** in admission rates and 11.0%*** in bed-days rates. The significant net increase occurred since the second year post-intervention (2.3%** in year 2 and 4.7%* in year 3) in elective admission rates and right after the Vanguard call (6.5%*** in rollout period, 10.5%*** in year 1, 12.2%*** year 2 and 10.0%*** in year 3) in elective bed-days rates. For population-based sites, we found no significant net change in elective bed-days rates and a significant net increase (1.5%***) in elective admission rates only at the first year of the Vanguard programme, not on average across the post-period.

¹⁰ Specifically, figures plots estimated parameters of DiD models on the four different outcomes. Full estimates are available upon request. Pre-policy period is between April 2013 and December 2014. Rollout period is between January 2015 (when the NHS invited individual organizations and partnerships to apply to become Vanguard) and March 2015 (when population-based and care home sites were selected). Post-period varies for different outcomes due to the truncated HES data.

¹¹ Stars denote significance levels: * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$.

¹² Note that the overall relative net reduction was found to be significant for care home sites only in the analysis reported in Morciano et al (2020) based on SUS data (-4.2%**). The significant net reduction was found only in the last year for both population-based and care home sites (-3.1%** and -6.5%**).

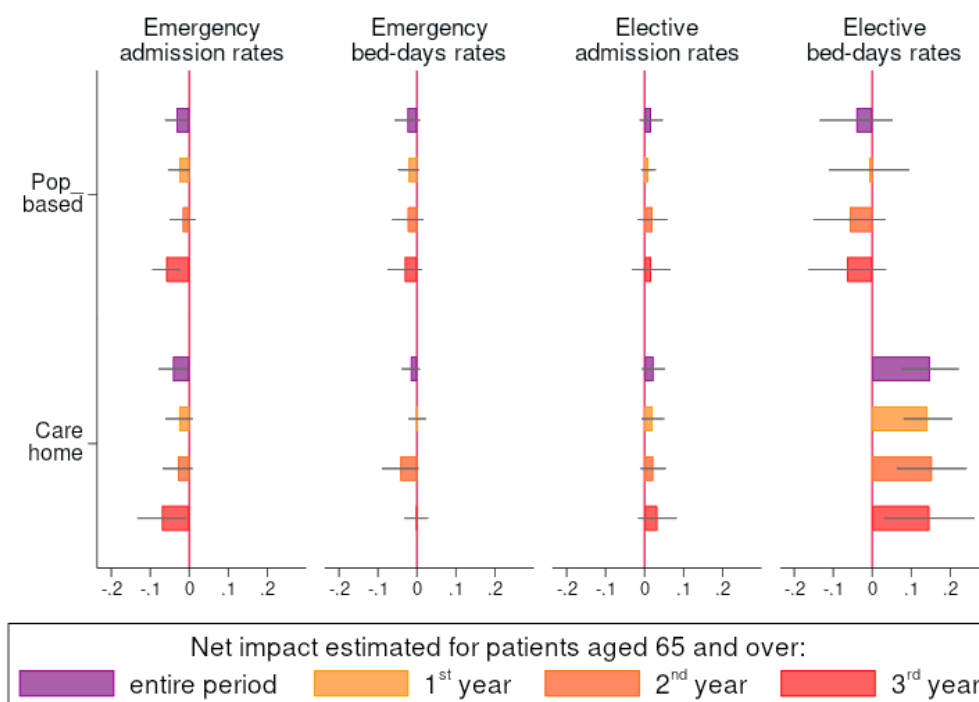
Figure 7: Difference-in-differences estimates of changes in types of emergency admissions and total bed-days rates attributable to the Vanguard integrated care and care home initiatives overall and by different post-implementation time windows.



Notes: Own elaborations on HES data (estimation sample 1).

The sub-group analysis of patients aged 65 and over reported in Figure 8 provides further insights. We found lower magnitude of the net reduction in emergency admission rates (-4.2%** vs. -5.5%**) but higher magnitude of the net increase in elective bed-days rates (14.9%*** vs. 11.0%**) among care home Vanguard CCGs, when comparing patients aged 65 and over registered with all adult patients. We did not find any significant net effect on emergency bed-days rates or elective admission rates attributable to the population-based and care home Vanguard schemes among patients aged 65 and over.

Figure 8: Subgroup econometric analysis of patients aged 65 and over - Difference-in-differences estimates of changes in types of emergency admissions and total bed-days rates attributable to the Vanguard integrated care and care home initiatives overall and by different post-implementation time windows.



Notes: Own elaborations on HES data (estimation sample 1).

We tested the robustness of results using two additional estimation samples (details available upon request). Excluding the Newcastle Gateshead CCG (estimation sample 2) which on average consist of 53.0% population registered with care home sites and 47.0% with non-Vanguard sites, the relative net reduction in emergency admission rates in the third year turns insignificant (-7.8%** vs. -7.4%); the magnitude of overall relative net increase in elective admission rates turned higher (2.6%** vs. 3.5%***); magnitude of overall relative net increase in elective bed-days rates turned lower (11.0%*** vs. 10.1%***). After excluding the ten CCGs participating in both the population-based Vanguard and Pioneer schemes (estimation sample 3), we found no significant net effects on any outcomes among population-based CCGs and the magnitude of overall relative net increase in elective bed-days rates turned smaller (11.0%*** vs. 8.5%***). The sensitivity analyses based on restricted samples of CCGs highlight the importance of examining variability in the effects of the program across individual organisations and partnerships and of taking into account the history of previously working together under a previous initiative (e.g. Pioneers).

5.4.6. Discussion

In this section we have extended the quantitative analysis to draw the following important messages:

- 1) There are **important difficulties in identifying the “exposed” and the “counterfactual” populations using patient-level data**, like those available in the Hospital Episode Statistics (HES). This difficulty is in line with what some local evaluations were faced and reported in Section 3.3 of this report. Namely, data sharing (3.3.2.5) and construction of the counterfactual (3.3.2.6). This is the main reason behind our decision to base our main quantitative analyses of the impact of Vanguard on hospital activities on aggregated data of counts of emergency admissions and bed-days, provided by NHS England, for the patients registered in GP practices that are part of a Vanguard site and those who were not. We have attempted at identify the exposed populations in HES data but without the full list of GP practices involved in the Vanguard initiatives, the

analysis had to be done at the level of the NHS Clinical Commission Groups (CCGs), exposing us to possible ecological bias. Moreover, as documented in Figure 5: Flow chart of sample generation for the CCG level analysis

- 2) , we had to exclude few Vanguard sites given their complex mixture of different Vanguard types or the changed CCGs boundaries.
- 3) However, **results from HES data broadly confirmed our previous findings with SUS data** for the care home Vanguard CCGs (-5.5%***). The HES data analysis found an overall significant relative net reduction in emergency admissions also for CCGs exposed to population-based Vanguard of about 3.0%**.
- 4) The analysis of bed-days rates of **overnight emergency admissions** has shown significant net reduction of 2.5%* in the first year and 3.9%* in the third year among population-based CCGs, making an average of 3.0%* net reduction over the three years. We found no significant net effect attributable to the care home CCGs.
- 5) For the **elective admissions**, on the other hand, care home CCGs experienced a significant overall relative net increase of 2.6%** in admission rates and 11.0%*** in bed-days. The significant net increase occurred since the second year of the Vanguard programme for the elective admission rates and right after the Vanguard call for the elective bed-days. However, for population-based sites, we found limited changes in both elective admissions and elective bed-days rates. The rise in elective bed-days for care home Vanguard CCGs is more evident among the population aged 65 and over.
- 6) As noted in Section 4.2 and in Morciano et al (2021) and Section 5.3, the analysis shows clear evidence of the **importance of previous experiences in working together** under previous initiative. In fact, when excluding CCGs that participated in both the population-based Vanguard and Pioneer schemes, we found very little or no evidence of significant net effects on any of the explored outcomes.

5.4.7. Conclusion

It proved difficult to analyse the impact of the Vanguard programme using individual level data because of the difficulty in defining an 'exposed' population. This is not surprising, given the fact that the Vanguard programme did not develop comprehensive 'models of care' covering whole populations; rather, Vanguards consisted of a variety of initiatives, many of which targeted specific populations. This means that our assessment of patient-level impact relies upon an assumption that patients covered by GP practices within a Vanguard-associated CCG are likely to have benefited from the programme. The finding of an increase in elective admissions from Care Home Vanguards is important, as it suggests the uncovering of significant unmet needs as care within care homes improved. This has important implications for NHS activity overall as Enhanced Care Home services are rolled out via Primary Care Networks.

5.5. Exploring the impact of Vanguards after the termination of the programme

5.5.1. Introduction

The quantitative analysis reported so far compared the changes in hospital utilisation between Vanguard and non-Vanguard exposed populations over time, so taking these differences before and during the three years of the Vanguard programme. However, the analysis highlighted that outcomes for integrated care and other initiatives should be assessed over the long-term. It was the underlying premise of the Vanguard programme that investment in reorganising care would rapidly become self-sustaining, with each Vanguard required to set out in its 'Value Proposition' how savings made would allow reinvestment to sustain initiatives in the long term. Our qualitative case studies demonstrated that this was generally not the case (see section **Error! Reference source not found. pError! Bookmark not defined.**); notwithstanding the modest positive impact on slowing the rate of growth in emergency admissions that we have demonstrated, none of our case study sites were able to demonstrate savings sufficient to continue to support initiatives once funding was withdrawn. However, beyond this (perhaps over-optimistic) belief in the potential for savings and re-investment, our case study participants were clear that being part of the Vanguard programme had yielded benefits in terms of trust and local relationships, and our comparison between Vanguards

and Pioneers suggests that these softer benefits may accrue over time as individuals work together and develop trusting relationships.

It is not clear if the beneficial impacts of the Vanguard programme persisted after the termination of the Vanguard streams of funding and associated support. We therefore identified that it was important to consider whether the modest impact on outcomes that we have demonstrated persisted after the discontinuation of the programme. This idea is reflected in Quimbo et al. (2016), who provide evidence for long-term effects of financial incentives to improve quality of health care. Their hypothesis is that even after program termination, the clinical skills once acquired and established into practice would not fade. In the context of the Vanguard programme, this would equate to the relationships and new ways of working developed during the programme persisting and bringing benefits beyond the end of the programme.

5.5.2. Data and Methods

We obtained from NHS England new SUS data that extends beyond the period after the Vanguard programme was terminated. We have received a dataset in monthly format beginning on 01 April 2013 and ends just ahead of the pandemic on, 01 January 2020.¹³ So the time horizon spanned over 24 months before the Vanguard programme, 36 months during the programme and 22 months after its termination. In this respect, the analysis builds upon the previous analysis published in Morciano et al. (2020) and reported in Section 5.2 but uses a follow-up period of 22 months after the end of the Vanguard programme. We observe 20 Vanguard sites that are PACS and MCP combined, and 5 Vanguards that are EHCH.¹⁴ 175 sites will form our control group.¹⁵ We also account for the overlapping with the Pioneer programme, building upon analysis reported in Morciano et al. (2021) and reported in Section 5.3.

We focus again on the two outcome measures available to us in the SUS extract: 1) Emergency Admissions (EA) are those with a 'specific acute' treatment function code; 2) Total bed-days (TBD), including stays after both emergency and elective admissions¹⁶. As before, to account for different population sizes, we analysed the emergency admissions rate per 1,000 persons and total bed-days rate per 100 persons.

5.5.3. Overall Results

As reported before, Vanguard initiative slowed the rise in emergency admissions (EA) observed in England during the Vanguard period (

Figure 9, panel a).¹⁷ The reduction occurred mainly in care home sites, at the programme's end.

After the termination of the Vanguard programme (Post-Vanguard), we observe that the slowdown in emergency admission rates for Vanguard sites appears to have abated, with an increase of emergency admission rates in care home sites. The gap between PACS & MCP sites and non-Vanguard sites has reduced.

In panel b) of

¹³ We received data up to March 2020, but we drop the last month from the sample to account for the possibility of any discrepancies.

¹⁴ We drop one vanguard from our analysis which appears to be an outlier with missing data and almost no variation in some outcomes. Only two Vanguard sites include more than one CCG in our sample.

¹⁵ The raw data had 184 sites that were coded as non-vanguard. We dropped 5 sites for which there were missing population values and another 4 sites which had unbalanced number of observations. Hence, we have 175 non-vanguard sites. These include part of those CCGs in Vanguard CCGs that were not exposed to the vanguard programme.

¹⁶ Data used here does not allow us to distinguish between the two types as we did in the analysis that has used HES data (see section 5.4).

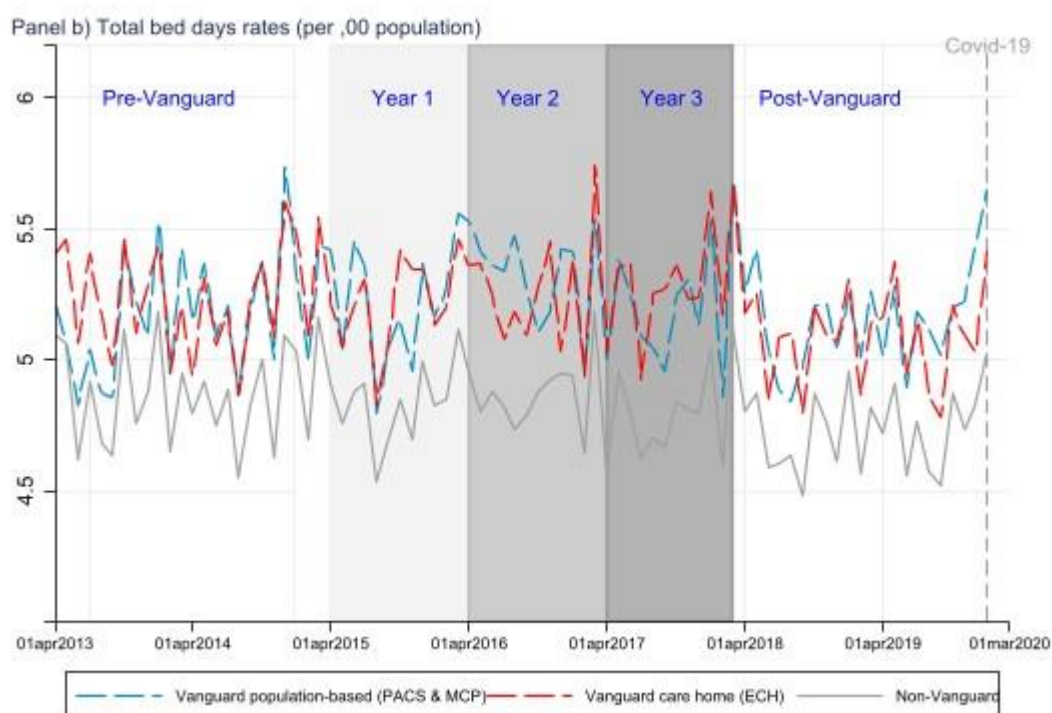
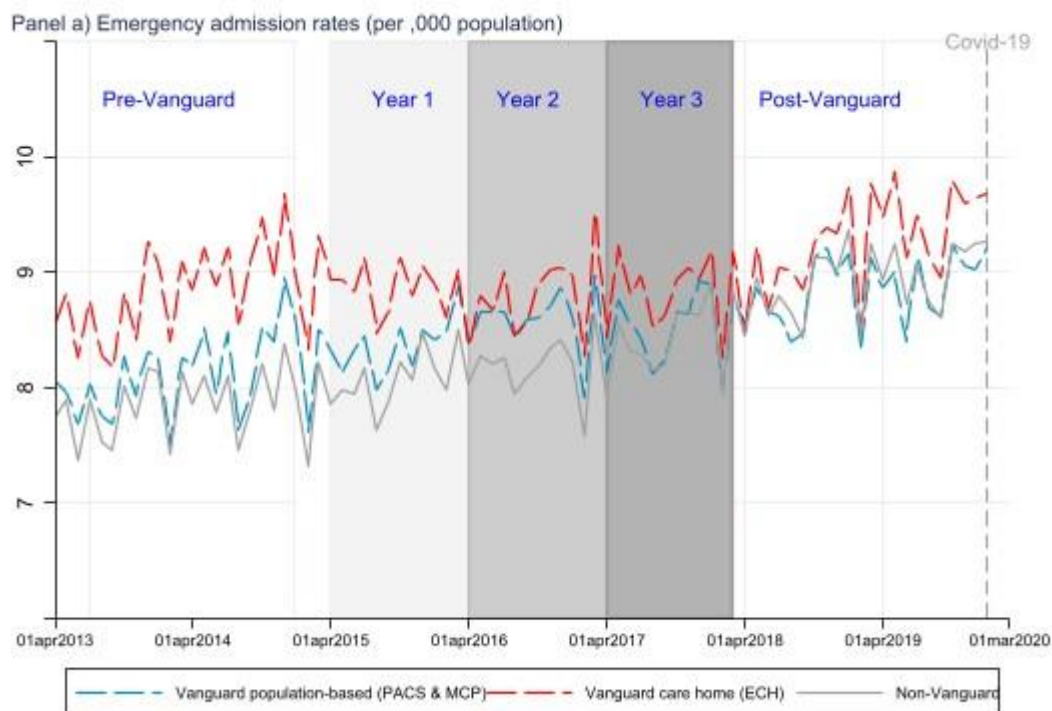
¹⁷ For the analysis in this section, we focus on a balanced sample with 82 monthly observations for each site.

Figure 9, we plot trends in total bed days (TBD) rates before, during and after the Vanguard programme. It appears that the non-Vanguard sites have no clear trend in TBD rates throughout the entire period. We observe little overall reduction of TBD in vanguard sites at the end of year 3 of the programme and at the beginning of the post-Vanguard period.

It is hard to discern trends from the graphical inspection of

Figure 9. We therefore performed statistical analysis to formally test the impact of the Vanguard programme and its implications after its discontinuation using a difference-in-differences approach.

Figure 9: Trends in Emergency admission rates (panel a) and total bed day rates (panel b) for Vanguard and non-Vanguard sites



The regression analysis¹⁸ confirmed a significant rise in emergency admission rates in England. After programme discontinuation, EA rates for non-vanguard CCGs increased by 17%, compared to the pre-vanguard period. The effect

¹⁸ We set up a difference-in-difference analysis to do a formal test of the effect of programme discontinuation upon logged values of EA rates and TBD rates among CCGs involved in Vanguard programmes (PACS & MCP combined and ECH) relative to non-Vanguard CCGs. We identify the effect of programme discontinuation through the effect on two Vanguard types. It is expected that the effect would be positive for sites that participated in the vanguard programme programmes (PACS & MCP combined and ECH) relative to non-Vanguard CCGs. We identify the effect of programme

of Vanguard persisted after its discontinuation, with a continuation of the slowing down in EA rates for both population-based (-3.7%) and care home vanguards (-7.4%), compared to non-Vanguard sites in the pre-Vanguard period. Excluding Pioneers CCGs decreases the net effect to 3.3% and 4.8% for population-based and care home vanguards, respectively.

Following Vanguard discontinuation we also find a small but significant increase (+1.3%) in TBD rates among population-based vanguards, but no significant effect among care home vanguards.

5.5.4. Discussion

In this section we have extended the quantitative analysis based on aggregate data to draw the following important messages:

1. We found evidence that the Vanguard initiative slowed the rise in emergency admissions compared to what was observed in the rest of England with an **effect that has continued after the discontinuation of the programme.**
2. This **apparent convergence of emergency admission rates** that continued after discontinuation of the programme suggests that **some CCGs previously participating in the Vanguard programme might have managed to institute changes that sustained after the end of the programme.**
3. However, it should be noted that the **net impact** we found is **higher** in magnitude and more significant **for population-based Vanguards and for CCGs involved in the Pioneer programme.** This reinforces previous findings that effects of integrated care initiatives on hospital activities are additive, take time to emerge and should be assessed over the long-term.

5.6. Assessing the impact of Vanguards on variation of hospital activities across localities before/during/after the Vanguard programme

5.6.1. Introduction

One of key aspects of integrated care models was to increase efficiency of individual sites at addressing patients changing needs, and reduce variations in quality of care as well as outcomes. Towards this end, the Vanguard programme included financial support, amounting to a total of £357 million over the three years of the programme (See the Box at the end of this chapter for further details). Alongside this funding, Vanguard sites received non-pecuniary and multi-faceted support on aspects such as design of care models, workforce, harnessing of technology, etc. (National Audit Office 2018). As detailed earlier in this report, the national support programme received £60 million in funding (over and above the money allocated to each Vanguard) and included:

- a designated national lead for each model;
- support to develop logic models describing the local scheme;

discontinuation through the effect on two Vanguard types. It is expected that the effect would be positive for sites that participated in the vanguard programme than the non-NCM sites, as a consequence of the previous Vanguard involvement.

$$\ln(Y_{it}) = \alpha_i + \beta_t + \gamma_j V_i + \delta_k P_{it} + \eta_{jk} V_i * P_t + \theta X_{it} + \epsilon_{it}$$

$\ln(Y_{it})$ identifies the logged outcome of interest (EA and TBD rates) for CCG i and month t . α and β identify the CCG and month fixed effects, respectively. To account for factors that vary over time within CCG, we add also controls (X) for CCG-level population structure as the monthly proportion of population by age-groups (0–24; 25–64; 65 and older). V identifies three groups: the control group of non-vanguard CCGs ($j = 0$) and the two treated groups of CCGs exposed to population-based ($j = 1$) and care home ($j = 2$) Vanguards. P identifies the pre-Vanguard period ($k = 0$), year 1 to year 3 of the Vanguard programme ($k = 1, 2, 3$) and the post-Vanguard period ($k = 4$). The key parameters of interest are those associated with the interaction terms V_i and P_k , η_{jk} . Specifically, they measure the net impact of population-based Vanguards in its first (η_{11}), second (η_{12}), third (η_{13}) years and in the follow-up period (η_{14}) compared to non-Vanguard CCGs ($j = 0$) in the pre-Vanguard period ($k = 0$). Similarly, the net impact of care home Vanguards is captured by η_{21} (year 1), η_{22} (year 2), η_{23} (year 3) and η_{24} for the follow-up period. Full results are available upon request.

- 10 support streams, covering: model design; evaluation and metrics; integrated commissioning and provision; governance, accountability and provider regulation; empowering patients and communities; harnessing tEHCHnology; workforce redesign; local leadership and delivery; and communications and engagement;
- local account managers for each Vanguard;
- A variety of learning and networking events and opportunities.

With this national support, we would expect that the programme would have reduce variation in performance across sites within a vanguard type, owing to the similar nature of support they received and the significant effort expended in sharing ideas and learning between Vanguards within each type (Checkland, Coleman et al. 2019). Further with the discontinuation of the programme, the variation across care home and population-based sites may increase if some sites significantly relied upon national support. On the other hand, the discontinuation may not have a significant effect on variation if sites were able to create sustainable models and were self-sufficient towards the end of the programme.¹⁹

In the previous sections, we noted that some Vanguard types reduced the growth rate in overall emergency admissions. Around these mean trends, it is expected to find sites with EA rates below and above the mean values that we have reported in e.g.

Figure 9.

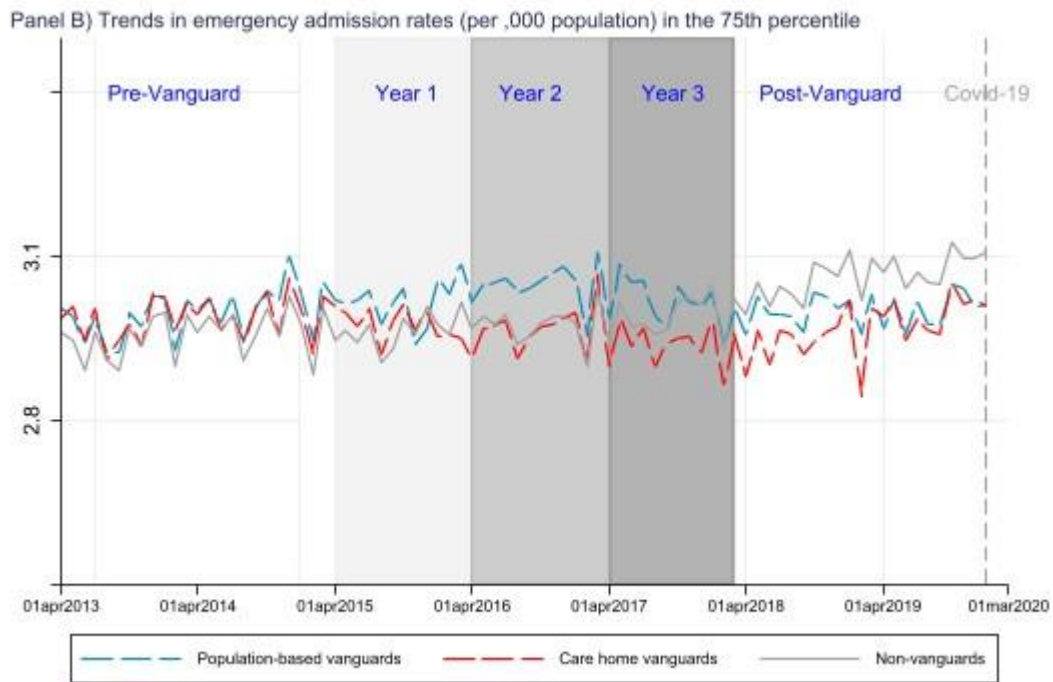
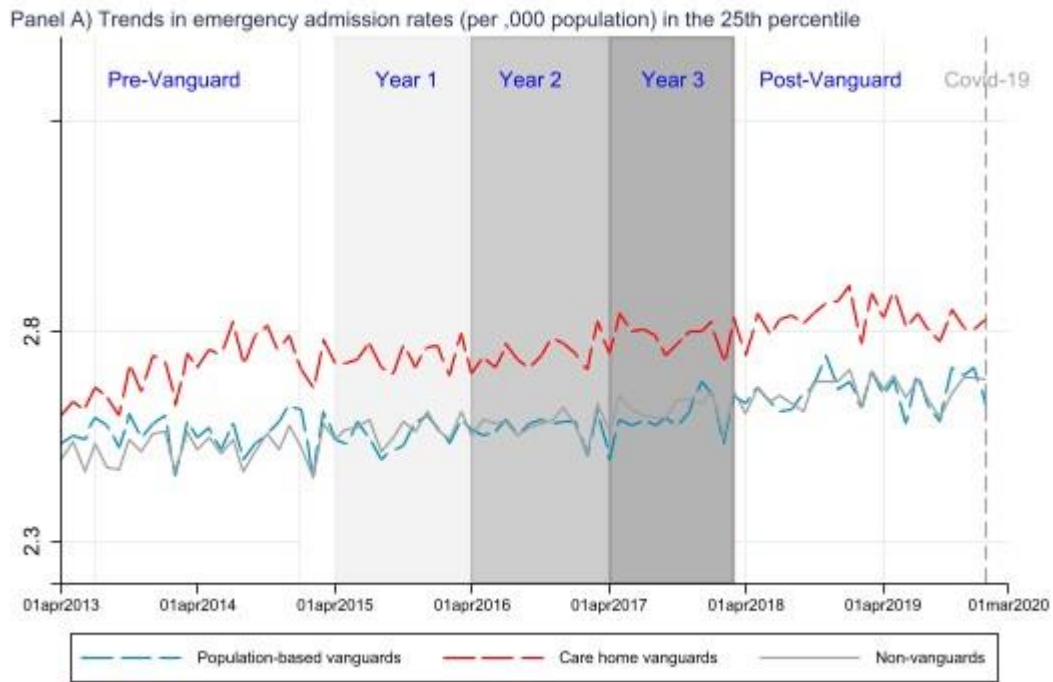
In this Section, we specifically look at the variation (or dispersion) of EA (TBD) rates in population-based sites and in care home sites before, during and after the Vanguard programme. We compare this variation with the variation of EA (TBD) rates we observe among non-Vanguard sites.

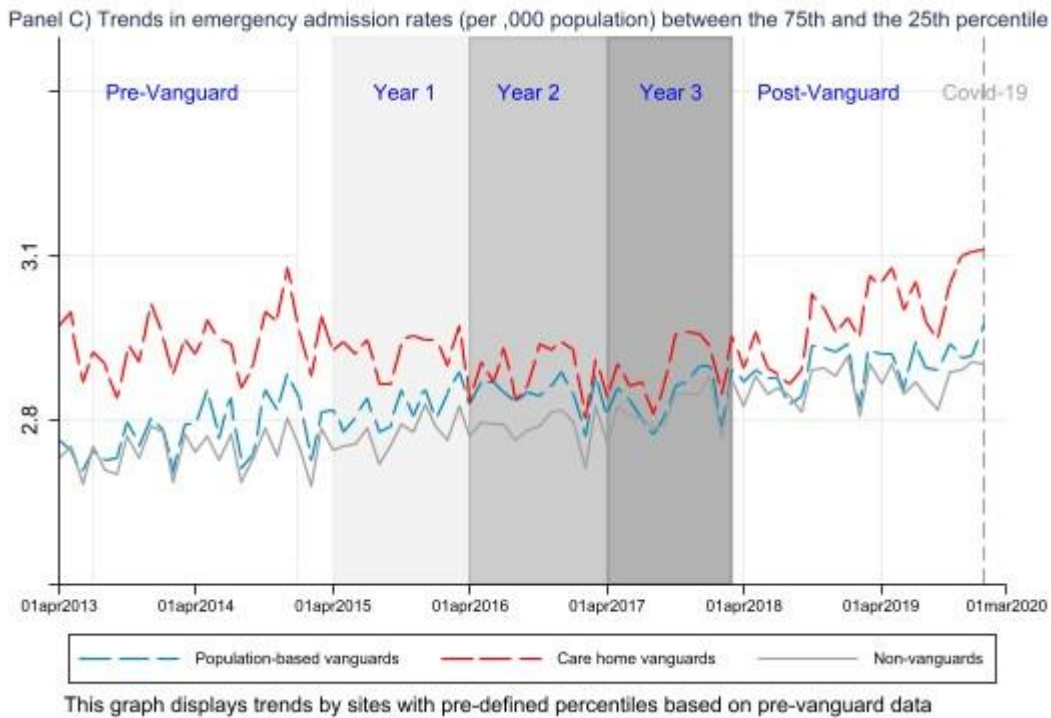
5.6.2. Results

We start by reporting the time series of monthly dispersion of EA rates for the non-Vanguard sites, Vanguard integrated care and care home sites. For each group, we have selected cut-offs that correspond to the 25th and 75th percentiles of the (log) EA rates distributions observed in the pre-Vanguard period. We use these cut-offs to classify sites and report mean values observed in these moments of the EA rate distribution, the 25th percentile (Panel A), the 75th percentile (Panel B) and those that are in between these two (Panel C).

¹⁹ The underlying mechanism that funding support could lead to increase in stock of assets that generate future returns has been studied in contexts such as, poverty alleviation and child health (Gertler, P. J., S. W. Martinez and M. Rubio-Codina (2012). "Investing Cash Transfers to Raise Long-Term Living Standards." *American Economic Journal: Applied Economics* 4(1): 164-192, Baird, S., C. McIntosh and B. Özler (2019). "When the money runs out: Do cash transfers have sustained effects on human capital accumulation?" *Journal of Development Economics* 140: 169-185.

Figure 10: Trends in emergency admission rates (per ,000 population), by Vanguard types and by moments of the log-distributions





In the panel A), we observed trends for sites that were on or below the 25th percentile and therefore relatively better performing sites in the pre-vanguard period. There is a clear upward trend throughout the programme duration for both the treated and control groups that continues into the post vanguard period. Interestingly, for population based vanguards the trend is not very different from those among better performing non-vanguards. For care home vanguards, there is an upward trend in the pre-vanguard period and a trend similar to other groups during the Vanguard programme and after programme discontinuation.

In panel B) we note the trends among the 25% of worst performing sites in the pre-vanguard period. Non-vanguards appear to have a stable trend before and during the Vanguard period but increasing in the follow up period. The poorer performing population-based sites which were following a similar trend compared to non-vanguard sites, registered an increase in the second year of the Vanguard programme and a decline in the third and final year. This downward trend continued into the post-Vanguard period, eventually falling below the trend line for non-vanguards. In comparison, care home vanguards show an early reduction from the first year of the programme. However, in the period following the termination of the programme these sites start a slow upward trend.

In panel C) we note the trends among the sites in the middle of the distribution. The non-vanguard sites experienced increasing EA rates throughout the period entire period. While population-based sites appear to be increasing at a rate faster than non-vanguards in the early years of the programme, they appear to slow down during the final year, maintaining a similar trend to non-vanguard sites in the post vanguard period. Care home vanguards experienced a significant slow down during the programme, but appear unable to keep up with the improvements following the end of the programme.

In

Figure 11 we combine results discussed above by reporting the time series of monthly dispersion, measured by the interquartile range²⁰ statistics, of EA rates (panel a) and TBD rates (panel b) for the Vanguard integrated care and care home sites against what observed in non-Vanguard sites. The trend for non-vanguards overall has remained stable, but for a slight increase in the EA rates dispersion among non-vanguard CCGs in the post-Vanguard period. After an increase in dispersion in the pre-vanguard period among population-based CCGs, the trend appeared stable thereafter. At the beginning of the pre-Vanguard period, care home vanguards reflect a sharp decline in dispersion, until they fall below the trend for non-vanguards around April 2014. Further, between CCGs variation for care home CCGs experienced a downward trend, in particular over the Vanguard period and the first financial year following its termination. However, at the end of our sample period and towards the beginning of the COVID-19 pandemic, there is a notable upward trend in variation among care home (and to a lesser extent among population-based) CCGs.

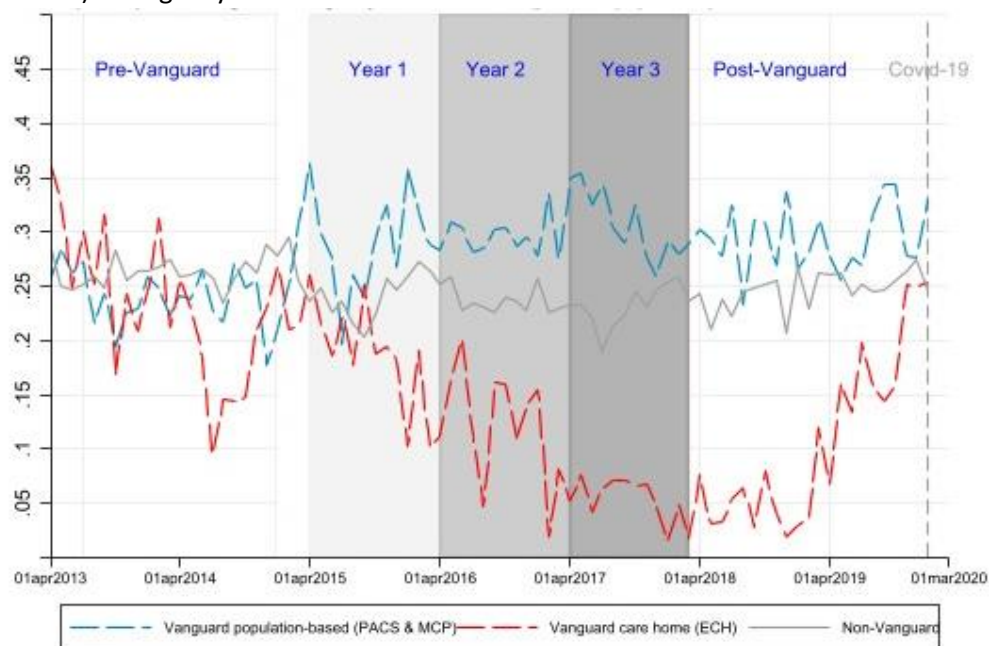
The case for TBD rates (panel b of

²⁰Interquartile range is a measure that tells us the spread in the middle half of the distribution. It captures the difference between the upper quartile (25 percent of values are above this) and the lower quartile (25 percent of values are below this).

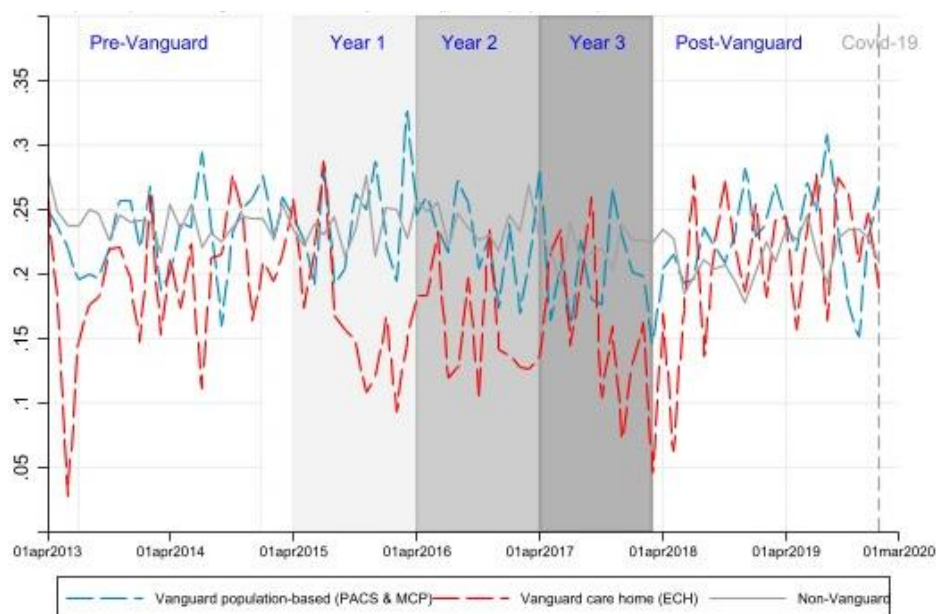
Figure 11) shows that non-vanguards remain stable in the pre-Vanguard period, before registering a slight decline in the beginning of year 2 and then in year 3. Among the population-based vanguard sites, there is no clear trend for dispersion in TBD rates, except for the decrease observed during Vanguard year 2. Whereas there appears a decrease in dispersion among CCGs exposed to care home vanguards during the programme, whereas an upward movement in the post-Vanguard period.

Figure 11: Interquartile range in EA rates among the Vanguard and non-Vanguard groups

Panel a) Emergency admission rates



Panel B) total-bed rates



We formally examine the effect of the programme upon trends among sites that were better or poorer performers at the start of the programme. To do so, we identify the sites that were above the cut-off for the 75th percentile and those that were below the cut-off for the 25th percentile in the first financial year of the pre-Vanguard period (April 2013-March 2014). Analogous to the interquartile range, which is the difference between the 75th and the 25th percentile, we compute the difference in the mean observed outcomes over the duration beginning April 2014 until February 2020 (70 months), for sites pre-determined to be in the top quartile and bottom quartile.

We examine this outcome measure through a formal test using a difference-in-differences method.²¹ We formally test the parallel trend assumptions for both EA and TBD rates, and reject the required assumption of parallel trends in the pre-vanguard period for TBD rates. A visual inspection of the case for trends in TBD rates in the 25th percentile (Figure 12 panel A) and 75th percentile (Figure 12 panel B), clarifies that for the sites in the 75th percentile a parallel trend across vanguard vs non-vanguard may be violated.

We discuss the trends for only EA rates, for which we cannot reject the assumption of parallel trends. Full results are available upon request and not reported here for sake of brevity. For population-based vanguards, the gap between better performers versus poorer performers appears to widen throughout the programme relative to the gap among their non-vanguard counterparts. Although, the magnitude of the effect is much lower in the final year of the programme. However, post programme discontinuation this gap reduces. This may possibly be due to the increase in average EA rates in the lower quartile after programme discontinuation. For care home vanguards, we found a similar increase in the gap between better and the poorer performing sites for the first two years of the programme, but this decreases in the final year. Interestingly, post programme discontinuation the gap further reduces among these sites. As evident from

²¹ Formally, we estimated the following equation

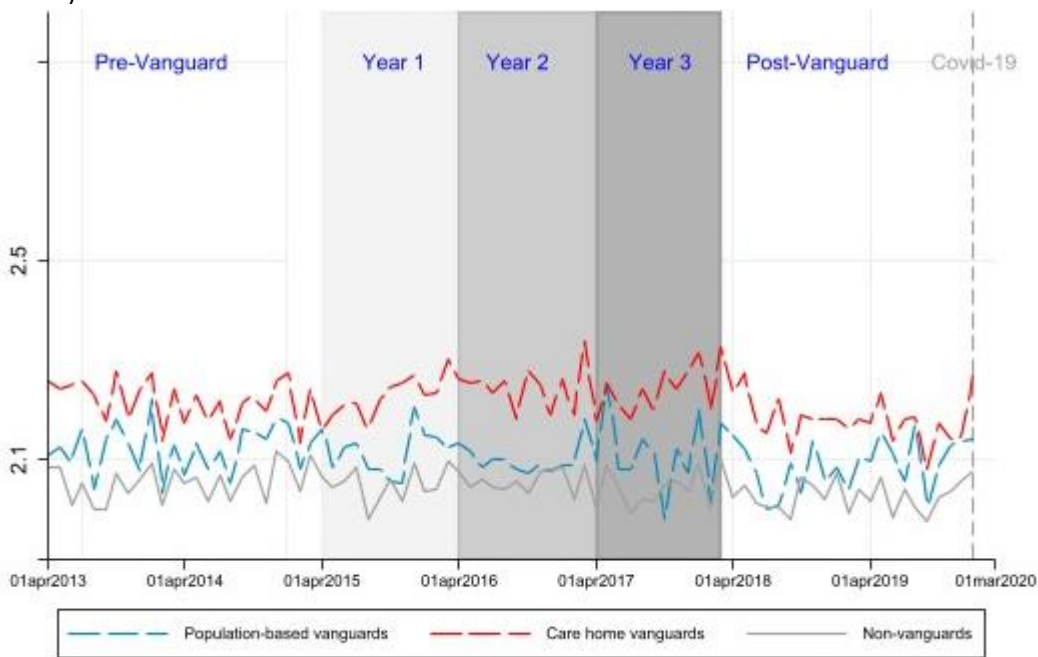
$$IQR(\ln(Y))_{jt} = \beta_t + \gamma_j V_j + \delta_k P_t + \eta_{jk} V_j * P_t + \epsilon_{jt}$$

$IQR(\ln(Y))_{jt}$ is the difference between of the logged value of the outcome of interest (EA and TBD rates) for sites in the 75th and 25th percentile in the pre-vanguard period, in vanguard group j and month t . β identifies month fixed effects. Among the independent variables, V identifies three groups: the control group of non-vanguard sites ($j = 0$) and the two treated groups of sites exposed to population-based ($j = 1$) and care home ($j = 2$) Vanguards. P identifies the pre-Vanguard period ($k = 0$), year 1 to year 3 of the Vanguard programme ($k = 1,2,3$) and the post-Vanguard period ($k = 4$). The main coefficient of interest is η_{jk} . Specifically, this measures the net impact of population-based Vanguards in its first (η_{11}), second (η_{12}), third (η_{13}) years and in the follow-up period (η_{14}) compared to non-Vanguard sites ($j = 0$) in the pre-Vanguard period ($k = 0$). A negative value for η_{jk} will indicate that in a given period, there is convergence in the outcome variable among vanguard sites.

Figure 10, this may be contributed by post programme discontinuation increased EA rates among all sites regardless of their performance in the pre-vanguard period. In contrast, for non-vanguards, the gap appears to be narrowing during all programme years, but after programme discontinuation this effect becomes non-significant.

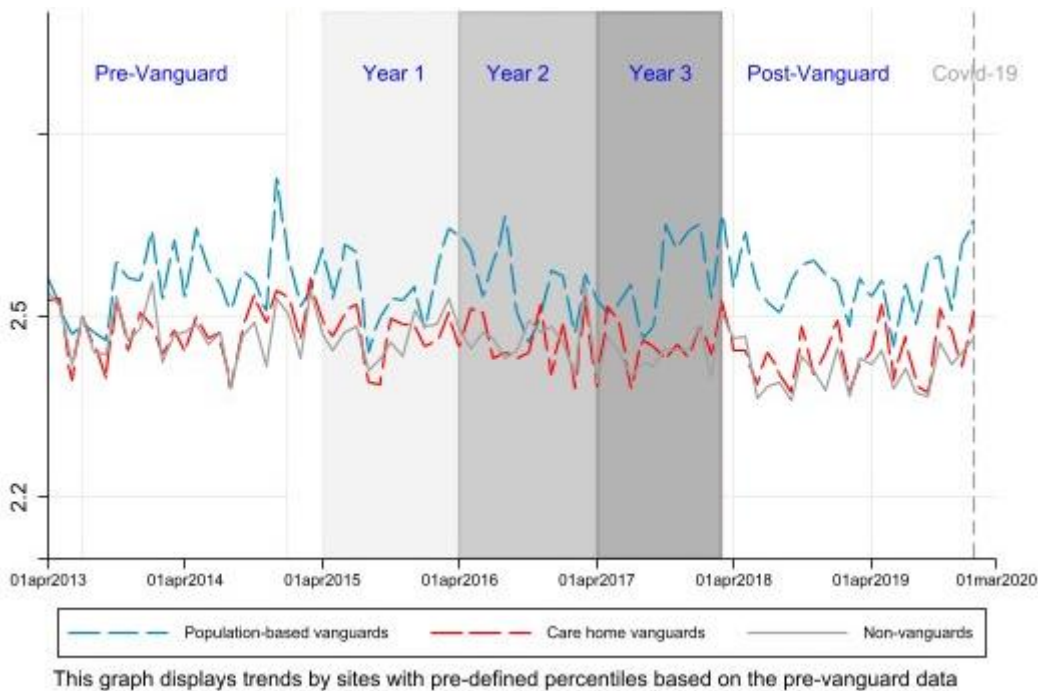
Figure 12: Trends in TBD rates in the 75th and 25th percentiles

Panel a) 25th Percentile



This graph displays trends by sites with pre-defined percentiles based on the pre-vanguard data

Panel b) 75th Percentile



5.6.3. Discussion

In this section we provided insights around the variation in EA and TBD rates across care home and population-based Vanguard sites, compared with non-Vanguard sites

1. The apparent convergence we found suggests that the **Vanguard initiatives might have produced reduced variability in hospital activities across population-based and care home vanguards.**
2. The effect **manifested quicker in care home vanguard CCGs than in population-based Vanguard CCGs.** This is possibly related with the fact that focused interventions on a concentrated population of care home residents who are vulnerable to high levels of emergency admissions are likely to produce depictable effects (in the overall and the variability of) hospital activities quicker than population-based interventions.
3. We find that the programme may have **enabled reductions in hospital admission rates among the worst performing population-based vanguard sites,** but evident only in the final year. These sites were able to sustain the effects after programme discontinuation. On the one other hand, we found that better and average performers were unable to sustain the effects after the end of the programme.
4. **For care home vanguards, the net reduction in emergency admissions emerged mainly from improvements in poor and average performing sites.** However, we found that **these sites were unable to sustain these net reductions after programme discontinuation,** registering similar trends to the rest of the country.

One explanation for the net effects we found in the post programme termination period could come from how funds from the vanguard programme were utilised and whether they were invested in making permanent changes in the way of working. The rules regarding the use of funding were flexible, and this seems relevant in order to bridge the gap in understanding why sites were able to achieve relatively lower EA rates, but the same strategies may not have been effective at reducing TBD rates.

However, there is no available data on spending patterns at site level. Therefore, any deeper investigation of this (and any cost-effectiveness analysis) is hampered by the lack of financial accountability of spending patterns for the Vanguard initiatives.

The only information available to us were on funds allocated to individual sites. We make use of them, with results discussed below. In Table 10: Fund by Vanguard sitesTable 10, we have provided some information on funding received by individual vanguard sites (NHS, 2016) but we do not have complete information for all population-based sites because, either the funding amounts were not confirmed for the last year of the Vanguard programme or where not submitted. For the care home sites, where we have complete data, it appears that the mean funding amounts and its variability decreased over the Vanguard period. Though it is important to consider that **funding itself may be endogenous to single Vanguard site performance.**²² In fact, Vanguard sites had to provide, in support of their application, ideas for how they would meet the goals of vanguard programme. Moreover, subsequent funding for years 2 and 3 was contingent upon meeting national targets.²³ Using funding data as a covariate in statistical analysis would introduce endogeneity bias and therefore, we restrict our analysis of these to descriptive statistics.

It may also be important to consider the fact that **the Vanguard programme provided non-pecuniary support** (for example, integrated commissioning, shared learning, etc.). This may have been instrumental in enabling participating sites to generate positive outcomes during the programme. As mentioned elsewhere in this report, collaborative working during the Vanguard programme fostered creation of local structures and enhanced trust and enthusiasm among participants, that were seen as valuable effects of programme. Such support may have also enabled reduction in inter group variation, at least in EA rates. Whether these reductions remain persistent over the longer term, remains an aspect to be examined.

Table 10: Fund by Vanguard sites

	Mean			Standard deviation		
	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3
PACS & MCP	1.577	1.272	1.702	1.136	1.149	1.026
EHCH	0.376	0.277	0.271	0.186	0.128	0.102
Total	1.392	1.107	1.225	1.133	1.114	1.077

Notes: £million (current prices), per population Funding standardised by population size. Source: (NHS, 2016)

5.7. Impact of the Vanguard programme on social care users' quality of life

5.7.1. Introduction

As noted in Chapter 0, there were a few types of initiatives implemented under the Vanguard programme: Primary and Acute Care Systems (PACS), aimed to better connect GP, hospital, community and mental health services; Enhanced Health in Care Homes (EHCH), aimed at better joined up health, care and rehabilitation services for older people; Multispecialty Community Providers (MCP), facilitating specialist care away from hospitals in communities; Urgent and Emergency Care Vanguard (UEC), directed at better coordination of services and reducing pressure on A&E departments; and Acute Care Collaborations (ACC), helping with linking hospitals to improve their clinical and

²² Elsewhere in the report, it has been noted that additional funding was considered crucial and initiatives were downgraded/abandoned when the funding was withdrawn.

²³ While on the one hand, funding is dependent upon with performance. But the inherent uncertainty in funding could have affected related aspects such as staff retention.

financial viability, reducing variation in care and efficiency (NHS England 2015). However, we already noted that, in practice, there were few observable differences between MCPs and PACS, with both made up of a wide variety of community-based initiatives such as multidisciplinary team management of frail elderly people and the introduction of social prescribing schemes. EHCH Vanguards focused on improving care in care homes, with a strong focus on admissions avoidance, whilst UECs and ACCs were secondary-care focused initiatives, aiming to support better collaboration between acute providers. The Vanguard sites were selected through a vigorous process from the localities that have already shown improvement and achievements in the mentioned areas, suggesting Vanguard partners may have already started at a better average performance levels than the rest of England localities.

Similar initiatives have been implemented in the past and internationally. World Health Organisation offers a summary of types of initiatives: individual models of integrated care (case management, individual care plans, patient-centered medical home, personal health budgets), group and disease specific models (chronic care model, integrated care models for elderly and frail, disease-specific integrated care models), and population based models (Kaiser Permanente, Veterans Health Administration, Integrated care in Basque country (World Health Organisation 2016)). The Vanguard programme straddled these models, with individual areas having scope to design their own approach.

The programme received praise and was considered a success by NHS England after it ended (NHS England 2019). It was also considered that some of integrated care practices should have a long-term positive effect even after the funding stopped (National Audit Office 2018) and we found some evidence of that reported in Section 5.5.

Research evidence on impact of Vanguards on various outcomes was mostly focused on social care and health care systems performance indicators. Vanguards were found to be associated with modest reductions in emergency admissions, finding mostly driven by Care Home Vanguards (Morciano, Checkland et al. 2020) (see previous sub-Sections of this report). Larger reductions were observed in delayed transfers or care associated with Urgent and Emergency Care Vanguards (personal communication, papers under review). Qualitative evaluation revealed that local areas considered their relationships and ability to work together across sector and organisational boundaries have notably improved (Checkland, Coleman et al. 2021) and it was expected to translate into improvement in patient outcomes.

So far, quantitative research evidence on the impact of the Vanguards has been based on the provider level data, yet it is plausible that some of the large number of initiatives implemented might have improved individual experiences of social care users in the community. However, so far there is no evidence on how service users' quality of life were affected by the Vanguards programme and limited relevant evidence as to users' preferences about closer integration of health and social care services (Carpenter, Schneider et al. 2004). Therefore, it is important to explore whether the benefits that staff identified in terms of their ability to co-ordinate care, translated into benefits in quality of life for those served and if the findings help justify the sizeable funding for the Vanguards programme.

In this sub-section (a paper is under review in XXX) we report on the relationship between Vanguard New Care Models and social care-related quality of life provided by the Adult Social Care Outcomes Toolkit (ASCOT) data. The ASCOT toolkit (Netten, Burge et al. 2012) is a measure of social care-related quality of life (SCRQoL) for adults with support needs which has been used in a number of evaluations of new policy initiatives (e.g. (Forder, Jones et al. 2012)). The annual ASCOT data from the Personal Social Services Adult Social Care Survey is available from NHS Digital (NHS Digital)). The survey collects service users' opinions around long-term services funded or managed by local authorities. The data is collected between February and April of each year. We aim to investigate if participation in Vanguard programmes is associated with any detectable change in the ASCOT social care-related quality of life outcome measure,, which could help make more informed future investment decisions in care integration programmes.

5.7.2. Data and Methods

Data. For the main analysis, we use eight waves of ASCOT data: five pre-Vanguard (2011-2015) and three pertaining the Vanguard period (2016-2018). Sensitivity analysis includes two additional swaps (2019-2020), referring to the post-Vanguard period.

Our primary outcome of interest is the ASCOT social care-related quality of life (SCRQoL) overall score, which is a summed weighted score (see Appendix 1 for details) from the following eight quality of life domains used as secondary outcomes: control over daily life; personal cleanliness; food and drink; feeling of safety; social situation; quality of time spent; home cleanliness; way of being helped and treated.

While the SCRQoL overall score is continuous, ranging from 0 (lower quality of life) to 1, the domain variables are categorical ranging from 1 (high) to 4 (low). We excluded data from two small Local Authorities (Isles of Scilly and City of London). We also excluded Richmond upon Thames and Slough Unitary Authority because information is missing for the former for the year 2011 and for the latter in the year 2013. The final sample comprised of 460,706 observations, related to response from service users of 148 local authorities over the study period. We used a pooled sample for our analyses.

The data included individual level information about the respondent: binary dummy variables for being male, white, aged 65+, using community based services, and using residential or nursing care. These variables were used as covariates in our main estimations and as stratifying variable for getting further insight in our results. There were no missing values in the final sample.

Vanguard involvement identification. We coded local authority involvement in the Vanguard programme by following their “official” partnership as stated in the NHS Vanguards Blueprint document (1). We also created binary indicators of Vanguard-types, distinguishing the three main programmes: Urgent and Emergency Care (UEC), Care Home initiatives (EHCH), and population-based initiatives (Multispecialty Community Providers (MCP) and Primary Acute Care (PAC)). Since some local authorities participated in more than one Vanguard programmes, we also create a dummy variable which includes participation in any Vanguard. We did not include Acute Care Collaborative Vanguards as these focused upon the organisation of secondary care services rather than impacting care in the community.

Statistical Analysis: We ran two-way fixed effects difference-in-differences models, using the following specification:

$$SCRQoL_{it} = \alpha_i + V_{it}\beta_1 + P_{it}\beta_2 + V_{it} * P_{it}\beta_3 + CI_{it}\beta_4 + LA_{it}\beta_5 + T_{it}\beta_6 + u_{it} \quad (1)$$

Where $SCRQoL_{it}$ is the overall and domain-specific quality of life measure for respondent i in year t . Explanatory variables of interest were represented by vector V_{it} , indicating Vanguard participation for the overall analysis, and Vanguard types (EHCH, UEC, and MCP and PAC combined) participation was subsequent analysis. P_{it} was a binary indicator for the Vanguard period (2016-2018). The coefficient associated to the interaction term $V_{it} * P_{it}$ was the main parameter of interest, capturing the net impact of the Vanguard programme. We also included a series of individual level control variables CI_{it} . We also conducted specific subgroup analysis with a variant of equation (1) without the stratifying CI_{it} variable. The subgroup analysis included: community services users only (337,415 obs.); residential and nursing care users only (107,120 obs.); those aged 65+ (280,870 obs.); community services users aged 65+ (197,026 obs.); residential and nursing care users aged 65+ (77,955 obs.).

All specifications included local authority fixed effects LA_{it} (to account for determinants of quality that differ across local authorities but do not change over time) and time fixed effects T_{it} (to flexibly account for common quality

trends across local authorities). All models used an ordinary least squares estimator (OLS), with standard errors clustered at LA level. All analysis was performed in STATA SE 16.

Sensitivity analysis. To test how robust the results were we ran our main regression (1) with a few adaptations:

- 1) extending sample time frame: using SCRQoL score as an outcome variable we extended the study time period to include additional two years 2019 and 2020, and then Vanguard activity period is expressed as: a) equal to 1 only for years 2016, 2017, 2018 and 0 afterwards since the programme stopped in 2018, and b) equal to 1 from 2016 onwards, assuming integration practices were maintained, as expected by programme creators, or potentially there is a lag in effectiveness of the programmes; both modifications run for 6 different samples.
- 2) Identifying Vanguards with a single categorical variable: using both, overall social care-related quality of life score and the separate ASCOT domains as outcomes. Vanguard participation was identified with one categorical variable for participation in all mentioned Vanguards: 0 – No vanguard participation, 1 – UEC; 2 – MCP+PAC; 3. EHCH, which was then interacted with Vanguards activity period 2016-2018. Inclusion of all Vanguards in one regression allowed observing if the Vanguards had cumulative effects on the ASCOT social care-related quality of life outcome. Regressions ran for the 6 mentioned samples.

5.7.3. Results

Quality of life overall score (SCRQoL) had a mean of 0.81 (the range is between 0 and 1, with 1 meaning the best possible outcome) for the full sample for the period between 2011 and 2018 (460,706 obs.). The sample consisted of 39.6% male participants, 89.7% of participants were white, 60.9% were 65 years and older. Of this sample 73.2% were community services users (71.7% are only community services users), and 23.2% were residential or nursing care users (21.7% use only residential nursing care), 1.6% used both services and 5.1% did not use either service. The lowest number of observations (respondents) per LA was 1,130, the highest number of observations per LA was 6,211, with balanced distribution in between and 3,103 average. Lowest number of observations per LA per year was 90, highest - 1,387, average – 388.8.

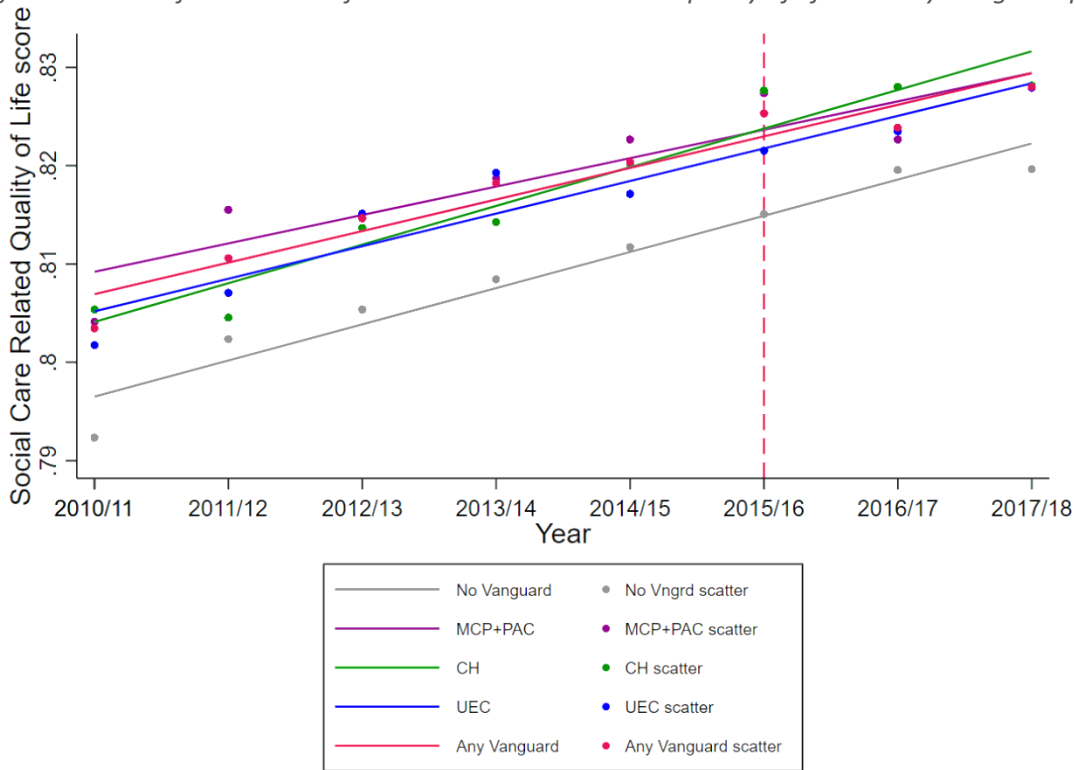
The SCRQoL outcome measure did not vary across the samples. The lowest mean values (78-80%) belong to community services users, and highest values were observed among residential and nursing care users (86-87%). Small variations in SCRQoL were observed between LAs involved in different Vanguards before and after their start. SCRQoL score had increased on average in all LAs after the start of the Vanguards, however those LAs that did not belong to any Vanguard had a lower score before and after the Vanguards compared to Vanguard partner LAs. For LAs that were participating in Vanguards, lowest average score belonged to care homes vanguard partners before the Vanguards' start, just as the highest average SCRQoL value (indicating improved quality of life) after the start of Vanguards (until 2018). Nonetheless, deviations between the different Vanguard partner LAs were minimal before and after their start on average (details available upon request).

Similar information is depicted in

Figure 13 showing linear fitted trends for the social care related quality of life measure over time by different Vanguard involvement for the period between financial years 2010/11 and 2017/18. Those LAs that were not Vanguard participants are plotted consistently below the Vanguard partners over time (indicating lower quality of life). Care home Vanguard partner score average starts below other Vanguards but is higher at the end of the financial year 2017/18 (indicating improved quality of life). However,

Figure 13 shows that SCRQoL score is fairly similar amongst different Vanguards partners over time.

Figure 13: Linear fitted trends of overall Social Care-related quality of life score by Vanguard participation



Note: scatter plots represent yearly SCRQoL means by Vanguard participation

Figure 14 shows locally weighted smoothed fitted trends (lowess smoother) for the period between 2010/11-2019/20. Similar pattern is observed to that in

Figure 13 – plotted trends by Vanguard participation appear fairly parallel prior to the start of the Vanguards (indicated by red vertical line). Similar difference was sustained between the Vanguard partners compared to non-partner LAs until the financial year 2017/18. However, since then there were more changes in SCRQoL amongst the indicated groups, with UEC Vanguard partner LAs score rising (indicating improved quality of life) above other Vanguard groups, while EHCH Vanguard partner score falling (indicating a decline in quality of life) below other groups to a similar level as non-Vanguard partner sites.

Figure 14: Locally weighted smoothed fitted trends of overall Social Care related quality of life score by Vanguard participation

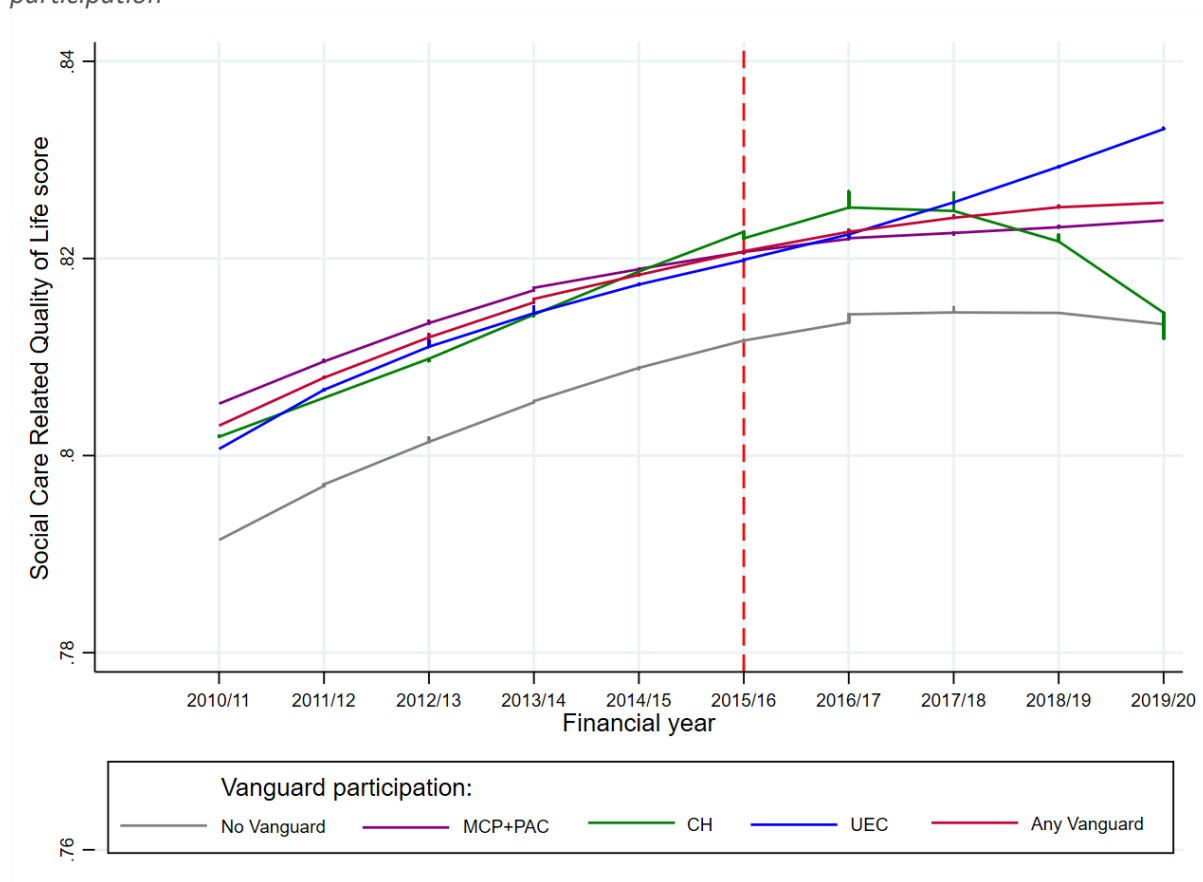


Table 11 presents the results for the relationship between overall social care-related quality of life outcome measure and the different Vanguard groups between the years 2010/11-2017/18. Overall, the care home (EHCH) Vanguard was associated with 0.008 increase in SCRQoL (quality of life improvement) amongst residential and nursing home users, significant at 5% level. There were mostly small insignificant reductions in social care-related quality of life in regard to the other vanguards.

Table 11: Linear regressions with SCRQoL overall weighted score, 2011-2018

Vanguard	Any	MPC+PAC	EHCH	UEC
All	-0.002	-0.003	0.002	-0.001
95% CI	[-0.006; 0.002]	[-0.007; 0.001]	[-0.005; 0.009]	[-0.006; 0.004]
Comm.Serv. users only	-0.002	-0.003	0.002	-0.0002
	[-0.006; 0.003]	[-0.008; 0.003]	[-0.005; 0.008]	[-0.006; 0.006]
Res.Nurs.users	-0.003	-0.004	0.005	-0.002
	[-0.009; 0.003]	[-0.012; 0.004]	[-0.002; 0.012]	[-0.008; 0.004]
65+	-0.002	-0.003	0.001	0.0005
	[-0.006; 0.003]	[-0.009; 0.002]	[-0.008; 0.010]	[-0.004; 0.005]
Comm.Serv. user & 65+	-0.002	-0.004	-0.001	0.001
	[-0.007; 0.003]	[-0.010; 0.003]	[-0.011; 0.009]	[-0.005; 0.007]
Res.Nurs.users & 65+	-0.002	-0.004	0.008**	-0.001
	[-0.009; 0.006]	[-0.014; 0.006]	[0.001; 0.016]	[-0.009; 0.007]

Note: significance level * - $p < 0.1$, ** - $p < 0.05$, *** - $p < 0.01$; 95 % confidence interval in parentheses

Table 12 presents the results for the separate ASCOT domains that constitute the SCRQoL measure by Vanguard involvement. Respondents from EHCH Vanguard partner LAs showed an increase in quality of life among residential and nursing home users of all ages and 65+ indicated improvements in home cleanliness and how they felt about themselves based on the way they are treated. Furthermore, EHCH Vanguards were associated with better outcomes regarding social time in the full sample and among community service users, and how residential and nursing home users aged 65+ spend their time. Although, EHCH Vanguards were also found to be associated with worse outcomes in personal cleanliness for community service users of all ages. MCP+PAC Vanguards LAs were only statistically significantly associated with a reduction in quality of their food and drinks amongst residential and nursing home users. Furthermore, UEC Vanguards were found to have a statistically significant associations with personal cleanliness in the full sample and among community service users, and with home cleanliness in the full sample and among residential and nursing home users of all ages (all associations indicating worse outcomes). Overall, there was little indication of Vanguards contributing to an improvement within the separate ASCOT domains with the exception of EHCH Vanguards initiative.

Table 12: Results for separate ASCOT domains constituting SCRQoL by vanguard

	Control	Clean	Fooddrink	Safe	Social	Time	Home	Way
Any Vanguard								
All	0.012	0.009	0.005	0.004	0.002	0.007	0.008	0.0003
Comm. Serv. user	0.010	0.012*	-0.0003	0.001	0.003	0.005	0.009	-0.002
Res. Nurs. user	0.017	0.010	0.021**	0.006	0.001	0.012	0.008	0.003
65+	0.013	0.007	0.003	0.004	0.001	0.005	0.003	0.001
Comm. Serv. user 65+	0.015	0.010	-0.002	0.003	0.005	0.008	0.005	0.003
Res. Nurs. user 65+	0.012	0.008	0.021*	0.003	-0.006	0.002	0.004	-0.001
MCP+PAC								
All	0.010	0.004	0.000	0.004	0.012	0.009	0.005	0.005
Comm. Serv. user	0.008	0.004	-0.008	0.003	0.012	0.008	0.006	0.003
Res. Nurs. user	0.023	0.010	0.026**	0.001	0.018	0.010	0.003	0.012
65+	0.018	0.002	-0.006	0.006	0.012	0.011	0.0002	0.007
Comm. Serv. user 65+	0.020	0.003	-0.017	0.008	0.013	0.017	0.003	0.009
Res. Nurs. user 65+	0.028	0.013	0.024*	-0.001	0.020	0.006	-0.002	0.004
EHCH								
All	-0.008	0.011	0.001	0.001	-0.036*	-0.030	0.002	-0.010
Comm. Serv. user	-0.008	0.015*	0.002	0.003	-0.046**	-0.034	0.008	-0.007
Res. Nurs. user	-0.009	0.002	-0.006	-0.007	-0.004	-0.021	-0.016*	-0.031**
65+	-0.005	0.001	-0.006	0.009	-0.030	-0.026	-0.007	0.001
Comm. Serv. user 65+	0.0004	0.008	0.0005	0.010	-0.037	-0.024	0.006	0.018
Res. Nurs. user 65+	-0.015	-0.014	-0.022	-0.003	-0.012	-0.040*	-0.033***	-0.041**
UEC								
All	0.003	0.013*	0.007	0.004	-0.003	-0.005	0.011*	-0.003
Comm. Serv. user	0.001	0.016**	0.007	0.002	-0.002	-0.006	0.009	-0.005
Res. Nurs. user	0.007	0.008	0.009	0.010	-0.001	0.002	0.013	0.004
65+	0.002	0.009	0.007	0.001	-0.009	-0.013	0.006	-0.002
Comm. Serv. user 65+	0.000	0.012	0.007	-0.0004	-0.006	-0.014	0.005	-0.005
Res. Nurs. user 65+	0.002	0.001	0.009	0.006	-0.015	-0.007	0.009	0.009

Note: significance level * - $p < 0.1$, ** - $p < 0.05$, *** - $p < 0.01$

5.7.3.1. Sensitivity analysis

Table 13 presents results for the overall ASCOT quality of life outcome measure for the extended time frame between 2011-2020. Results in specification a) which extended the years but not the Vanguard activity period, were very similar to those in

Table 111 - It was only EHCH vanguard having a statistically significant association with an improved quality of life score amongst residential and nursing home users 65 years and above. For the b) specification, where it was assumed Vanguards remained in effect beyond 2018, this effect was no longer found statistically significant, and it was only MPC and PAC Vanguards that showed small statistically significant (at 10% level) quality of life reducing effects in the full sample, and among residential and nursing home users of all ages and aged 65+.

Table 14 shows the results for the second part of sensitivity analysis, where we accounted for all Vanguards in the same regressions and Vanguards activity period 2016-2018 using the full range of outcome variables: the total ASCOT quality of life score and also the separate domains. . These regressions allow assessing the cumulative effect of Vanguards, especially for those LAs that are partners to more than on type of Vanguard. We found some similarities in these results to those obtained in main results. i) the EHCH Vanguard had a statistically significant (at 10% level) positive association with quality of life score for residential and nursing home users aged 65+; ii) EHCH Vanguards were found to improve social life quality in the full sample and among community service users; iii) EHCH Vanguards were found to improve home cleanliness for residential and nursing home users aged 65+; iv) EHCH Vanguard was found to improve the way residential and nursing home respondents (all ages and 65+) felt about themselves. However, the EHCH Vanguard was found to be associated with a decline in personal cleanliness (quality of life reducing effect) of community services users; v) MCP+PAC Vanguards were associated with food and drink quality reducing effect for residential and nursing home users. Overall, EHCH Vanguard was mostly related to small improvements in separate ASCOT domains and in the total score, apart from personal cleanliness, while MCP+PAC and UEC Vanguards tended to be associated with small reductions in the separate ASCOT domains.

Table 13: Linear regressions with SCRQoL overall weighted score, 2011-2020

Vanguard	Any		MPC+PAC		EHCH		UEC	
	a)	b)	a)	b)	a)	b)	a)	b)
All	-0.002 [-0.006; 0.001]	-0.001 [-0.005; 0.002]	-0.002 [-0.005; 0.002]	-0.004* [-0.008; 0.001]	0.002 [-0.004; 0.008]	0.0004 [-0.007; 0.008]	-0.001 [-0.006; 0.003]	0.001 [-0.004; 0.006]
Comm. Serv. user	-0.002 [-0.006; 0.002]	-0.001 [-0.005; 0.004]	-0.002 [-0.007; 0.002]	-0.003 [-0.008; 0.002]	0.001 [-0.005; 0.008]	0.0004 [-0.006; 0.007]	-0.001 [-0.007; 0.004]	0.002 [-0.004; 0.007]
Res. Nurs. user	-0.002 [-0.007; 0.003]	-0.003 [-0.009; 0.003]	-0.001 [-0.007; 0.006]	-0.007* [-0.014; 0.0004]	0.004 [-0.002; 0.010]	0.004 [-0.005; 0.013]	-0.003 [-0.008; 0.003]	-0.001 [-0.008; 0.005]
65+	-0.002 [-0.006; 0.001]	-0.0004 [-0.005; 0.004]	-0.002 [-0.006; 0.003]	-0.004 [-0.010; 0.001]	0.0003 [-0.008; 0.008]	0.001 [-0.007; 0.009]	-0.001 [-0.005; 0.003]	0.003 [-0.002; 0.008]
Comm. Serv. user 65+	-0.003 [-0.007; 0.002]	0.0003 [-0.005; 0.005]	-0.003 [-0.009; 0.003]	-0.003 [-0.009; 0.004]	-0.002 [-0.012; 0.007]	0.001 [-0.008; 0.009]	-0.001 [-0.006; 0.005]	0.004 [-0.001; 0.009]
Res. Nurs. user 65+	-0.001 [-0.007; 0.005]	-0.002 [-0.009; 0.005]	0.001 [-0.007; 0.009]	-0.008* [-0.017; 0.0005]	0.008** [0.001; 0.015]	0.005 [-0.005; 0.016]	-0.002 [-0.009; 0.005]	0.0005 [-0.008; 0.008]

Note: significance level * - p<0.1, ** - p<0.05, *** - p<0.01; 95 % confidence interval in parentheses.

Table 14: Results with ASCOT SCRQoL total score and separate domains as outcomes with Vanguard identified in a single categorical variable

	SCRQoL	Control	Clean	Food/drink	Safe	Social	Time	Home	Way
All									
UEC	-0.002	0.010	0.013	0.009	0.004	0.006	0.010	0.014*	-0.002
MCP+PAC	-0.003	0.019*	0.006	0.002	0.003	0.010	0.015	0.005	0.005
EHCH	0.001	-0.004	0.013*	0.002	0.002	-0.034*	-0.026	0.004	-0.009
Comm. Serv. user									
UEC	-0.001	0.008	0.016	0.007	0.001	0.010	0.010	0.012	-0.005
MCP+PAC	-0.003	0.017	0.006	-0.007	0.001	0.012	0.014	0.006	0.002
EHCH	0.001	-0.004	0.018**	0.002	0.004	-0.042*	-0.030	0.010	-0.008
Res. Nurs. user									
UEC	-0.003	0.009	0.011	0.020	0.014	-0.011	0.015	0.021**	0.004
MCP+PAC	-0.004	0.029	0.011	0.029**	0.004	0.011	0.018	0.006	0.012
EHCH	0.004	-0.003	0.006	0.001	-0.005	-0.003	-0.016	-0.012	-0.028*
65+									
UEC	-0.0002	0.004	0.009	0.011	-0.000	0.001	0.000	0.009	-0.005
MCP+PAC	-0.004	0.025*	0.006	-0.001	0.005	0.012	0.019	0.002	0.006
EHCH	0.0003	-0.001	0.003	-0.004	0.010	-0.027	-0.022	-0.005	0.002
Comm. Serv. user 65+									
UEC	0.001	0.003	0.012	0.008	-0.004	0.010	-0.002	0.005	-0.009
MCP+PAC	-0.004	0.029*	0.008	-0.012	0.007	0.015	0.026	0.004	0.008
EHCH	-0.002	0.006	0.010	-0.0004	0.010	-0.033	-0.020	0.007	0.018
Res. Nurs. user 65+									
UEC	-0.001	-0.001	0.008	0.023	0.008	-0.026	0.004	0.021*	0.007
MCP+PAC	-0.004	0.028	0.013	0.009*	0.0002	0.011	0.012	0.001	0.004
EHCH	0.008*	-0.010	-0.010	-0.013	-0.002	-0.014	-0.037*	-0.029***	-0.039**

Note: significance level * - p<0.1, ** - p<0.05, *** - p<0.01

For SCRQoL outcome, positive coefficient indicates an increase in quality of life; for separate ASCOT domain a positive coefficient indicates a reduction in that measures specific quality of life.

5.7.4. Discussion

New Care Models – Vanguard have been a recent attempt to encourage healthcare and social care integration, and were found to have some positive influence towards healthcare performance indicators, such as emergency admissions, delayed discharges from hospitals etc. However, it is also important to know if the Vanguard programme had any effect on the service users' experience, which we assessed using ASCOT data on service user social care-related quality of life. Results show that there may be some indication that Vanguard also had an impact on social care related quality of life. It is mostly EHCH Vanguard that was found to improve the overall score of quality of life, especially for residential and nursing home users aged above 65 years. Looking into separate ASCOT domains included into the quality of life overall score, we find more statistically significant associations, however, it is only EHCH Vanguard that mostly showed improvement in those domains, while other Vanguard are found to be associated with small reductions in the quality of life domains. ASCOT domains were personal cleanliness, food and drink and home cleanliness, particularly within the residential and nursing home cohorts.

EHCH Vanguard due to its care home focus could partially explain why residential and nursing home users could be impacted positively by this initiative. This finding adds to the evidence that Care Homes Vanguard had more of an impact than other types of Vanguard. This is, perhaps, unsurprising, as they were focused upon a small segment of the population in a sector which had arguably previously been somewhat neglected. There was therefore considerable scope for improvement, which the programme appears to have achieved. However, it is more difficult to explain why other Vanguard could have a negative impact on quality of life evaluations. Nonetheless, finding any statistically significant impact from user's perspective is an important finding, considering the Vanguard were not aimed at improving social care-related quality of life among individuals who require support. This finding suggests that the integration programme potentially had a positive impact beyond measurable performance.

Strengths and limitations. This work benefits from large service users individual level data from ASCOT, which allows an insight into how Vanguards might have affected service users' perceptions. This is important since research so far only offers evaluation of outcomes for service providers. However, the overall ASCOT social care-related quality of life measure and the separate domains are subjective evaluations, dependent on multiple individual factors and likely an influence of such integration programme as the Vanguards may contribute to individual perceptions only by a very small extent, which naturally limits the precision of our findings. Furthermore, quality of life measure might not be best suited to evaluate the impacts of Vanguard initiatives as they were aimed at improving service provision with more measurable outcomes. Additionally, Vanguard partnership is allocated at LA level in this analysis, while the Vanguards were implemented at service provider level: hospitals, care homes etc., which did not exclusively serve only certain LAs. This consequently would additionally reduce the probability of finding any statistically significant associations. Nonetheless, finding any statistically significant association is a good indication of the Vanguards having impacted service users' experience as well. However, the extent to which the Vanguards might have affected service users is questionable and there is some evidence suggesting that Vanguard partner LAs were locations that had a higher service user quality of life score even before the start of this integration programme which gives a reason to suspect that some locations were more likely to self-select into specific Vanguards.

Notes

SCRQoL is a sum of weighted scores from following questions, weighting used:

control 1=1 2=0.919 3=0.541 4=0

clean 1=0.911 2=0.789 3=0.265 4=0.195

fooddrink 1=0.879 2=0.775 3=0.294 4=0.184

safe 1=0.88 2=0.452 3=0.298 4=0.114

social 1=0.873 2=0.748 3=0.497 4=0.241

time 1=0.962 2=0.927 3=0.567 4=0.17

home 1=0.863 2=0.78 3=0.374 4=0.288

way 1=0.847 2=0.637 3=0.295 4=0.263

(Source: <https://www.pssru.ac.uk/ascot/wp-content/uploads/2020/04/ASCOT-SCT4-guidance.pdf> pages 6-7).

Sum replaced by missing value if any of the measures was missing.

To create final score formula was applied: $(scrqol * 0.203) - 0.466$

ASCOT variables:

control

Which of the following statements best describes how much control you have over your daily life?

- 1 I have as much control over my daily life as I want
- 2 I have adequate control over my daily life
- 3 I have some control over my daily life but not enough
- 4 I have no control over my daily life

clean

Thinking about your personal care, by which we mean being clean and presentable in appearance, which of the following statements best describes your situation?:

- 1 I feel clean and am able to present myself the way I like
- 2 I feel adequately clean and presentable
- 3 I feel less than adequately clean or presentable
- 4 I don't feel at all clean or presentable

fooddrink

Thinking about the food and drink you get, which of the following statements best describes your situation?

- 1 I get all the food and drink I like when I want
- 2 I get adequate food and drink at ok times

- 3 I don't always get adequate or timely food and drink
- 4 I don't always get adequate or timely food and drink, and I think there is a risk to my health

safe

Which of the following statements best describes how safe you feel? (By 'feeling safe' we mean how safe you feel both inside and outside the home. This includes fear of abuse, falling or other physical harm.)

- 1 I feel as safe as I want
- 2 Generally I feel adequately safe, but not as safe as I would like
- 3 I feel less than adequately safe
- 4 I don't feel at all safe

social

Thinking about how much contact you've had with people you like, which of the following statements best describes your social situation?

- 1 I have as much social contact as I want with people I like
- 2 I have adequate social contact with people
- 3 I have some social contact with people, but not enough
- 4 I have little social contact with people and feel socially isolated

time

Which of the following statements best describes how you spend your time? (When you are thinking about how you spend your time, please include anything you value or enjoy, including leisure activities, formal employment, voluntary or unpaid work, and caring for others.)

- 1 I'm able to spend my time as I want, doing things I value or enjoy
- 2 I'm able to do enough of the things I value or enjoy with my time
- 3 I do some of the things I value or enjoy with my time but not enough
- 4 I don't do anything I value or enjoy with my time

home

Which of the following statements best describes how clean and comfortable your home is?

- 1 My home is as clean and comfortable as I want
- 2 My home is adequately clean and comfortable
- 3 My home is not quite clean or comfortable enough
- 4 My home is not at all clean or comfortable

way

Thinking about the way you are helped and treated, and how that makes you think and feel about yourself, which of these statements best describes your situation?

- 1 The way I'm helped and treated makes me think and feel better about myself
- 2 The way I'm helped and treated does not affect the way I think or feel about myself
- 3 The way I'm helped and treated sometimes undermines the way I think and feel about myself
- 4 the way I'm helped and treated completely undermines the way I think and feel about myself

5.8. Overall discussion: Vanguard outcomes

In this chapter we have addressed research question 4:

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

We assessed the programme from a provider perspective and from an individual perspective, reflecting the dual nature of Vanguard objectives: to redesign services in such a way as to reduce hospital activity and thus free up

resources to support continued investment in community-based services; and to fulfil local areas' own goals in terms of improved patient experiences and quality of life. We found a modest effect of the programme in reducing the rate in growth of emergency admissions. This effect developed later in the programme, and was initially seen in the care home Vanguards and in those which had also taken part in the Pioneer programme. A small sustained benefit was found to persist beyond the life of the programme, and this was observed in the population-based Vanguards (MCPs and PACS) and in the EHCH Vanguards. We also found a small improvement in quality of life measures in EHCH Vanguards for those living in residential care.

All of these impacts are small in magnitude. It was our intention to formally assess the cost-effectiveness of the programme, but in the absence of any meaningful data on expenditure we are only able to comment that a large investment of more than £300 million has generated at best very modest improvements in outcomes (see section 5.6.3). The programme did not achieve its goal of being self-sustaining. In the initial 'value propositions' put forward by Vanguard sites assumptions were made as to how much money would be saved by the initiatives; the National Audit Office estimated these projected savings as being as much as £324 million per year (National Audit Office 2018). The underlying assumption appears to have been that these savings would be reinvested in the continuation of the initiatives past the end of the programme. However, local areas were not monitored on this, and our qualitative case studies found that many initiatives linked to the Vanguard were not continued after the end of the programme due to lack of funding, as realisable savings did not materialise. This is an important finding for future initiatives, as it highlights how difficult it is to realise and utilise savings. This in turn implies that so-called 'transformational' initiatives will need funding in the longer term, with any savings realised at a system rather than local level.

As initially established, the programme was intended to support the design of new contractual models, in which local care providers were linked together within a large-scale population-based contract. In practice, as we have seen, this proved difficult to achieve. Only one Vanguard (Dudley MCP) out of the 50 attempted to create a new type of provider, but struggled due to the constraints of current legislation (Thomas 2020). In the absence of a new contractual model, each organisation collaborating together within a Vanguard is subject to individual financial monitoring, and it would be difficult for savings made in one sector (e.g. via a reduction in emergency admissions) to be reinvested in another (e.g. the Care Home sector). This provides further evidence to suggest that in the absence of wider changes in funding models, investment needs to be continued for the longer term.

In summary, the Vanguard programme achieved a modest improvement in outcomes at a significant cost, and some of these improvements were sustained beyond the life of the programme, in spite of the fact that some services introduced during the programme were terminated once the additional investment ceased. In the final two chapters we will bring these findings together in order to consider which aspects of the programme may have been beneficial, in what ways, and to draw conclusions relevant to future large scale integration programmes.

CHAPTER 6: Overall assessment of the Vanguard programme as an approach to major system change

6.1. Introduction

Our final research question was:

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

In addressing this question, we first consider the Vanguard programme in the light of Turner et al's (Turner, Ramsay et al. 2016) modifications of Best et al's (Best, Greenhalgh et al. 2012) 'rules' for major system change (see section 2.4.4 p32). This addresses the meso-level of change, considering how local systems can best organise themselves to achieve system change which may require local actors to behave in ways which they find difficult or which run counter to expected norms. In the next chapter we address the broader question of to what extent, and in what ways, might the Vanguard programme be considered to have been a 'success'?

6.2. Understanding the outcomes associated with the Vanguard programme

Our quantitative analysis has shown the following:

- There was a small reduction in emergency hospital admissions associated with the programme. This was seen initially in the Care Home Vanguards, and later also in the population-based Vanguards, MCPs and PACS.
- This effect was greatest in sites which had taken part in other integration initiatives such as the Pioneers programme
- There was an associated increase in elective admissions in Care Home sites, suggesting that the improved care provided uncovered unmet need.
- There is some evidence that the programme reduced variation between the best and worst performing sites in terms of emergency admissions, with the sites which performed worst at the start of the programme maintaining their improved performance after the end of the programme

These effects were generally relatively small, but they do suggest that the Vanguard initiative did generate some sustained change at a local level which was effective in reducing the rate of growth of emergency admissions. How can this be understood?

The Vanguard programme did not, despite the initial intentions, result in the implementation of coherent and well-defined models of care. Rather, Vanguard sites implemented a suite of initiatives such as multidisciplinary teams, social prescribing and co-ordination centres. It is not possible from our study to determine which initiatives generated which outcomes, because it proved impossible to categorise the Vanguards in any coherent way. However, we have some evidence from our qualitative work that may provide some explanation of these findings. Across all of our case study sites, those involved with the Vanguard programme were unanimous in claiming that being part of the programme had had local beneficial effects. They particularly pointed to the effect of working collaboratively across organisational boundaries in increasing trust, and suggested that being part of a high profile national programme was helpful in initiating change. The fact that beneficial effects were most likely to be seen in areas which had worked together as part of previous national initiatives supports the interpretation that effective working across boundaries takes time and requires prolonged effort and support, and that investing resources and support in this way can have longer term benefits. Increased investment initially was helpful, but the short-term nature of this funding means that it is difficult to clearly attribute beneficial effects to the investment. The ability to develop local approaches and solutions was valued, and the difficulties experienced in developing standard approaches suggests that allowing local areas to develop their own solutions may be more effective than seeking to develop standard models of care. Overall, our study would suggest that empowering and supporting local areas to design their own approaches to working together, and continuing this support over the longer term, may lead to improvements in care over time.

We now bring these findings together to address the broader question as to how major system change can best be supported.

6.3. Understanding major system change.

Turner et al (2016) studied an instance of major system change, and used the findings from this to adapt the 'rules' for major system change that Best et al (2012) derived from a realist review of the literature. These modifications are set out in Table 15 below:

Table 15: Turner et al's modification of Best et al's 'rules' for major system, change.(adapted from (Turner, Ramsay et al. 2016))

Rule	Adapted rule
Blend designated leadership with distributed leadership	System-wide authority is needed to align multiple stakeholders over a large scale and encourage clinical commitment to system-wide improvement goals.
Establish feedback loops	Feedback may need to be combined with other tools to encourage behaviour change, e.g. financial incentives
Attend to history	Contextual factors can be a barrier to implementing lessons learned; political authority may be needed to challenge the existing context and enable more radical forms of transformation.
Engage physicians	Need to involve a range of stakeholders in planning major system change, and have a system-wide governance structure to align their interests.
Include patients and families	Awareness that the drivers of major system change (e.g. clinical, political, social, financial) influence how different stakeholders' views come to count during implementation; potential tension between patients' and others' perspectives.

In this section we explore these normative claims, and consider how our insights might modify or expand them.

6.3.1. System-wide authority and leadership

In our qualitative study of Vanguard implementation we found that 'leadership' of local Vanguard implementation was a complex thing. Whilst engagement and leadership by those who had hierarchical authority was important, we also found that other individuals in local areas were able to behave in ways which constituted 'leadership', using a wide variety of 'social skills' (Moulton and Sandfort 2017) to initiate and maintain change. This finding could be said to support Turner et al's (2016) call for 'distributed leadership'. However, the concept of 'distributed leadership' is often poorly defined and specified (Boak, Dickens et al. 2015), with limited attention paid to who exactly is able to exercise such leadership in any given situation. We found two groups of 'leaders' who were able to utilise their social skills in this way: those with hierarchical positions of authority; and those who had earned credibility in a local area. This credibility seemed to rely upon: occupational credibility (i.e. those with a history of providing clinical services); longevity in a local area (i.e. those who had worked in the same area for some time); and the demonstrable ability to work across organisational boundaries.

We found that those acting as local leaders in this way utilised a number of 'sources of authority' (Moulton and Sandfort 2017) to underpin their change activity. Whilst hierarchical authority (i.e. the right invested in senior leaders to decide to engage with the Vanguard programme) was obviously necessary, we found a wide variety of

other sources of authority used to initiate and sustain change. We found that *belonging to the Vanguard programme* was a potent symbol and enabler of local change, building a narrative about the unique and special nature of the particular area. Beyond this, we found that: a compelling narrative of economic necessity; a strong sense of norms and values of co-operation associated with the programme which chimed with staff perceptions of their role; and the judicious use of data to underline the case for change were all important sources of authority wielded by those leading change. These things came together into the local creation of a compelling story, containing many of these elements: the establishment of a sense of crisis and pressing need for change; a narrative about why this particular area had been singled out or was recognised as being ‘special’; a moral case for why this particular change was required; and a road map or vision as to what was going to be done.

Our study thus expands and contextualises Turner et al’s (2016) call for system-wide authority and distributed leadership. We suggest that authority does not just arise from being in a hierarchical position, and that skilful local leaders will mobilise a variety of sources of authority to create a compelling narrative for change. Who is able to act in this way will be dependent upon local context, but personal credibility arising out of longevity in a local area and a history of front line service delivery and cross-boundary working is helpful.

We therefore offer this modification of Turner et al’s (2016) adapted rule:

Change requires skilful mobilisation of a variety of different sources of authority by both hierarchical leaders and local middle managers with earned personal credibility. Earned personal credibility is supported by prolonged employment in a local area, and by local experience as a clinician. Hierarchical authority must be backed up by a compelling narrative as to the moral and economic case for change, and why this particular area is well-placed to engage.

6.3.2. Feedback and incentives

The Vanguard programme was established with a number of feedback and incentive mechanisms in place. The ‘Evaluation strategy’ published early in the programme promised the following:

Our evaluation strategy includes a commitment to use a Health Data Lab which is being developed with the Health Foundation to strengthen our capability to measure the impact of NHS transformation programmes. The Health Data Lab will provide selected vanguards with the capability to rapidly evaluate the impact of specific interventions.

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

The Health Data Lab will play an important role in the development of the new care models by improving the evidence base on the extent that interventions are achieving their aims. By providing regular information to sites participating, the Health Data Lab will enable these sites to adapt their approaches over time. (NHS England 2016 p12)

In practise, the Improvement Analytics Unit (as it was eventually called) struggled to be able to provide feedback in real time, due to complexities around establishing counterfactuals and in obtaining relevant data. Whilst a number of analyses of local Vanguard performance have been published (<https://www.health.org.uk/funding-and-partnerships/our-partnerships/improvement-analytics-unit>) these have generally been published after the end of the programme, and so were not available to provide real-time feedback. Local evaluations also struggled to provide

meaningful quantitative feedback, although qualitative assessments of progress were provided (Wilson, Billings et al. 2021).

In addition to this attempt to provide objective feedback, during its operation the national support programme also provided motivational feedback in the form of ‘success stories’ or ‘case studies’ of Vanguard successes. These appeared on the NHS England website, and were promulgated at national and regional events, with local leaders invited to give presentations about the positive progress that they had made. Local areas told us that they found the opportunity to demonstrate their local success motivating, but there was something of a tension between these ‘good news stories’ and the desire of the internal evaluation programme to establish robust measures of success and to learn from things which had not gone well.

In terms of incentives, there was a significant incentive to join the scheme in terms of the significant amounts of funding available. However, this funding was not allocated at the outset for the full duration of the programme; rather it was contingent upon performance. Some Vanguards found themselves to be refused funding in the latter stages of the programme because they had failed to meet targets round emergency admissions. Given that reducing emergency admissions was not necessarily the main focus of many Vanguards, this was experienced as demotivating. Vanguard sites told us that there was a tension between the need to demonstrate short-term success and their perception that the changes they were trying to make were fundamental, structural and only likely to generate measurable change over a longer timescale. This perception is reinforced by our quantitative findings, which show that beneficial change against quantitative metrics associated with integration programmes takes time to be seen.

These findings suggest that qualitative feedback has an important role to play in generating and maintaining enthusiasm for change programmes. However, it is optimistic to expect to be able to demonstrate quantitative change in the short term, as raw figures are subject to significant fluctuations and counterfactuals are not easy to establish. Incentives must be used with care, as these can be demotivating if applied in ways which run counter to the aspirations of the programme. In the case of the Vanguard programme, the programme was established as a bottom-up, locally driven approach, but was subsequently subject to a top down target potentially at odds with local objectives.

We therefore suggest that a modified rule might be:

Qualitative feedback can be useful in supporting beneficial change. However, it is unlikely that meaningful quantitative metrics demonstrating positive outcomes will be available in the short term, and attempts to provide it may be counter-productive, as change takes time to take effect. Incentives need to be carefully designed to ensure that they reinforce the objectives of the programme.

6.3.3. Local context and its impact on change

Best et al (2012) and Turner et al. (2016) highlight the fact that local context and history are vitally important in enabling change, with Turner et al highlighting the fact that sometimes local context will generate significant problems which require careful management and which may only be overcome via hierarchical authority. Our study explored implementation in volunteer pilot sites, and as such these might be expected to be receptive contexts for change (Pettigrew, Ferlie et al. 1992, Hunter, Erskine et al. 2015). Within this group of volunteers, we found that exactly what constitutes an important or relevant local contextual condition to be ‘managed’ may not be obvious until initial action has been taken. This is in keeping with the work of Weick (1995), who highlights the importance of action in allowing retrospective sensemaking about any given situation. The Vanguard programme interacted with

this local complexity, supported by its associated political and economic authority, and its consonance with public service beliefs and values.

We found a number of local contextual conditions which may make an environment a receptive context. In particular, we found that having individuals championing change who had a significant history within a local area was helpful. Such individuals had garnered trust through previous roles and responsibilities and were able to leverage that trust to support the Vanguard programme. Inevitably in any health and care system individuals will move between roles and across geographical areas, and it is often considered that mobility and experience of multiple roles is useful in advancing in a chosen career. However, our study also suggests that investing in staff in situ, valuing their longevity and their deep knowledge of a particular context may bring dividends, as such people can, if engaged and involved, be powerful agents of change. Similarly, our study suggests that the ability and willingness to seize opportunities was very important. This implies a system architecture which encourages local managers to be alert to potential opportunities and to feel empowered to act when such opportunities arise. This in turn suggests that a supportive approach to risk taking, in which performance management processes reward and encourage activity beyond narrow role specifications, may be valuable. Whilst in some ways the Vanguard programme was an unusual one (in particular it was unusually well-funded and supported), in others it was quite typical of health system policy programmes, in that it was announced with a very short timeframe for application and it grew out of previous similar initiatives. Our study suggests factors which may make systems more able to respond to such initiatives, including nurturing a stable cadre of engaged and knowledgeable staff, and setting up performance management and other systems which reward initiative and willingness to take calculated risks.

Where local contextual conditions were not so supportive or required 'managing', our study suggests that, alongside the political authority which Turner et al (2016) suggest is required, economic authority was also important, alongside the authority arising out of the consonance between the beliefs and values embedded in the programme, and those common in public organisations and espoused by local actors. This consonance was a vital element in the Vanguard programme. Similarly, the strong supportive structures put in place – including the role of the local account managers – were important in initiating and maintaining the programme, with meso-level encouragement and recognition from someone outside the local area seen as a very important element promoting engagement.

More widely, beyond the end of the programme we found that roll out of the EHCH programme in particular could be hampered by an over-rigid specification which did not take account of local context and pre-existing programmes. Allowing a flexible approach which can adapt to local context may therefore also be important.

In summary, therefore, we suggest that:

Whilst contextual awareness and an ability to manage local context remain vital in change programmes, there are also some common local contextual conditions that may act to facilitate change, and these could usefully be established as a routine in order to ensure an adaptable service able to change when required. These include: investing and supporting staff to sustainable long term careers in one area; support managers to be alert to and act to seize available opportunities; and ensure that appropriate risk taking is valued and supported. In overcoming contextually-driven problems, all available sources of authority should be mobilised.

6.3.4. Engage stakeholders and the public

Vanguard sites did establish both internal (amongst staff) and external (amongst the public) engagement programmes, but these tended to occur early in the programme when greater funding was available. Moreover, we found some evidence that public engagement in particular was, to some extent, performative – i.e. it was used politically early in the programme in order to support the development of a compelling narrative for change, but we

found little evidence of ongoing engagement beyond this initial effort, and some instances where information from public engagement was ignored. Staff engagement, including strong internal communications remained important throughout the length of the programme, but towards the end and soon after its end we found that the rhetorical association of initiatives with the Vanguard programme could be counter-productive.

Interestingly, we did not find that the very limited public engagement associated with the Vanguard programme necessarily inhibited progress. This may be because, contrary to the initial aspirations of the programme, the changes introduced were, in the main, incremental and limited in their overall impact on the shape of local services. In other words, the changes made were not sufficiently disruptive to the status quo to generate public disquiet. For example, most Vanguard sites initiated multidisciplinary team (MDT) management of patients of some kind. These initiatives tend not to be visible to the patients involved, as MDT meetings are usually focused upon professional co-ordination rather than involving direct patient input. Similarly, social prescribing initiatives or the employment of more clinical pharmacists tends to be experienced by patients simply as an increase in available services, whilst new hospital transfer pathways and improved health and social care liaison will usually be unnoticed. Larger scale changes, as envisaged in the original policy were contentious, and in fact only attempted in one area, where failure to engage wider stakeholders such as secondary care providers proved a significant problem (Thomas 2020, Thomas and Illman 2021).

Our study thus proposes that, as Turner et al (2016) suggest, wide stakeholder and public engagement is important. In particular, staff engagement was perceived as having been very important in supporting the new ways of working set up in Vanguard sites, with local leaders utilising a variety of skills and sources of authority to engender engagement and enthusiasm. However, the role of public engagement was less clear, with no evidence that limited public engagement was detrimental to the Vanguard programme. This suggests that the extent to which public engagement is crucial in supporting change programmes depends upon the scale and scope of those changes, and the extent to which the intended outcome will be perceived as disruptive by different groups. Notwithstanding the important democratic argument that, if public money is to be spent, the public must be engaged, the Vanguard programme was one in which lack of widespread public consultation did not, in general, hamper many aspects of the programme.

6.3.5. Summary

Our study has confirmed and further elaborated the conclusions drawn by Turner et al (2016) about the factors affecting the implementation of large-scale system change. In particular, we have: elucidated the variety of sources of authority that can be mobilised to support change, and suggested some characteristics which might support individuals to be local change leaders; highlighted the difficulties associated with demonstrating meaningful change in the short term using commonly available metrics; suggested some contextual conditions which, if present, may support a range of different change programmes; and provided some contextual understanding of the circumstances in which internal and external engagement may or may not be useful or necessary. Importantly, these findings may provide an explanation for our quantitative finding that some impacts of the Vanguard on hospital activity may have been sustained after the end of the Vanguard programme. It seems that the subtle improvements in trust between organisations and the beneficial impact of local collaborative activity that we have documented may lead to longer-term improvements in local services.

This analysis treats the Vanguard programme as similar to any other system change programme. In the next chapter we return to its unique character as a nationally-driven, politically supported programme and consider it as a policy pilot programme, addressing the question: how far may the Vanguard programme be considered to have been 'successful'?

CHAPTER 7: What can we learn about policy pilot programmes from the Vanguard new Care Models programme?

7.1. Introduction

The Vanguard programme has been claimed to be a ‘success’ in official communications and in subsequent policy documents. For example, the NHS Long Term Plan explains that:

‘Following three years of testing alternative models in the Five Year Forward View through integrated care ‘Vanguards’ and Integrated Care Systems, we now know enough to commit to a series of community service redesigns everywhere’ (NHS England 2019 p13)

However, the meaning of ‘success’ in the context of policy pilots is rarely clearly defined. In the quote above, the Vanguards are situated as ‘testing alternative models’, but as we have seen in this report, the only ‘alternative model’ that arose from the programme is the Enhanced Care in Care Homes service subsequently rolled out via Primary Care Networks. In this section of the report we suggest an approach to judging pilot success, and consider how the Vanguard programme has performed. This content is adapted from a paper which has been published in the Journal Public Administration (Checkland, Hammond et al. in press).

7.2. Judging pilot success

Building upon the work of McConnell et al (Bovens 2010, Marsh and McConnell 2010, McConnell 2010, McConnell, Grealy et al. 2020), we suggest that the ‘success’ of policy pilots can be judged in terms of both programme and politics. In other words, a pilot might achieve all its goals, but fail to overcome political objections, or it might fail to achieve any goals but political considerations mean that it is widely rolled out regardless. These different dimensions of success are set out in table 16.

Table 16: Dimensions of policy pilot success (from (Checkland, Hammond et al. in press))

	Programme success	Political success
Pilot process	Did the piloting programme happen – i.e. was it developed and implemented?	Did pilot initiation have any positive political consequences, for whom?
Pilot outcomes	Did the piloting programme meet its ostensible goals?	Did its eventual outcome have any positive political consequences, for whom?
Pilot effects	Was the programme locally sustained and /or more generally rolled out? OR was it rationally modified or discontinued? Was future policy altered as a result?	Did roll out or discontinuation have positive political consequences, for whom?

It is important that programme evaluation considers any particular policy pilot programme across all of these dimensions, as policy making is rarely fully rational, and policy pilots do not usually act straightforwardly as experiments (Ettelt, Mays et al. 2014).

7.3. The Vanguard programme as an example of a policy pilot

In this section we consider each of the categories in our matrix in turn.

7.3.1. Pilot process programme success: was the programme successfully developed and initiated?

From this viewpoint, the programme was a resounding success. The timescale involved was extremely tight: the Five Year Forward View (NHS England, 2014a) proposing the pilot programme was published in September 2014, with details about how to apply to join the programme announced in December and the first 29 Vanguard sites chosen in March 2015. Pilot initiation followed within months. At the same time a wide-ranging support programme was set

up (NHS England 2015), providing individual ‘account managers’ for each chosen site, alongside workstreams addressing anticipated issues in integrating care across organisational and sector boundaries.

By September 2015 (only 6 months after pilot initiation) all 50 sites were in operation across all five ‘models’, a designated National lead, Vanguard ‘model’ leads, support stream leads and strategic account managers appointed, funding distributed to sites and the support programme in operation. In programme terms, therefore, the pilot process was extremely successful.

7.3.2. *Pilot process political success: what was the political impact of the initiation of the programme?*

The political impact of the initiation of the Vanguard programme must be seen in the context of the contemporary political environment. When the Five Year Forward View was published in 2014, the NHS, along with other public services in the UK and elsewhere, was subject to so-called ‘austerity’ policies (The Centre for Local Economic Strategies 2014) designed to support recovery from the global financial crash of 2008. NHS funding was consequently growing slowly and below the level of health care cost inflation (Appleby and Gainsbury 2017). The NHS was predicting a significant funding shortfall (Torjesen 2012), and NHS England and the Department for Health and Social Care were negotiating with HM Treasury for additional funding. This was obtained in the form of ‘sustainability and transformation’ funding, a proportion of which was used to support the Vanguard programme (NHS England 2014). This funding came with an expectation that there would be associated ‘transformation’ in service delivery, rather than being used to pay down deficits. The Vanguard programme was thus established at least in part to ‘frame the future’ (Nair and Howlett 2016 p1) by demonstrating that the NHS could change, and it could do so rapidly. Our respondents picked this up:

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)

Whilst funding was initially offered to all Vanguard sites, in the second and third years of operation ongoing funding was tied to performance against centrally-determined targets, with Vanguards required to show that they had ‘earned their way’ (NHS England 2017 p47). In November 2017, just over a year into the programme, a speech made by the Chief Executive of NHSE England (NHSE) (<https://fabnhsstuff.net/fab-stuff/simon-stevens-ceo-nhs-england-speEHCH-nhs-providers-birmingham-november-8th-full>) argued that the ‘Five Year Forward View ‘recipe’ is working’, before asserting that the main problem facing the NHS is not excess demand but ‘fragmentation and funding’. The speEHCH finished with a suggestion that to support the further roll-out of the beneficial service changes demonstrated by the Vanguards, further additional funding would be required. Thus, the appeal to the Treasury for additional funding over and above that already provided was explicitly linked to the demonstration that the NHS had made rapid beneficial changes in service delivery. The rapid initiation and delivery of the Vanguard pilots was thus used politically to argue for additional funding for the NHS, and this argument was successful, with a new five year funding deal announced in July 2018 (<https://www.gov.uk/government/speEHCHes/pm-speEHCH-on-the-nhs-18-june-2018>). Thus, in political terms as we have defined them, relating to the distribution of power or resources between actors in a political system, the pilot process was also successful, with NHS England achieving its objective of obtaining additional funding.

7.3.3. *Pilot outcome programme success: did the pilot programme achieve its stated goals?*

In terms of Ettelt et al’s (2014) characterisation of the purposes of pilot programmes, policy documents (NHS England 2014, NHS England 2014, NHS England 2015, NHS England 2015, NHS England 2017) suggest that the Vanguard programme was conceived of as supporting both early implementation and learning, with an explicit intention that Vanguard sites would test out approaches to change, which could be spread more widely (Checkland,

Coleman et al. 2019). There was also an element of demonstration, with the argument made that: ‘All three of these care models [PACS, MCPs and EHCH] 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 2015 p4).

In July 2015 further guidance 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 p9)

In addition, the programme was established with a well-resourced evaluation programme, suggesting that these pilots also embodied an experimental approach with genuine uncertainty as to whether the new approaches would work:

The new models need to show how they help solve the particular issues confronting that particular health community, with proper safeguards against unintended consequences. 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. (Stevens, 2014)

There were thus a number of programme goals:

- To implement integrated care programmes in designated Vanguard areas;
- To use Vanguard experiences to design ‘standard approaches and products’ which could be rolled out;
- To monitor performance against ‘benchmarks’ and use this information to guide future investment decisions.

The service changes introduced by Vanguards were eclectic, building upon previous initiatives and existing collaborative relationships. A great deal of activity happened in Vanguard sites, and new services or ways of working were introduced. In Pilot Outcome terms, there was thus demonstrable programme success in initiating and running new services.

However, there was less success in developing the promised ‘standard approaches and products’ to be rolled out widely. The programme ran for three years, and towards the end of the programme ‘frameworks’ for each of the Vanguard types were published (NHS England, 2016b, 2016c, 2016d). Two of these (MCPs and PACS) are at a high level of abstraction and diffuse, indicating areas of work which might be considered by those seeking to better-integrate care across sectors. Neither offers standard approaches or ‘products’ which could straightforwardly support local action. The Enhanced Healthcare in Care Homes framework is somewhat more specific, setting out services which should be provided to improve care in Care Homes. (NHS England, 2014a)

Finally, it was intended that performance would be monitored and managed. At the start of the programme Vanguards were given significant leeway to determine their own outcome objectives, but halfway through the programme this changed, with funding for the final two years contingent upon success against two metrics – reducing emergency hospital admissions and reducing the average length of stay in hospital.

The impact of the programme on these standardised metrics has been explored in a quantitative evaluation (Morciano et al., 2020). The findings are nuanced, but essentially show that the programme was associated with a small fall in emergency admissions towards the end of the programme, and this was concentrated in the Care Home Vanguards. There was no effect on hospital length of stay.

In summary, in programme terms the success of the pilot programme was mixed. Following rapid initiation, pilot sites worked quickly to make changes to the way services were delivered. However, the intention to use the programme to develop 'standard approaches and products' to support rapid replication of the Vanguard 'new models of care' was not realised, apart from to a limited extent in the Care Home sites. Finally, by midway through the programme, funding was contingent on reducing emergency admissions, a standardised metric of success. There is evidence that this outcome was achieved in a limited way towards the end of the programme, mainly in the Care Home sites.

7.3.4. Pilot outcome political success: did the outcomes of the programme have political impact?

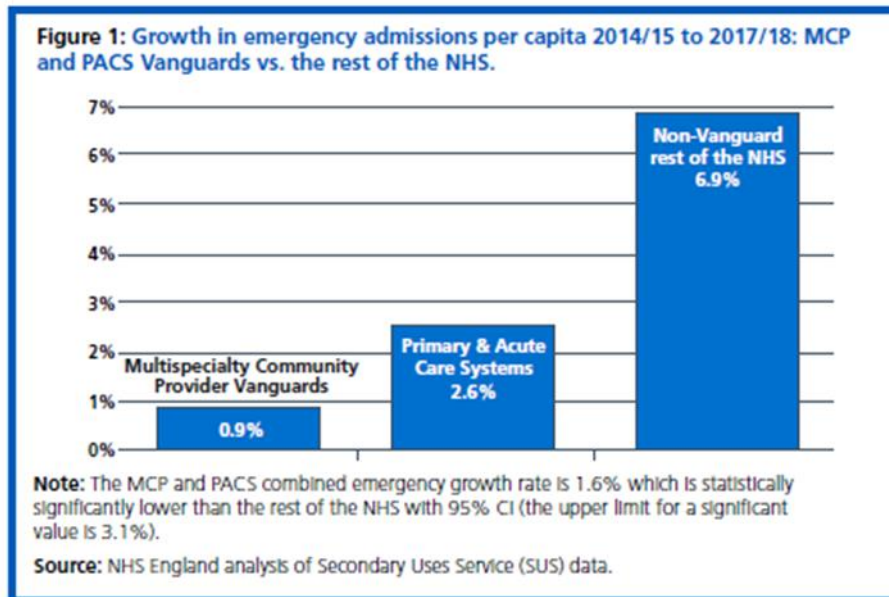
We will now consider the political impact of the programme outcomes, in terms of our definition of 'political' as relating to the distribution of power and resources within the UK state and from the perspective of those initiating the pilots. In 2019 NHS England published its NHS Long term Plan (NHS England, 2019b). This 10 year plan set out NHS priorities over the longer term and was, in part, a response to the announcement that spending on the NHS would increase at more than the rate of inflation for the next five years. The Plan sets out how the NHS will spend this 'taxpayers' investment' responsibly (NHS England, 2019b p100). Whilst not explicitly asking for further additional funding, the Plan could be argued to be part of the ongoing case being made by one public service that it was deserving of an additional share of public resources.

In making this case, the 'success' of the Vanguard programme forms a prominent element of the argument:

Following three years of testing alternative models in the Five Year Forward View through integrated care 'Vanguards' and Integrated Care Systems, we now know enough to commit to a series of community service redesigns everywhere. The Vanguards received less than one tenth of one percent of NHS funding, but made a positive impact on emergency admissions, and demonstrated the benefits of proactively identifying, assessing and supporting patients at higher risk to help them stay independent for longer. (NHS England, 2019b p13)

This was accompanied by a bar chart (figure 15):

Figure 15: Figure 1: the impact of the Vanguard programme as set out in the NHS Long Term Plan (NHS England 2019b, p13)



The source of this chart is an internal evaluation of the Vanguard programme which has not been published; it is therefore not available to be examined. Notwithstanding this, the existence of a single outcome metric showing a positive effect is used in national policy documents as evidence of pilot programme success. The outcomes of the pilot programme (as presented in this chart) are thus being used politically because they are underpinning the claim that the NHS is deserving of additional resources.

7.3.5. Pilot effects programme success: what happened next?

Although the Long Term Plan references ‘a series of community service redesigns everywhere’, in practice, only the Enhanced Healthcare in Care Homes Vanguard has been implemented more widely. Linked to a new primary care contract, groups of GPs are being incentivised to set up new services for Care Home residents which have some similarities to the Vanguard EHCHC service framework (Coleman, Croke, & Checkland, 2020). In other areas elements of the Vanguard MCP and PACS service changes have been retained or locally spread, but there has been no systematic wider implementation as envisaged by the initial pilot policy, with no ‘simple standard approaches’ which can straightforwardly spread (Checkland et al., 2021). Thus, there was no clear programme success in the form of widespread implementation of new service delivery models derived from the pilots.

One reason for the failure of the pilot programme to catalyse the widespread changes originally envisaged is that national policy changed only a year into what was intended to be a five year programme. This new policy mandated the formation of 44 geographical areas of the country into groups of care providers who were obliged to produce plans (Sustainability and Transformation Plans - STPs) to promote service integration (Hammond et al., 2017). At this point, the pilot projects had yet to be fully implemented, and there were no obvious beneficial outcomes. Yet the STP national policy stated that funding would only be granted to each area if they could address 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 Vanguards? (NHS England, 2015a p15)

Thus, before any beneficial outcomes were possible, initiating wider roll out was a condition of obtaining additional funding for a different programme. However, as we have seen, such roll out has not occurred, apart from in the limited case of Care Homes. Participants in the Vanguards told us that they felt that in the second half of the programme policy attention had shifted elsewhere.

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

...we expected there to be some kind of conference where all the Vanguard teams would come together, and everybody would say what they'd done, you know, specific to their own team, and you know, what their own statistics were. There was nothing, nothing like that at all. (S4R011)

The programme effect success of the pilots has also been attenuated by the failure to realise the initial aim of learning from the pilots' experience. Whilst there was a broad and well-financed internal evaluation programme (NHS England, 2016a), and each Vanguard procured a local evaluation (Wilson et al., 2019), no overall report has been published, and there is no public statement of 'lessons learned' available. It could thus be said that, despite a rhetorical commitment to drawing together wider lessons to facilitate pilot impact, there were only limited attempts to do this.

In summary, there has only been limited success in terms of longer term pilot programme effects, with only a small degree of roll out to non-pilot areas (in respect of Care Homes) despite announcements and policy requirements that this should happen.

7.3.6. Pilot effect political success: what has been the political effect of the pilot?

It is perhaps too early to clearly identify the extent to which the overall effect of the pilots supports political claims to success. As evidenced by the Long Term Plan and narratives around Sustainability and Transformation Partnerships there is a political narrative that the Vanguard programme has 'worked' and has shown how services should be redesigned to improve integration as well as demonstrating the efficient use of 'taxpayers' investments', but there is limited evidence that this has led to any specific subsequent activity, with the exception of new services for Care Homes. Policy focus is now upon the transformation of Sustainability and Transformation partnerships into what are known as 'Integrated Care Systems'. In policy documents setting how these are being developed, the Vanguard programme is again referenced as providing a blueprint:

[Integrated Care Systems] also incorporate learning from initiatives such as the 50 'vanguards' that tested and refined new care models. In the most successful of these vanguards, NHS providers and commissioners, councils, care homes and others developed more preventive approaches to care and saw significant reductions in emergency admissions. (NHS England, 2019a p2)

Thus, it is claimed that Vanguard learning has been incorporated into new policy, in spite of limited publicly-available evidence that this is actually the case. Whilst this new development is not overtly political in the sense of bolstering arguments for an additional share of resources, the Integrated Care Systems policy has a political element in that their establishment will require legislative change (NHS England, 2020). Therefore, claims to lasting effects arising from the Vanguard pilots are being used to support calls for particular changes to legislation. Moreover, Vanguards received considerable additional funding (National Audit Office, 2018), whereas follow on initiatives have not. This embeds a political (distributional) inequity in the developing system.

There is thus some evidence of ongoing political dividends and effects associated with the pilot programme, with ongoing legislative developments predicated upon claims of pilot success.

7.3.7. Discussion: how far was the Vanguard programme 'successful'?

Building upon others' work in this field, we have developed a framework to support deconstruction of the impact of policy pilots across a number of dimensions and exploration of success within each. Applying this framework to the Vanguard programme case study, we have found that it supports a more nuanced, detailed account of different aspects of pilot 'success'. This facilitates moving beyond a simple assessment of whether or not initial outcomes were met to interrogate the ways in which the pilot programme has been used politically to achieve other things. This fits with Ettelt et al's (2014) account of the complexity, ambiguity and mobility of the purposes of policy piloting, providing a framework that surfaces pilot impacts which might otherwise be hidden, and potentially allowing more nuanced causal explanations to be considered.

Table 17 summarises our assessment of the 'success' of the Vanguard pilot programme against 3 categories within 2 dimensions: programme and politics.

Table 17: Assessment of the 'success' of the Vanguard programme (adapted from (Checkland, Hammond et al. in press))

	Programme success	Political success
Pilot process	Full success – rapidly and successfully initiated	Rapid initiation of change programme used politically to bolster arguments for additional funding
Pilot outcomes	Pilots successfully implemented and locally popular. Some outcome goals met. Standardised 'models of care' only developed in the care of Care Home Vikings	Outcome success against a single metric used politically to support a longer term policy programme
Pilot effects	Roll out limited to Care Home Vanguard, although elements from other models used locally to inform integrated care developments Limited evidence of systematic learning from the pilots	Claims made that new initiatives are based upon 'learning from the Vikings'; pilots used to make arguments about new legislative change.

In this case, whilst claims have been made that current policy is building upon lessons learned from the Vanguard programme, there is little public evidence of any systematic attempt to draw lessons from the pilot programme. One possible explanation for this may lie in the strongly positive political claims to success which have been made nationally. Once the Long Term Plan had declared the programme a 'success', a more nuanced study of what had gone badly as well as what had gone well becomes unnecessary and perhaps more difficult, with the danger that public consideration of problems or difficulties might disturb the narrative of success constructed to bolster the case for additional NHS funding.

7.4. What can we learn from the Vanguard programme for future policy pilot design and implementation?

As we have seen, the Vanguard programme has, in many ways been very successful: pilots were quickly initiated; local areas responded with enthusiasm and engaged well with the support programme; an early indication of possible impact on metrics related to secondary care usage was successfully leveraged as part of a bid for additional funding for the NHS; the Care Home Vikings generated a new service model which has been widely rolled out; and we have found some evidence of longer term beneficial effects on hospital usage in those areas which took part.

On the other hand: the programme has not led to any recognisable ‘new models of care’ beyond Care Homes; it was a very large investment, and no accurate accounting for spend is available, preventing any assessment of value for money; improvements in headline metrics relating to hospital admission are modest, and it is impossible to examine whether or not they were cost effective; and, perhaps most importantly, it is difficult to see any connection between the experiences and outcomes of the pilots and subsequent national policy. In particular, contrary to claims to having ‘learned from the Vanguards’, the current Health and Care Bill focuses upon the creation of structural integration across geographies considerably larger than those involved in the Vanguard programme and does not make any specific references to local inter-organisational collaborative endeavours such as those which made up the Vanguards (NHS England 2021). It is possible that the as yet undefined ‘place level collaborative structures’ will resemble Vanguard initiatives, but current guidance on this offers a range of further reading without including any reference to evaluations or other sources of learning from the Vanguard programme (NHS England 2021). A Government White Paper in Integration issued in February 2022

(https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1055687/joining-up-care-for-people-places-and-populations-web-accessible.pdf) focuses upon place-level collaboration, but does not mention the Vanguards. This is surprising, given that this is the level at which most Vanguards operated. The Five Year Forward View (NHS England 2014) explicitly envisaged the creation of new formal contractual models by which local organisations worked together across a defined geography and received a unified budget to deliver a full range of services. Whilst the new Bill would allow an Integrated Care System to let such a contract, there is no indication in current guidance that this is intended or expected, and the local arrangements suggested in the new Integration White paper do not refer to this as a likely option. Given that it is seven years since the Five Year Forward View first put forward this aspiration, it is perhaps surprising that there has been no public analysis of why it has so far proved impossible to develop and implement.

This analysis provides a number of potential lessons for future policy development, for policy implementation and for policy operationalisation. We have addressed policy operationalisation in section 6.3 (p108) above, suggesting some aspects of the programme which may have supported the beneficial effects seen. In this section we address the lessons relating to policy development and implementation, and finish with a comparison with existing literature.

7.4.1. Policy lessons

Policy recommendation 1: establish clearly at the outset of policy pilots what the intended outcomes are in terms of both programme and politics

In this chapter we have built upon the work of Ettelt et al (2014) to demonstrate that policy pilots cannot and should not be seen as straightforward experiments; rather they exist to fulfil a number of objectives, many of which are currently tacit or unacknowledged. We would suggest that our framework for exploring success could also be used in advance by policy makers to establish what would count as ‘success’ in each of our categories. Whilst such an analysis might just be for internal consumption, it would potentially allow a more considered analysis as to what has worked well and what needs to happen next. For example, in the Vanguard programme the need to claim success may have inhibited a clear analysis of why contractually based new models of care could not be developed. If the different dimensions of success could be more transparently identified, it may be possible to learn relevant lessons whilst still acknowledging successful aspects of any given programme.

Policy recommendation 2: there remains confusion as to what is meant by integrated care, and this may limit the extent to which lessons can be learned from different policy initiatives

As set out in a recent analysis by the Nuffield Trust, the term ‘integrated care’ has multiple meanings (Scobie 2021) (see Box 3)

Box 3: Type of Integration (Scobie 2021)

Organisational integration focuses on coordinating structures and governance systems across organisations, such as organisational mergers, or developing contractual or cooperative arrangements.

Administrative or functional integration involves joining up non-clinical support and back-office functions, for example, accounting mechanisms or sharing data and information systems across organisations.

Service integration involves the coordination of different services, such as through multidisciplinary teams, single referral structures, or single clinical assessment processes.

Clinical integration involves the coordination of care into a single or coherent process, either within or across professions. This could involve developing shared guidelines or protocols across boundaries of care.

The Vanguard programme as eventually operationalised focused largely upon *service* and *clinical* integration, with some attempts to implement a degree of *functional integration* around sharing of records (see Table 8 p49). Subsequent policy, by contrast, focuses upon *organisational* integration. Whilst it is claimed that current Integrated Care System policy builds upon what has been learnt from the Vanguards, this seems unlikely in practice, given that the level at which these initiatives operate are so different. This suggests that rather than referring to ‘integrated care’ it would be helpful if future policy identifies clearly the level at which integration is being attempted and sets out clear objectives for that integration.

Policy recommendation 3: consider requiring policy pilots in receipt of funding to account for expenditure

As we have seen, the Vanguard programme was expensive, providing in excess of £300 million to pilot sites. Our case studies showed that this money was used in many ways, including pump priming, double running services and employing project managers. Staff were also seconded from one position to another, and staff worked across organisational and sector boundaries and often beyond their formal roles in ways that are difficult to account for. The failure to require any detailed accounting for expenditure means that it is impossible to determine whether or not the modest improvements in hospital outcomes achieved were value for money. Given the importance which these improved outcomes assumed in subsequent policy discourse, such as assessment would have been valuable, particularly in considering how important the increased investment was in driving the improvements seen. An internal report by the NHS England Operational Research and Evaluation team attempted to account for the costs of two individual interventions in Vanguard sites. They found many difficulties in this process, including: difficulty in ascertaining costs across the many organisations involved; lack of understanding of the difference between financial (i.e. money spent) and economic costs (i.e. accounting for the opportunity costs of the interventions); difficulty in ascertaining the boundaries of interventions, which often built upon pre-existing initiatives; difficulties in measuring staff activities; and difficulties in establishing a counter-factual. However the team did conclude that, if an intention to properly evaluate costs was built into an intervention from the beginning, it should be possible (Operational Research and Evaluation Unit and NHS England 2018).

Policy recommendation 4: beneficial outcomes from integration initiatives may take some time to appear.

Assessment of the outcome of any given initiative must take this into account.

Our analysis of the additive effect of the Pioneer/Vanguard programmes and our longer-term assessment of outcomes after the end of the Vanguard programme suggest that the impact of such initiatives takes time to develop and that it may derive less from specific interventions than from more subtle and difficult to quantify cultural and operational change. Allowing initiatives time to develop and avoiding premature judgement is therefore important.

This analysis also suggests that the approach adopted by which funding for the final year of the Vanguard programme was contingent upon improvement in a limited range of outcome measures may have been mistaken.

7.4.2. Policy implementation

Implementation lesson 1: the policy support programme initiated for the Vanguards was valued and successful

The support programme associated with the Vanguards was credited by our respondents with providing an important sense of belonging to a special group, which supported local efforts to implement change. The role of 'account managers' was especially valued, and respondents also told us that they enjoyed the opportunity to engage with other Vanguards, learning from one another and sharing ideas. However, we identified a tension between the desire of the associated evaluation programme to objectively assess progress and the desire of the programme managers to seek out and publicise 'good news' stories in order to build engagement. The abrupt end of the programme after 3 years was experienced somewhat negatively; it is possible that more structured learning from the programme could have been achieved if some sort of 'run off' support had been provided.

Implementation lesson 2: evaluation and feedback are important but very difficult to do well

At the outset of the programme it was intended that Vanguards would be provided with near real-time evaluative information (see section 6.3.2 p109). In practise, this proved impossible, with only two analytical reports published during the Vanguard programme. Whilst the further analyses published by what became the Improvement Analytics Unit (<https://www.health.org.uk/what-we-do/quality-and-data-analytics/improvement-analytics-unit-publications>) following the end of the programme provide useful assessments of the programme's impact, the fact that it proved impossible to provide them in real-time is important, as this meant that Vanguards could not use the findings to support what they were doing. Moreover, the internal evaluations commissioned by the Vanguards themselves were of variable quality and of limited use in supporting rapid adjustments to programmes of work (Wilson, Billings et al. 2019). Taken together, this suggests that supporting the implementation of change programmes via evaluation and feedback is difficult. Considering our findings alongside those from the internal evaluation team suggests that:

- Procuring individual local evaluations is an expensive approach that requires careful oversight and guidance;
- Real-time feedback as to progress is very difficult to provide;
- Cost-ascertainment is also difficult and requires careful attention from the beginning.

The overall evaluation programme for the Vanguards was well-designed, but hampered by the fact that there was limited attempt to draw the findings of the different strands together after the programme ended. Our study suggests that the expectations of what evaluation can provide need to be realistic, and that careful attention to the needs of evaluation should start at the outset of the programme.

Implementation lesson 3: pilots which are not fully integrated into the wider system are unlikely to have a lasting legacy

Vanguards were largely established at the level of what is currently being called 'Place' – ie local health economies covered by Clinical Commissioning Groups (CCG) or, historically, Primary Care Trusts. Most involved collaborations between a CCG, a local authority and one or two hospital trusts. Half way through the programme, larger scale collaborations were established as Sustainability and Transformation Partnerships (STPs). Our survey of STP leads suggested that Vanguards were not seen as important contributors to STPs; rather, their influence was dependent upon serendipitous factors such as the involvement of individuals in both programmes. This disconnect between the Vanguard pilots and wider system developments has continued, with no evidence of any systematic learning from the Vanguard programme in the development of Integrated Care Systems. We would therefore suggest that, in future, the implementation of pilots such as this should plan for the end of the programme and ensure that the effects (both positive and negative) of the pilots can be systematically accounted for and incorporated into subsequent policy developments.

7.4.3. Comparison with existing literature

There have been a number of recent review articles reflecting initiatives designed to improve integration across the health and social care system. In a review reflecting upon a decade of integration initiatives in England, Miller et al (2021) examine a series of official reports and National Audit Office assessments. They highlight some successes, but suggest that: integrated care initiatives tend to be associated with over-optimism in terms of what can be achieved; locally-focused specific initiatives are more likely to be successful than broad aspirations; mechanisms to foster trust between individuals across organisational boundaries are vital; and a 'hyperactive' policy context in which successive initiatives rapidly follow one another is unhelpful. All of these findings are consonant with those of this study. The authors go on to suggest that the current policy drive towards the formation of Integrated Care Systems remains too NHS focused, with a danger that the needs of the hospital sector are likely to shift focus away from the needs of the social care or voluntary sectors. Lewis et al (2021) draw upon published evaluations of major integration initiatives in England (including this one) and conclude:

The pilots were highly heterogenous and results varied both within and between the three programmes. While staff were generally positive about their achievements, pilots had mixed success especially in reducing unplanned hospital admissions. Common facilitators to achieving pilots' objectives included effective senior leadership and shared values, simple interventions and additional funding. Barriers included short timescales, poor professional engagement, information and data sharing problems, and conflicts with changing national policy. (Lewis, Checkland et al. 2021 p5)

The authors highlight the lack of a stable understanding of what 'integrated care' actually means as being problematic, and suggest that, given the size and complexity of the health and social care system, boundaries will always exist between organisational units. This in turn suggests that collaboration across these boundaries will always be required, and that the precise means by which this can be achieved will always be locally specific. The authors conclude that rather than seeking to define 'integrated care', policy could more fruitfully focus upon the common factors which support collaboration across boundaries, including: systems to allow information sharing; supporting and developing local leaders; and providing adequate resources. They further suggest conceptualising integration as 'work done' by staff as they collaborate, with policy therefore most fruitfully focusing upon approaches to making this work easier.

Taking a wider view and reviewing international literature, Hughes et al (2020) draw attention to the diverse ways in which the notion of integrated care has been conceptualised, operationalised and studied. They particularly highlight the tension between the stated objective of many programmes that patients should experience their care as more 'joined up', and initiatives which focus largely upon organisational and system changes which remain invisible to patients. In keeping with our findings, they conclude that integrated care initiatives may serve a wide variety of objectives beyond simply improving the care experienced by patients. In the case of the Vanguard programme, we have suggested that this wider agenda included the need for the system orchestrator (NHS England) to demonstrate to the paymaster (HM Treasury) that additional investment in the NHS would be well spent.

These reviews thus confirm and contextualise many of the findings of our study. In particular, they confirm the lack of clarity around what integrated care actually is, and situate the Vanguard programme as one of a number of such initiatives in the English NHS. They also highlight the importance of local context in determining how initiatives play out, and confirm our finding that such programmes cannot necessarily be expected to reduce costs elsewhere in the system.

7.5. Conclusion: how might evidence from the programme inform current policy?

The Vanguard New Care Models programme was initially set out in the Five Year Forward View in 2014. The programme as initially envisaged included repeated rounds of Vanguard pilots which would collectively and

iteratively define a number of new 'models of care' which were intended to be comprehensive, population-based approaches to service provision, underpinned by contractual models which tied provider organisations together to deliver seamless care to patients via a capitated budget. It was assumed that such models of care would reduce the need for in patient care, thereby reducing overall costs. As enacted, the programme supported participating areas to work together across organisational boundaries to implement a variety of individual collaborative initiatives, facilitated by significant amounts of funding. There is some evidence that these areas were able to slow the growth in emergency admissions and these effects were sustained past the end of the programme, but there is no evidence of overall savings being made, and many initiatives were not continued past the end of the programme. Rather than being an ongoing rolling programme as intended, the Vanguard programme became the latest in a number of short-lived pilot initiatives designed to support more integrated care. Looking across these programmes suggests that: working together across organisational boundaries is possible and valuable, but takes time and investment, including financial and managerial resources; that such work is facilitated by the engagement of trusted local leaders who understand the context; and that integration initiatives which seek to proactively manage population health are as likely to uncover unmet need as they are to reduce overall health service activity. The beneficial effects of working together across organisational boundaries include the development of trust and better working relationships, and it seems as if these local effects may support the provision of better care in the longer term. Importantly the Vanguard programme failed to generate the expected contractual models. Why this proved impossible has not been explored publicly, but the NHS Long Term Plan suggests that new legislation is needed to support the development of new NHS organisations, arguing:

Since the repeal of NHS trust legislation in 2012, the NHS has limited options if it wants to create a new NHS integrated care provider (ICP), for example to deliver primary care and community services for the first time under a single, streamlined ICP contract. Remedying this would both reduce administration costs and help with clinical sustainability. (NHS England 2019 p113)

This suggests a continued appetite for integrated care provision by a single care provider, despite a lack of evidence that such an approach is helpful or necessary. Under current legislation making its way through Parliament, such Integrated Care Providers would operate at what is currently called 'Place' level (Checkland, Allen et al. 2021), covering populations of around 300,000 people; this is the scale over which most Vanguards operated. However, the operation of services at this level, and the statutory framework which will underpin them remains undefined.

Our study has documented the fact that the opportunity to learn from the Vanguard programme has not been systematically pursued, with limited evidence that the subsequent STP/ICS programme built upon Vanguard experiences. We would suggest that, given that there is yet limited guidance available for the development of 'Place' level collaborations, there is an opportunity to use this evaluation and the evidence gathered from other programmes such as the Integration Pioneers programme to develop more detailed guidance as to how collaboration at this level might best be structured and managed.

CHAPTER 8: Strengths and weaknesses of this study

8.1. Adherence to the original project plan

An initial project plan was set out in 2016/7 at the outset of the project. Whilst a clear plan was proposed, it was acknowledged in the commissioning process that the evaluation would need to be flexible, as the policy context was continuing to change. In keeping with this flexibility, some elements of our initial proposal could not be delivered, and additional elements were added.

Table 18: Project elements, additions and outcomes

Project element	Outcome
WP1a: initial scoping and creation of a typology of Vanguard initiatives	A database of Vanguard initiatives was established, but it was not possible to develop a typology. This phase of the project established that fact that Vanguards were not generally implementing 'models of care'; rather they were implementing a range of integration initiatives. There was no clear empirical distinction between the MCP and PACS Vanguard types.
WP1b: national policy context – programme leads and national regulators	This was completed as planned
WP1c: regional context, STP lead interviews	This was completed as planned
WP1d: economic modelling of Vanguard initiatives	This was not possible because the information provided in logic models and value propositions was insufficiently detailed
WP2: investigation and synthesis of local evaluations	This was completed as planned
WP3a: understanding the impact of the national support programme	This was completed as planned
WP3b: process evaluation using qualitative case studies	This was completed as planned, and an additional phase exploring the scaling and spreading of Vanguard initiatives was also carried out
WP3c: national quantitative evaluation of outcomes	Four analyses were carried out: <ul style="list-style-type: none"> - initial evaluation of Vanguard outcomes - comparison of Vanguards with Pioneers - evaluation of longer term outcomes associated with Vanguards - evaluation of the impact of Vanguards on aspects of the experience of those receiving social care support using ASCOT measures. This was instead of new data collection at local level (agreed with the project advisory group) The planned economic evaluation of costs and cost effectiveness was not possible due to the lack of available information.
WP 4: synthesis across all data sources	This was completed as planned

8.2. Qualitative case studies

This project was commissioned and started in 2017. This was towards the end of the Vanguard programme, which formally ended in April 2018. This meant that we were unable to capture in real time the processes associated with the setting up of the Vanguards, relying instead on retrospective recollections from those involved. However, this also had the benefit that we were able to explore the legacy of the Vanguards, exploring in detail the extent to which 'scaling and spreading' occurred. The data collected in the case studies were extensive, but it was sometimes difficult to access respondents who were very busy or who had moved on. This was particularly true of GPs, many of

whom had limited engagement in their local Vanguards. It is also probable that those we were able to access were likely to be those most enthusiastic about the Vanguard experience; those disengaged were unlikely to respond to invitations for interview.

8.3. Quantitative analyses

As discussed above, we were unable to carry out an analysis of the cost effectiveness of the programme due to the lack of available financial data. However, working closely with the NHS England internal evaluation team we were able to carry out an early analysis of Vanguard impact which was not originally planned. In addition we were able to work with the Pioneer evaluation team to carry out an additional analysis. Specific limitations associated with the quantitative analyses are detailed in the relevant sections.

8.4. Patient and public engagement

Our approach to PPIE was based around engaging with the PPIE groups established by the Vanguards. However, this proved difficult in practice. Whilst most Vanguards had undertaken some public engagement activity at the outset of the programme, we found that in general this had been instrumental in purpose (ie to legitimate what was proposed, rather than to determine its direction (Harrison and Mort 1998)) and not sustained. We therefore did not find any groups with which to develop ongoing engagement. We are preparing a paper which explore PPIE within the Vanguard programme more generally.

8.5. Overall assessment of this evaluation

This national evaluation was conceived of as an evaluation of the *Vanguard programme* rather than as an evaluation of the individual Vanguards. As such it has successfully generated evidence about:

- the design and impact of the national support programme
- the common factors supporting implementation of Vanguard initiatives
- the factors affecting the scaling and spreading of pilot initiatives
- the overall impact of Vanguards on hospital use, with some evidence about the factors driving this, including the fact that beneficial impacts take time to develop and may be associated with collaborative activity generally rather than the impact of individual initiatives
- the nature of Vanguards as pilots, including a proposed framework for assessing policy pilot success more generally.

The project produced a number of interim reports and, initially at least, met frequently with the internal evaluation team, ensuring that our findings were fed back to those responsible for the programme. However, this evaluation was commissioned to take four years (extended by agreement by 6 months to allow the longer-term assessment of outcomes), and, in keeping with the rapid pace of policy change in the NHS in England, by the time it was complete policy had moved on. The current Health and Care Bill going through the Houses of Parliament does not appear to draw upon the experience of the Vanguard programme, and this means that the opportunity for this final report to feed into current policy development is necessarily limited. However, the fact that the integration approach taken by the Bill focuses upon much larger populations and on structural rather than functional or operational integration as occurred in the Vanguard programme, could be said to be evidence that the programme overall did not achieve its objective of defining new 'models of care' which could be spread more widely. This report offers some insights into why that might be the case and would support a more detailed exploration of what constitutes the most appropriate level at which to integrate types of services. It could also be used by those responsible for developing the as yet undefined 'place-based partnerships' to consider how best to approach this task.

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APPENDIX: Published work upon which this report draws.

Some of the material reproduced in this report reproduces the executive summaries or abstracts of reports or academic papers previously published elsewhere. The full texts of these reports and papers are available via the links set out below.

1. Interim report: Understanding the National Support Programme

Published 2019: [https://www.research.manchester.ac.uk/portal/en/publications/national-evaluation-of-the-vanguard-new-care-models-programme\(82d5187d-38ee-4ef5-a264-89af2df7e0d0\).html](https://www.research.manchester.ac.uk/portal/en/publications/national-evaluation-of-the-vanguard-new-care-models-programme(82d5187d-38ee-4ef5-a264-89af2df7e0d0).html)

2. Report on survey of Sustainability and Transformation Partnership leads

Published 2019: <https://prucomm.ac.uk/new-care-models-programme-survey-of-stp-leads.html>

3. Report on Local Evaluations

Published 2019: [https://www.research.manchester.ac.uk/portal/en/publications/investigating-locally-commissioned-evaluations-of-the-nhs-vanguard-programme\(3c8cfbf6-52de-4639-b715-2df5627c105e\)/export.html#export](https://www.research.manchester.ac.uk/portal/en/publications/investigating-locally-commissioned-evaluations-of-the-nhs-vanguard-programme(3c8cfbf6-52de-4639-b715-2df5627c105e)/export.html#export)

4. Academic paper: Ambiguity and conflict in policy implementation: the case of the new care models (vanguard) programme in England.

Coleman, A., J. Billings, P. Allen, R. Mikelyte, S. Croke, J. MacInnes and K. Checkland (2020). "Ambiguity and conflict in policy implementation: the case of the new care models (vanguard) programme in England." *Journal of Social Policy* 50(3): 385 <https://www.cambridge.org/core/journals/journal-of-social-policy/article/ambiguity-and-conflict-in-policy-implementation-the-case-of-the-new-care-models-vanguard-programme-in-england/C7940C916B80DF02AB50D2214FBB5B2F>

5. Academic paper: Supporting integrated care in practice.

Billings, J., R. Mikelyte, A. Coleman, J. MacInnes, P. Allen, S. Croke and K. Checkland (2019). "Supporting integrated care in practice." *Journal of Integrated Care* 28(1): 27 https://www.emerald.com/insight/content/doi/10.1108/JICA-05-2019-0018/full/html?casa_token=JWO51scPebEAAAAA:CKPeGh4zIENUrFn4o9fmhV-YFjVlIYZTsCagse0gsrLQ24I97R4FjW4bED2rEzmqQoWV86r8NtXHzyoITPuj17YZnW83y78Y70HRdp7cCeyxw8js6m

6. Academic paper: Investigating the nature and quality of locally commissioned evaluations of the NHS Vanguard programme: an evidence synthesis

Wilson, P., J. Billings, J. MacInnes, R. Mikelyte, E. Welch and K. Checkland (2021). "Investigating the nature and quality of locally commissioned evaluations of the NHS Vanguard programme: an evidence synthesis." *Health research policy and systems* 19(1): 1-10 <https://link.springer.com/article/10.1186/s12961-021-00711-3>

7. Qualitative case study report: National Evaluation of the Vanguard New Care Models Programme: Report of qualitative case studies: understanding system change

[https://www.research.manchester.ac.uk/portal/en/publications/national-evaluation-of-the-vanguard-new-care-models-programme-report-of-qualitative-case-studies\(aa7b1f74-4c19-4cd8-b46c-01bd34bcfdef\).html](https://www.research.manchester.ac.uk/portal/en/publications/national-evaluation-of-the-vanguard-new-care-models-programme-report-of-qualitative-case-studies(aa7b1f74-4c19-4cd8-b46c-01bd34bcfdef).html)

8. **Qualitative final report: National Evaluation of the Vanguard New Care Models Programme: Phase 3: Understanding the legacy of the Vanguard Programme (Enhanced Health in Care Homes)**
9. **Academic paper: New integrated care models in England associated with small reduction in hospital admissions in longer-term: a difference-in-differences analysis**

Morciano, M., K. Checkland, J. Billings, A. Coleman, J. Stokes, C. Tallack and M. Sutton (2020). "New integrated care models in England associated with small reduction in hospital admissions in longer-term: a difference-in-differences analysis." *Health Policy* **124** (8): 826–833.

<https://www.sciencedirect.com/science/article/pii/S0168851020301585>

10. **Academic paper: Comparison of the impact of two national health and social care integration programmes on emergency hospital admissions**

Morciano, M., K. Checkland, M. A. Durand, M. Sutton and N. Mays (2021). "Comparison of the impact of two national health and social care integration programmes on emergency hospital admissions." *BMC Health Services Research* **21**(1): 687.

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