National Evaluation of the Vanguard New Care Models Programme: Phase 3: Understanding the legacy of the Vanguard Programme (Enhanced Health in Care Homes)

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Executive Summary

Introduction and research aims

The Vanguard New Care Models programme was established in 2015 o 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, ECH) 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 ECH 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 below.

- Every care home aligned to a named PCN
- 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 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.

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.

Findings

Relationship of the EHCH service to the ECH Vanguard framework

Our national-level interviewees were clear that the EHCH service programme as eventually rolled out did derive from the Vanguard ECH 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.

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.

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.

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.

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 impacted on 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.

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.

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.

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.

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

There is some evidence that the ECH Vanguards 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.

Discussion

EHCH services as a legacy of the Vanguard programme

Our national level interviews suggested that the Vanguard ECH 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 Vanguards (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 practise, 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.

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 ECH 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.

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.	• 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 ECH 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	• 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	• 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	• 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	• Which individuals locally will drive roll out? • Which organisations will provide support? • Who is accountable, for what?	The shift from ECH Vanguards to PCN-led EHCH service roll out entailed a shift in responsibilities from a shared model across a Vanguard footprint to a PCN (ie general practice)-led approach. Organisational churn resulted in some ambiguities.

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.

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, Checkland, Coleman et al. in press), 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 ECH 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.

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1. INTRODUCTION

The Five Year Forward View (FYFV, (NHS England 2014)) set out a blueprint for change in the NHS. This was in response to the idea that new ways of working were needed due to changing demographics and increasing demands for health care. The programme focused upon breaking down the barriers between different organisations and professional groups in the NHS. The FYFV had been developed in partnership between NHS England, the Care Quality Commission, Health Education England, NHS Improvement, Public Health England and the National Institute for Health and Care Excellence, and included a proposal for pilot projects to test approaches to delivering integrated care, known as 'Vanguards'.

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 NCM programme was established to develop and test new ways of delivering care in line with the visions for the health and care system set out in the FYFV"* (NHS Providers, NHS Clinical Commissioners et al. 2018 p1).

The Guidance circulated by NHS England stated that: "*Our focus is on **creating simple, standardised approaches and products**, based on best practice and co-produced with vanguards. These are to be **designed from the outset for national spread**, with the ability to respond to the needs of diverse population groups of all ages*" (NHS England 2015). In addition, the FYFV (NHSE 2014) backed "diverse solutions and local leadership" and at the national level a support programme was established to facilitate the developing policy environment and support local Vanguard teams.

Five so-called 'new care models' were proposed: primary and acute care systems (PACS); multispecialty community providers (MCPs); enhanced health in care homes (ECH[1]); urgent and emergency care networks (UECs); and acute care collaboratives (ACCs). In January 2015 local areas (individual organisations or partnerships) put together proposals for new initiatives and ways of working and 50 were designated as Vanguards across England (NHS England 2014). 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. The initial intention was that successful models developed under the vanguard programme would be spread and scaled across England (Checkland, Coleman et al. 2019). Our final report will explore the impact of the programme as a whole, including the extent to which this aspiration was realised and the factors which may have affected this. In this short phase 3 report we consider the factors affecting the scaling and spreading of pilot initiatives, using the ECH Vanguards as an exemplar.

More information about the purpose of Vanguards and their early development can be found in our reports (Checkland, Coleman et al. 2019, Checkland, Coleman et al. 2021) from earlier rounds of this research.

2. RESEARCH AIMS AND QUESTIONS: USING 'ENHANCED HEALTH IN CARE HOMES' TO UNDERSTAND SPREAD AND SCALE

The first two phases of this study explored the design, roll out and impact of the Vanguard programme, and its local implementation. In this final phase we consider the programme's goal of scaling and spreading initiatives beyond initial pilots. Whilst the initial descriptions of the Vanguard programme made it clear that it was intended that each of the identified 'new care models' would

[1] In this report we distinguish between the Care Home Vanguards, referred to as 'ECH Vanguards' and the new service rolled out via Primary Care Networks, referred to as the 'EHCH service' or EHCH.

be codified and spread more widely, in practice the only initiative from the NCM Vanguard programme which has been formally spread and scaled systematically across the country is the Enhanced Health in Care Homes (ECH) Vanguard model, which has subsequently been rolled out as a new Enhanced Health in Care Homes service (EHCH service) via Primary Care Networks. In the final phase of this study we have therefore examined the EHCH service programme in detail, exploring the factors which have affected its roll out and considering what this tells us about the roll out of pilot initiatives more generally.

The research questions addressed are as follows:

- 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?

3. THE ENHANCED HEALTH IN CARE HOMES SERVICE MODEL

When the Vanguard programme was first established it was recognised that historically Care Homes had been somewhat neglected in health policy, with residents often not receiving the health care that they needed (NHS England 2014). Situated largely in the private sector, care provided to residents in Care Homes was often fragmented and failed to meet the needs of a frail population (Kerrison and Pollock 2001, Gordon, Franklin et al. 2014). In order to address these challenges, one of the New Care Models established during the programme focused upon care in Care Homes. Drawing upon lessons learned from the 6 ECH Vanguards, a 'framework' for improving care in care homes was published (NHS England 2016). As set out in the NHS Long Term Plan of 2019 (NHS England 2019) a new EHCH service based upon this framework was subsequently rolled out nationally via collaborative networks of primary care practices, known as Primary Care Networks (PCNs) (Checkland, Hammond et al. 2020). An additional contract known as a Directed Enhanced Service offers payments to groups of GP practices if they work together to offer additional services to their patients. The EHCH service represents one of these services.

The NHS Long Term plan (NHS England 2019), as part of a wider Ageing Well Programme, set out detailed and specific support to be delivered by Primary Care Networks (PCNs) to all care home residents by 2023/24 (starting in 2020). The EHCH service provision focuses upon proactive care that is centred on the needs of individual residents, their families and care home staff, delivered via collaboration between primary, secondary, community and social care services. In a detailed comparison between the proposed EHCH service elements of the new contract and the original model developed by the Vanguard programme, we found some interesting modifications (Coleman, Croke et al. 2020). Key elements have remained, including: enhanced primary care support for Care Homes; multi-disciplinary team support; a focus on enablement and rehabilitation; high-quality end-of-life care and dementia care; access to a consistent, named GP (linked to a wider primary care team); data sharing; and training. However, some elements proposed within the Vanguard framework lost prominence within the draft EHCH proposals (NHS England and NHS Improvement 2019), only to be reinstated in the EHCH Framework Version 2 (NHS England 2020) in response to the pandemic. These included: joined-up commissioning and collaboration between health and social care; workforce development; and data, IT and technology.

After several iterations the minimum standards for the service are outlined in the Network Contract DES (NHS England/NHS Improvement 2020). This describes the roles and responsibilities of PCNs, and the associated NHS Standard Contract setting out the responsibilities of community services. These are:

- Every care home aligned to a named PCN
- 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 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)

It was made clear that this programme was a direct legacy of the Care Homes (ECH) Vanguards. This approach represented a change in approach from the bottom-up permissive development which had characterised the Vanguard programme, moving instead to a top-down prescription of a defined model of care and support, to be delivered to national standards to achieve tightly specified national targets across all parts of the country. This approach is in keeping with the initial Vanguard aim of using the national programme to develop what were called 'standard products and frameworks' to allow the straightforward spreading of well-defined service 'models'.

Funding for PCNs includes a variety of incentive payments and funding to employ new staff such as Pharmacists and Care Co-ordinators. In addition, funding up to the level of £60 per Care Home bed is paid to each PCN, rising to £120 from April 2021. The funding is paid directly to PCNs, although delivery of additional services to Care Homes (such as Multi-disciplinary Team management of complex patients) requires collaboration with other providers such as Community Service Providers.

With the current rapidly changing policy context, including the global COVID-19 pandemic, PCNs face new and unforeseen challenges (Coleman, Croke et al. 2020). Reflecting this, most service requirements associated with PCNs were paused to take account of COVID-related pressures. However, the difficulties in respect of COVID response experienced by Care Homes prompted NHSE/I to require Clinical Commissioning Groups to roll out some elements of the EHCH service policy early (May rather than October (Serle 2020). Funding for this was assumed to come from existing community service budgets.

ECH Vanguards were, in general, established and led by Clinical Commissioning Groups (CCGs), in collaboration with Local Authorities and GPs. A lack of clarity over responsibilities and the intention to allow bottom-up development meant that each of the 6 ECH Vanguards established their own local arrangements for co-operation between GPs, community nursing services, social care and the CCG, with the role of GPs both variable and locally determined (Checkland, Coleman et al. 2021). In the new EHCH Service l, by contrast, responsibilities lie with the GP-led PCNs, who are responsible for establishing and facilitating the required collaborative arrangements.

Many areas, whether having an ECH Vanguard or not, had already put into place locally specific measures to benefit populations living in care homes. Some of these predated the Vanguard programme altogether, whilst others developed in parallel as part of initiatives designed to improve the quality of primary care services more generally. For example, the Wakefield care home vanguard

(Vestesson, Lloyd et al. 2019 p4) 'identified six overarching areas within their [existing] Care Home Outcomes Framework that they were hoping to impact: Care is co-ordinated and seamless, urgent care should only be provided to those who require it, improved management of long-term conditions and falls, improved management of end-of-life care, increase proactive case management and personalised care planning and all staff understanding the system and work in it effectively'. Under the EHCH PCN-provided service, the approach required was highly prescribed and did not take into consideration the diverse ways of working already in place in all areas. Therefore, some areas had to change, or at least adapt, already existing and often successful initiatives in order to meet the new requirements and associated targets.

The implementation of the EHCH PCN service had only just begun when the COVID-19 pandemic arose in the UK during early 2020. Due to the significant impact of the pandemic on all aspects of Care Home operation (e.g. infection control, shortages of adequate PPE, patients with COVID-19 being discharged into care homes and the need for end of life care), NHSE/NHSI had to rethink its approach again, bringing forward some elements of the EHCH service immediately "*to be established as part of the COVID-19 response by CCGs, working with general practice, community services providers, care homes, local medical and pharmacy committees and wider partners in their area*" (NHS England/NHS Improvement 2020 p.1) with some additional elements yet to be trialled. It was acknowledged that PCNs were not necessarily in a position to do this, and so CCGs were told to take responsibility where PCNs were not able to, with transfer of responsibility to PCNs via the DES contract from 1/10/20 (NHS England/NHS Improvement 2020 p2).

4. FRAMEWORK FOR UNDERSTANDING IMPLEMENTATION, SPREAD AND SCALE

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 the EHCH service 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:

9. an **organizational structure** that is adaptive and flexible, with structures that support devolved decision making;
10. **leadership and management** at different tiers that are supportive of and committed to change, including the articulation of a **clear and compelling** vision;
11. early and widespread **stakeholder involvement**, including staff and service users;

12. **dedicated and ongoing resources**, including funding, staff, infrastructure and time;
13. Effective **communication** across the organization (and, where relevant, between organizations);
14. **adaptation** of the innovation to the local **context** and integration with existing programmes and policies;
15. ongoing **monitoring and timely feedback** about progress; and
16. **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 the rest of this report we use these same eight criteria to examine the processes by which the EHCH service specification has been 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.

5. DESIGN AND METHODS

5.1 New Care models (Vanguard) research

Between 2017- 2021, our national evaluation of the New Care Models (Vanguard) programme, funded by the NIHR Policy Research Programme, explored the effects of the Vanguard programme on local healthcare systems. We investigated local organisations, wider partnerships and service users. We have published our findings to date elsewhere (Billings, Mikelyte et al. 2019, Checkland, Coleman et al. 2019, Coleman, Billings et al. 2020, Morciano, Checkland et al. 2020, Checkland, Coleman et al. 2021, Wilson, Billings et al. 2021)

In phase 1 (Checkland et al 2019) we focussed 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. With initial scoping undertaken to understand different types of Vanguard, the support programme in greater depth and the developing national context, we conducted 29 national level interviews between October 2017 and March 2018. In parallel we synthesised the findings from local evaluations (Wilson et al 2019). In **phase 2** (Checkland, Coleman et al. 2021)a qualitative case study approach was adopted to enable in-depth exploration of the processes and experiences of participants directly involved in implementing and operating the Vanguard programme (2015-2018) at the local level. Six case-study sites were selected (summer 2018) to study in depth and gain an understanding of how new models of care were developed and implemented: two MCPs, two PACS and two ECH Vanguards. The research team carried out a series of focus groups and interviews with a variety of respondents at six case study sites between October 2018 and July 2019. 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 across the sites, including current and past representatives from Clinical Commissioning Groups (CCGs), provider organisations, local authorities, voluntary sector organisations, Vanguard programme leads, frontline staff and patient/public contributors.

Phase 3 (July to December 2020) revisited the same 6 sites, using COVID-19 safe data collection methods (Interviews by Zoom, MS Teams or telephone). The team initially spoke to national level policy makers (July 2020) to gain a context and understanding of the developing EHCH service being rolled out by PCNs, and subsequently interviewed key informants in the six sites. We spoke to a total of 32 people (in 28 interviews) which included 3 national level informants. We also collected available documentation via respondents and / or public facing websites. This proved challenging as participants appeared either unwilling or unable to provide such documentation and few of the public websites had links to relevant documents. The few documents we were able to find were related to specific meetings which mentioned the issues we were interested in only in passing. We concluded this was due to the rapidly changing environment and decision making having to be quicker than under normal circumstances to allow the initiatives to be introduced rapidly to help counteract the challenges of COVID-19 at the time of fieldwork.
It should be noted that our sites were 2 of each different Vanguard types. Sites 1 and 2 were MCPs, Sites 3 and 4 were ECHs, Sites 5 and 6 were PACs.

In both phases 2 and 3 interviews and focus group discussions were recorded and transcribed verbatim, followed by a thematic analysis using a coding schedule based on previous literature and our previous work on Vanguards (Checkland et al 2019). In phase 2 we systematically utilised NVivo software, while in phase 3, we used thematic notes and quotes to inform comprehensive case study write ups, focused around Nolte's criteria. To preserve anonymity, each respondent was given a unique ID number. Throughout this report sites will be identified by a Phase number (**P3**), followed by site and a respondent number to maintain anonymity. For example P3S4R01 (Phase 3, Site 4, respondent 1). National level interviewees for this phase will be referred to as P3N and respondent number e.g. P3NR01 (Phase 3, national level, respondent 1).

Ethics approval for this evaluation was obtained from the University of Manchester (Phase 3: 2020-9300-15062).

5.2 **Primary Care Networks Research**

Alongside the National Vanguard Evaluation, members of the research team are also involved in a study funded and undertaken by the NIHR Policy Research Unit in Health and Care Systems and Commissioning (PRUComm) to explore the development of Primary Care Networks (Hammond, Checkland et al. 2020). In order to better understand how areas which had not been involved in the Vanguard programme had experienced the roll out of the EHCH service specification, the two studies worked together to share data relevant to the implementation of the EHCH service specification. Ethical approval for this collaboration was obtained. The aims of the Primary Care Network (PCN) research study were to understand the rationale underlying the establishment of PCNs, factors affecting their establishment and early operation and the impact on related outcomes. A longitudinal mixed methods approach has been adopted, bringing together qualitative and quantitative methods to explore the development and impact of PCNs. For the purpose of the NCM work, we have been specifically focused on the work package which aims to try and understand local PCN arrangements, using a qualitative case study approach. Additional data were collected in the PCN sites to find out how the EHCH service specification was being implemented.

Four CCG case study sites, covering 5 PCNs (none of which were Vanguards) were purposively sampled (ethics approval: 2019-6922-11177) to ensure for geographical coverage, differences in PCN characteristics and population heterogeneity. Although PCNs are the main focus of the project, Clinical Commissioning Groups (CCGs) were selected as the most appropriate level to enter the field because of their key role in PCN establishment, support and maintenance of PCNs. At the point data was shared, 31 semi-structured qualitative interviews with CCG and PCN staff had been conducted between July 2020 and March 2021The topic guide included questions about the Enhanced Health in

Care Home service specification and the Vanguard programme. Data was shared and discussed with the NCM team. In this report PCN Sites will be referred to as PCNS1, PCNS2 etc.to differentiate between sites.

Table 1: Data collection (Phase 3 NCM and PCN study)

	National level		Local level		
	Respondents	**Interviews**	**Respondents**	**Interviews**	**Documentation**
Phase 3 (NCM)	3	2	29	26	√
PCN study	-	-	31	31	-

6. FINDINGS

6.1 Overview

In order to answer our research questions in phase 3, we first consider how the EHCH service which is being rolled out via Primary Care Networks arose out of the Vanguard programme, drawing upon interviews with national-level policy makers involved in these developments. We then provide a thematic exploration of the findings from our research sites, using the same framework as that used by Nolte et al. (2018). Finally, we consider what factors we found to be relevant in our sites which do not fit within this framework. In our discussion we then go on to consider the broader lessons for policy scale and spread beyond pilots, building upon and extending the insights provided by Nolte et al.

The data used come from three sources (see Table 1): national level interviewees; interviews in our six NCM case study sites; and interviews with those involved with primary care networks. Respondent identifiers are coded as: national (N); case study sites (S); or PCNs (PCNs).

6.2 The development of the EHCH DES from Vanguards

As we have previously documented (Morciano, Checkland et al. 2020, Checkland, Coleman et al. 2021), the six care home Vanguards were felt to have been one of the most successful elements of the programme, with clear progress against quantitative metrics. Their wider roll out was therefore seen as an obvious next step, with the NHS Long Term Plan (NHSE 2019) stating:

> *1.14. NHS England's Enhanced Health in Care Homes (ECH) Vanguards have shown how to improve services and outcomes for people living in care homes and those who require support to live independently in the community. For example, in Nottinghamshire, people resident in care homes within the Vanguard experienced 29% fewer A&E attendances and 23% fewer emergency admissions than a matched control group6.*
>
> *1.15. We will upgrade NHS support to all care home residents who would benefit by 2023/24, with the ECH model rolled out across the whole country over the coming decade as staffing and funding grows. (p15/16)*

National level respondents told us that during the summer of 2019 it was felt that the ECH Framework derived from the Vanguard programme should be reviewed before it was rolled out by Primary Care Networks. Alongside evidence from Vanguard evaluations, the review was to be '*light*

touch' and would try to find out from stakeholders '*what worked well, what was missing and what could be better'*. According to a national level respondent

> "*a number of stakeholders were engaged, approx. 20, representing Vanguard sites, a range of providers, care homes, CCGs, LAs, DASS, the LGA etc." (P3NR01)*

In terms of making the case for the roll out of the ECH model, it was felt to be important to be able to show quantitative evidence of improved outcomes.

> *"In shaping the aging well programme, the policy team did look at the evaluations from the enhanced health in care homes and were looking at…when we're thinking about the type of impact that rolling out enhanced health in the care homes could have, we were looking at the data [….] in terms of the impact on secondary care, so what's the likely impact or potential impact if you roll the programme out across the country" (P3NR02).*

The Vanguard programme was accompanied by a well-funded evaluation programme, which included both national-level evaluation against standardised metrics and locally-commissioned evaluations. In total, a sum of £10 million was used to procure the local evaluations (Wilson, Billings et al. 2021), but in practice the evidence provided by these was found to be of limited use in designing the new service specification:

> *"To try and separate out the different spheres, the impact of the different strands of enhanced health in care homes and that's very difficult to do with the data and the information, so, that wasn't possible" (P3NR02).*

However, some of the contextual evidence provided by these local evaluations was felt to have been useful:

> *"I think at the end of the evaluation programme, I don't think they were used to the full extent that we might have used them if we were clear at the start of the programme, due to the fact that the data completeness wasn't as good or we couldn't really draw meaningful findings from it but they were still utilised to enrich the evaluation" (P3NR03).*

At an event held in June 2019, attendees shared some of the things that they felt had worked well and issues they found most difficult under the Vanguard programme. Difficulties were said to often be related to 'relationships' rather than it being a flaw with the framework itself.

> *"We've learned from what the Vanguards did, from what worked well and particularly from where they found it more difficult. I think one of the really key bits of information and feedback, that I think we probably inherently knew anyway, was that it takes time. It's based on human relationships and you can't create those overnight by shoving two people into a room" (P3NR01)*

At the time of our interviews (summer 2020) there were concerns nationally around the budget for the EHCH programme roll out. As discussed above, the PCN service specification for Care Homes attracts a payment per Care Home bed looked after. However, when, in the early stages of the pandemic, it was announced that CCGs should commission the service whilst PCNs established themselves, it wasn't clear whether this funding would be available to CCGs:

> *"So we're waiting for that realignment document from government to say this is what services now need to deliver, here's your new budget. So until we can give that budget to our regions they're really stuck to be able to deliver anything, other than things that don't cost anything, which isn't a lot" (P3NR01)*

At the same time, the significant difficulties experienced by care homes led many local areas to feel that they needed to make changes in advance of national guidance or funding:

> "*One of the things about COVID having delayed things is areas are just getting on with it. They know they need to do a lot of work in care homes, so in the absence of any guidance they're producing their own, which is great because if that's duplicable we can share that across the regions" (P3NR01)*

This brings with it a significant risk of inconsistency in services and support provided in different areas of the country, with potential impact on the eventual delivery of EHCH services as they roll out. At the same time, national –level respondents told us that they were concerned that, in the context of COVID-19, Care Homes were being overwhelmed with guidance and new services; being '*killed with kindness'* as one respondent put it in an interview.

The EHCH service framework (NHS England 2020) included an increase in the use of data and digital platforms (e.g. video consultations) to support care home staff. The preliminary work required with respect to contracts and information governance requirements was underway before the pandemic started, often having been adopted as part of the Vanguard programme, but the relaxation of controls associated with the pandemic facilitated the more rapid implementation of digital platforms such as an online capacity tracker (see Communication section 6.7) and the extension of the NHS-specific secure email platform, NHS mail to care homes. In this latter case, pre-pandemic it was felt that information governance rules precluded Care Homes from using NHS mail. Once the pandemic was under way this stipulation was rapidly reversed, with managers agreeing that the relevant security checks could be done at a later stage.

In summary, our national-level interviewees were clear that the EHCH service programme as eventually rolled out did derive from the Vanguard ECH 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. We will return to this contextual factor throughout this report, as it has shaped many aspects of the EHCH programme.

In the following sections we will use the 8 criteria set out by the Nolte (2018) framework (previously set out on p5) to examine the processes by which the EHCH service specification has been spread (or not) across England.

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

The structures within which the EHCH were being rolled out were themselves not fully developed or implemented. PCNs were only set up in 2019, and at the time that EHCH service was to be rolled out (April 2020) were still in the throes of developing their working arrangements and structures (Smith, Parkinson et al. 2021). This generated some issues, as it meant that the organisations with responsibility for the new services were not yet in a position to do so. As a result, in some areas EHCH developments were being led by colcal Commissioning organisations, CCGs, rather than being

led by PCNs. The arrival of COVID-19 in early 2020 accelerated the process and in many cases CCGs had to step in to help to aid the initial implementation, due to the lack of experience of PCNs. Local systems thus needed to be adaptive and flexible to implement the new EHCH service to allow them to keep what was already working well but also bring in necessary changes.

For example in site 6, the same PCN model, within an overarching collaborative framework, was being implemented across all areas but with some adaptations for local context. Across this site there had been a number of previous local initiatives, but no overall co-ordinated attempt to improve care in care homes. The PCN EHCH model was therefore seen as an opportunity to 'level up' services across the local area. This was complicated by the simultaneous merging of CCGs to cover a larger footprint, with some parts of the 'new' CCG more advanced in developments regarding services to care homes than others:

> *"Each PCN has a named clinical lead for care homes. It was a bit tricky because what we've tried to do is get something as a sort of generic so that rather than it being a single person, a single GP, kind of thing, there was more of a generic nature to it to give us more flexibility to respond. It didn't go down too well 'cause it didn't quite fit the bill for the… national lot but we have got a name…we've done some adjustments…. And each care home now has some measure of care home support. It's not exactly 100 per cent universal…sorry, consistent everywhere. By that I mean everyone's got a basic minimum but in certain parts of the patch there is a little bit more because there's a legacy that we had something ongoing anyway…As you said, we talked about MDTs and we put in place case managers, care navigators and where there were still people in post and they were well embedded and those folk had been around for quite a while, it was easier to build on that and connect any requirements to that around the care homes… (P3S6R01)*

In Site 1, those responsible for rolling out the new service felt that the amount of funding was inadequate. They therefore acted flexibly and provided additional 'top up' funding:

> *"So the system that we had in place in [x] was a tiered system that tiered the homes depending on the complexity of the residents they care for and had a sliding tariff based on the tier. And so what we've said is that the DES tariff, the 120 pounds, is equivalent to the lowest tier and all home or care home beds attract that tariff, and we'll pay a top up on beds in homes with more complex needs. And we've put that in place everywhere, including the places that previously had no scheme. And so we've been able to, if you like accelerate that levelling up that we needed to do, because of the DES" (P3S1R06)*

In supporting the necessary adaptability and flexibility, sites told us that the relationships built up during their participation in the Vanguard programme were very helpful:

> *"I think the thing about the Vanguard legacy was really about relationships. So [Vanguard] had all the right staff and so it had the staff in place and it had really good relationships. So it had prioritised the, you know, investment in the right kind of support for care homes. We have a very large number of care homes, which is why the Vanguard was important in the first place. And we had really, really good relationships, which helped enormously, I think… I don't think the organisations matter at all in lots of ways. It's all about the continuity of the individuals. So yes, I think pretty much everyone who was involved in Vanguard rolled into business as usual" (P3S3R01)*

The practicalities of adaptation could be complex. One of the key tasks was to establish exactly what was happening locally, as many areas had had a variety of historical initiatives involving care homes. This included the non-Vanguard sites, many of which had developed local schemes in the absence of any additional funding or support. For example, in PCNS1 under an initiative known as. the 'Care Home Advanced Model', additional services for Care Homes were piloted across 7 areas, led by two PCNs. Whilst not formally the same as the ECHC framework, this model was loosely based upon the work which had been going on in Vanguard sites. In addition, in this site local pharmacies had been involved in providing additional services which were deemed a success with a reduction in A&E attendances and a reduction in drug errors and reactions. A current programme provides weekly

ward rounds in care homes with the community geriatrician, community matrons and GPs. In PCNS3, they had had a Local Enhanced Service (LES) for care home work that covered 70% of the city and paid substantially higher than the DES. Each of these legacy programmes had to be redesigned or adapted to fit within the requirements of the ECHC service specification. Ex-Vanguard Site 4 welcomed the opportunity afforded by the EHCH roll out to streamline this patchwork of initiatives:

> *"Across the Council, the CCG and [named] NHS Trust, there are a number of funded initiatives that are currently supporting care homes or system processes that interface with care homes. Based on feedback and evaluation, we believe there are opportunities to reshape and remodel some of these to improve their effectiveness. We also feel that a better system level shared understanding and ownership of care home support initiatives will result in better system outcomes". (Site 4 Joint Care Homes Strategy 2020-25 p11)*

Having been part of the Vanguard programme was claimed by some to have been of value regardless of which specific type of Vanguard they had been. In addition to the relationships that they had developed during the programme, they also talked about a '*can do attitude*' to making things work at a local level which supported them in implementing the Care Home service and in managing the flexibilities required to cope with COVID-19. They felt that the relationships and capabilities that they had developed during the Vanguard programme had supported flexible working and potentially quicker decision-making.

> *"Yes, I think I would just add absolutely, I think it was incredibly beneficial to the new ICS system, the new way of working, the new system architecture and the PCNs, having that foundation of vanguard for us to build on, and I think it sort of has given us confidence to be more ambitious and give us that feel of the art of the possible, really, to strive to what can be delivered. I think, like Liz says, it's quite a can-do attitude that there is across the system that embraces the change, and I think that's why the PCNs haven't readily walked away from some of the asks that have been thrown at them, whereas I know other parts of the country, they have found it more challenging." (P3S5R02).*

In addition, these relationships tended to feed into new developments. For example, in Site 5 respondents suggested that the alliances developed under their Vanguard had continued and had formed the basis upon which local PCNs had been formed. When the PCN policy was rolled out, they had already developed locality collaborations arising out of the Vanguard work, and these included such enabling features as data access agreements between practices and shared provision of services. This meant that when PCNs were required to be formed in July 2019, all that was required was the signing of a new 'network agreement'.

> "It was a bit of a dream come true really". (P3S5R04).

Most sites recognised that quick and effective decision-making within organisations and across the healthcare system was essential for business continuity and continuation of services as the COVID-19 pandemic hit. This was facilitated by existing relationships, trust built during past joint working, devolved decision making and willingness to take some risks:

> "*kind of speeded up and the legacy of the Vanguard, of the partners working together and you can see this particularly where interpersonal relationships because people had got to know each other across organisations where there was that strong legacy that helps speed up some of this work….And that, as I say, at the moment we're working through an exercise to see which of these things were temporary and will go back as COVID demand reduces, which will continue anyway because they were just straightforward, which might need a bit of help to get them to continue but we don't want to lose that good work"* (P3S6R01).

> *"The governance and the barriers came down between organisations because we had one goal to focus on and that was the COVID response, and I think some of the things that hamper us are around,*

you know, governance of each organisation, and of course to an extent we were allowed to bypass some of that in the emergency response, and it actually showed me the value of people on the ground working together to make the right decisions rather than all the committees sometimes they put in the way" (P3 S1R01)

However, prompt decision-making and innovation, enabled by existing relationships in local systems, made the pace and volume of requests to which care homes were required to respond difficult to manage:

"The extraordinary amount of work that is going on around care homes means that our programmes grow like topsy. And it's very, very hard for care homes to respond to that much activity". (P3S3R01)

Local relationships could be a problem as well as an asset, with relationships in some areas not as good as they needed to be, and previous tensions between the CCGs and Care Homes a problem. For example in Site 1 this was related to quality, with the relationship potentially rather adversarial or performance management-oriented. This meant that, in order to successfully engage around the development of the EHCH service, the CCG and developing ICS felt the need to tread carefully and offer support rather than directives in order to gain their trust:

"There was some nervousness, probably because of the past experiences that they've had when a member of the CCG...there's been an incident and they've been investigated, so there's a bit of wariness. But trust is earned, isn't it, you have to earn somebody's trust?... it wasn't Big Brother coming in, the health colleagues coming in and saying, or the CCG coming in and saying, you're not doing it right. It's how you sell it, isn't it?" (P3S1R02)

Respondents in Site 4 described how the past building of trust due to working together across multiple organisations could allow some local risk taking / sharing:

"Odd times but I think COVID has really turned it around. It's forced people to work closely together. It's actually stopped people covering their backs all the time. I think people are more willing now to take a bit of additional risk. And that's to do with trust because they can trust their partners to back them up and support them a little bit more. I think we're working in an environment where there's massive unknowns. So you've got to make, whatever decision your making is going to be, there is going to be risk attached to it because, so because you know working in this really it's fluid, this environment and I think all of that's contributed, definitely" (P3S4R05).

Others were concerned that after the pandemic, things would slip back to 'old' ways of working, returning to more formal structures and decision-making processes with less of a collective willingness to take risks to solve longstanding issues:

"There's something of the Vanguard way that things have gone with COVID as well. It first happened, everyone pulls together, everyone's working together to achieve and control that there is a bit more money, or not that there was more money, but suddenly people were looser with the purse strings, because we were told do whatever it takes. Now things have eased, you drift back into…I've got my priorities to work on, you've got your priorities to work on. Yes, it did have a positive impact in terms of we established relationships with teams that we previously wouldn't have had…" (P3S4R01)

Some sites, however, also identified that the national pandemic response negatively affected the previously built trust and relationships:

"The element around the NHS capacity tracker has created enormous stress and strain because of the time it takes them to report, but the fact that we then need to in essence check up on them, because the system isn't telling us what we need to do. So, our first assumption is, well, the care home hasn't done it, but actually, certainly I know over recent weeks, the local authority has done some really focused

work with care homes to find out that, actually, the system is flawed. The care home is there in good faith putting their data in, but the system isn't picking it up, so it puts us in a difficult position in terms of being, you know, please don't shoot the messenger. And, you know, a lot of our care homes, and this has been where the relationships have been key in terms of actually being able to acknowledge that, yes, this is rubbish, but this is national policy" (P3S3R03)

In summary, 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.

6.4 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

EHCH service rollout is occurring against a background of shifting structures, roles and responsibilities, with good leadership at each level vital if duplication of responsibilities is to be avoided. The emerging architecture of the NHS in England is complex, with a tiered systems of levels – system, place and neighbourhood – officially promulgated (NHSE 2019) but not yet established in statute. As a result, EHCH service rollout requires good communication and leadership at each level. The service is to be provided by PCNs, which operate at neighbourhood level (assumed to be a population of between 30-50,000 people), but support and co-ordination is required from CCGs which historically have operated across what is increasingly being referred to as 'place' level – i.e. towns and boroughs, often, but not always, based around a Local Authority boundary. However, CCGs are currently in the process of being merged up to cover a much larger area – known as 'system', often covering a population as large as 1-3 million people.. An official NHS England document puts it thus:

Learning from the EHCH Vanguards suggests that "truly collaborative commissioning involves shared system leadership and the development of a shared culture of working and trust at operational level, regardless of the formal health and local authority commissioning structures that are in place" (NHSE/NHSI, 2020a, p. 23).

Our local interviewees concurred, often suggesting a complicated web of engaged organisations:

"We're working with PCNs through their clinical leadership network. We're working with boroughs through the enhanced health in care homes programme approach, with the managerial, operational

leads, and we're working at an ICS level on the strategic initiatives to improve our relationships with care homes". (P3S3R01)

In some sites respondents described the PCN commitment to and involvement in EHCH service rollout as outstanding, and driven by leaders who have been involved in the Vanguard.

"I think particularly for primary care and PCNs, it has really galvanised them to provide really good care in care homes in a way that, perhaps, hadn't been comprehensively done before. Certainly in [named area], we've now got an outstanding… Well we've got two clinical leads. We've always had a very good clinical lead on the commissioning side but we've now got an outstanding clinical lead on the PCN provider side as well." (P3S3R01)

Elsewhere there was evidence of mixed enthusiasm:

"Some of them you've perhaps got a less enthusiastic [clinical] lead and a less enthusiastic manager" (P3S1R03)

There was recognition that despite the PCNs having responsibility for the EHCH DES, there was a need for co-ordination, agreement and support to come from across the healthcare system, especially as PCNs were relatively new entities:

"…so it is the responsibility of the PCNs to ensure that all the care homes in their geographical boundary are covered by the care home DES. Now, we've had to take guidance from regional primary care leads and NHS England, because of the systems and process that we've got in place. So, the involvement of [local oversight group] is going to be important going forward, in the delivery of the service requirements. So, you know, we've asked them to help support this, rather than just pass this all over to the PCNs and say, right, you've got to deliver it, when we've already got processes in place, you see? So it's a little bit of a mixture." (P3S2R02)

In some cases there was evidence that the previous Vanguards had presented opportunities for some in the system to take on leadership roles they may not otherwise have done. This was generally seen as advantageous and utilising the skills of these individuals who are often boundary spanners across organisations and who understand the front line operational issues better than those at strategic management levels.

"I probably haven't gone on enough around the fact that how energising the Vanguard legacy has been. So, I think a lot of people got some real development opportunities there, the kind of coaching that they got helped them to be leaders who mightn't, obviously, have been leaders otherwise […] I think we've had opportunities to create really good roles, as well, so some of our care navigator roles and case manager roles" (P3S6RO3)

Good will and a common purpose (having a clear shared vision), established working under the Vanguard and continued into later implementation of the EHCH service:

"So I think even in the difficult times that we've all been through, I think it does remind you, it's quite nostalgic talking about it, that anything is possible with goodwill and a common purpose, so hopefully those of us that had the benefit of being deeply imbued in Vanguards were a little bit more…probably had some greater appetite for real transformation and experimentation than we may have had, for me, certainly had I not been involved in a Vanguard." (P3S5R02)

Due to changing organisational configurations, in some of the areas, some of the system working was now proving more complex and some organisations were less engaged:

We've had a good relationship with our local care team in the CCG. [It is] challenging now as the CCGs all merged and people's jobs … so that's always challenging when the people are changing" (P3S1R04)

"Engagement by other organisations, that's crucial, so our social service person doesn't come weekly

at the moment because [local authority] have said they can't release her, they don't have time. So you must have the buy-in from the big other organisations so that they keep coming, because if we don't have a social worker for a month, we're not going to achieve much at our MDT" (P3S1R03)

Respondents told us that often it was particular individuals who were important in establishing the new service, and that longevity within a local area was also important:

"Workforce, having the right people, the right system leaders at the time within the system to drive it forward, definitely. If you've got the right people around the table it makes a huge difference" (P3S1R02)

I don't think the organisations matter at all in lots of ways. It's all about the continuity of the individuals. So yes, I think pretty much everyone who was involved in Vanguard rolled into business as usual […] I think the thing about the Vanguard legacy was really about relationships. So [named place] had all the right staff and so it had the staff in place and it had really good relationships. So it had prioritised the, you know, investment in the right kind of support for care homes. We have a very large number of care homes, which is why the Vanguard was important in the first place. And we had really, really good relationships, which helped enormously, I think. (P3S3R01)

In addition to individual leaders and the role of lead-organisation, new ways of managing locally were also required. Spurred on by the need to work collaboratively during covid-19, in site 2 joint management meetings had been established. Respondents told us that they intended to carry on with these after the pandemic:

"As soon as COVID hit, lots of joint meetings were set up, and from that we've just been able to create really good working relationships. And then we've noted how much help we can get from each other, and how much we should have been linking in with each other anyway. They've already said once COVID's died down, that we'll still keep at least weekly meetings, because it's proved beneficial to us being able to share information between the teams" (P3S2R03)

One of the aspects of the Vanguard programme which those involved had valued was the reduction in bureaucracy and ability to make local decisions for the good of the population. Respondents were keen that this flexibility could be maintained:

"When I was in the Vanguard, what was really great was, we didn't have any committees or barriers or anything…and it's been the same. Everyone's stopped worrying about who's doing what and who's responsibility, everyone's just saying, what are we going to do for our population, what can we do for these patients. That was just great to work in and I really hope we don't lose it" (P3S1R05)

In summary, 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.

6.5 **Criterion 3: Early and widespread stakeholder involvement, including staff and service users**

Gaining widespread engagement from all stakeholders in facilitating the roll out of the EHCH service was seen as important. However, exactly who the relevant 'stakeholders' were was locally specific

and tended to be driven by previous initiatives and ongoing relationships. 'Boundary spanners' who were locally respected and able to work across sectors were particularly important.

Our sites told us that getting engagement was not always easy and in some cases was one of the biggest challenges, especially where the initiative being implemented is driven by a top down process. However, engagement facilitated the joint work across the healthcare economies and in many places, relationships build under the Vanguard programme locally were now helping during the EHCH service introduction and in the challenging times of COVID-19:

"Getting colleagues' engagement is the biggest challenge to be honest" (P3S1R03)

"So, one of the legacies from the Vanguard which has continued is around the engagement side with care homes and helping them to feel part of the system, so that side did continue." (P3S3R03)

Moreover, there was some evidence that the sense of emergency created by COVID_19 had facilitated stakeholder engagement where previously this had been more mixed. However, this did not extend to service user engagement.

Top up funding which came with the ECHC service was seen as a sweetener in the process:

"If you weren't doing the DES, you wouldn't get it [top-up funding], but it's to make…I suppose it was a bit of a sweetener because some of the practices said, look, it's just not viable doing the DES, but we've got these homes where this [payment] is never going to cover the work that we do" (P3S1R03)

Relationships built under the Vanguard programmes locally were seen as important as illustrated below:

"It's been a massive challenge. It's magnified the areas where we knew we had weaknesses, but it's also, interestingly, magnified our strengths and I think we've done some really good work. So, yes, I think any of the, kind of, little partnership working that we did before was almost like a rehearsal for this" (P3S6R03).

"I think we were, from a relationship perspective in a good place to start with, but I think that is somewhat reflective of the work we've been doing over the last couple of years, both for the CCG and the council, I guess, as well" (P3S3R03)

At the time of the fieldwork, in Site 5 there was a focus on involving the wider stakeholders, such as working with a community provider to implement the enhanced health in care homes DES. Respondents told us that 'there were many familiar faces around the table' so relationships were already in place. For example, the community nursing team was already working in integrated fashion with the PCNs and the GP practices. There was also a [named] partnership board which had been meeting for a couple of years and included the voluntary sector, district council, and county council. So in this site the residual structures associated with past working (including the Vanguard) has been useful to form the foundations.

Maintaining relationships through retaining ex-vanguard staff in central ICS/PCN/ECHC rollout roles was emphasised as crucial for successful initiatives. However there was recognition that change in all forms was disruptive:

"We've had a good relationship with our local care team in the CCG. [It is] challenging now as the CCGs all merged and people's jobs … so that's always challenging when the people are changing" (P3S1R04)
"what's really interesting is that for the smaller independent home there has been a change of leadership and a change of manager, and that wasn't every handed over to her so it fizzled out because

it wasn't embedded in the organisation, or didn't have time to be embedded before the other manager left. So, you know, a change in people is always hard and has a big impact" (P3S3R03)

In summary, 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.

6.6 **Criterion 4: Dedicated and ongoing resources, including funding, staff, infrastructure and time**

In healthcare economies across England, workforce planning is important. In the Vanguard programme the short term nature of the funding provided meant that staffing was often provided via secondments and short-term appointments. This approach to workforce carries with it significant issues for the sustainability of what the programme can achieve (Fowler Davis, Hinde et al. 2020). Healthcare communities need to be confident of long term funding in order to invest properly in the changes being made for delivering the changes under the EHCH service.

Having dedicated and stable resources throughout the Vanguard programme and the EHCH service roll out has been seen as vital. Such stability gives those leading the process confidence to make investments (staff, equipment, changing services) and innovate and for those taking the jobs confidence that the role will be sustained:

"So clearly there's had to be ongoing discussions around existing resources and how those resources can be best configured, but I think it's fair to say that the local learning and legacy arrangements from the Vanguards has continued to be built on and that's been a blend of the immediate COVID response to care homes as well as thinking more strategically about how those resources will continue to come together as the specification starts to go live". (P3S5R01)

The extra resources provided by the Vanguard programme allowed things to be tried out and tested without having to take resources away from other services / roles:

"To some extent, I suppose we've always had close working relationships with the local authority. We developed that as part of the [previous scheme funding] arrangements, to a greater or lesser extents. I guess what the Vanguard process enabled us to do, was to test out new services, because we had the resources to do that. We've been able to demonstrate that they work… So, that has enabled us to progress." (P3S2R01)

However, as we found in phase 2, during the Vanguard programme there was concern when future years funding became contingent on meeting nationally imposed targets not set by local systems

(Checkland, Coleman et al. 2019, Checkland, Coleman et al. 2021). This makes systems, and individual organisations, more wary and often less willing to invest having experienced difficulties. Sites talked about the difficulties of staffing during short term funding periods, having to rely on short term posts and secondments that many high calibre staff were not willing to take, and the potential loss of momentum around the initiatives being developed and implemented. Future initiatives were also more difficult to sell if the system had experienced short term and / or a reduction in the promised funding:

"There's always the concern…will the funding stay and then what happens when the funding doesn't. I think we use a lot of ANPs doing our care home work and GPs. We've done it for a long time. We are managing to recruit at the moment, last year we struggled with recruitment, but we have filled actually now, we had a year using a lot of locums, and one of the things then we were talking about was stopping the care home rounds. We didn't get to that point, but if we hadn't recruited, we might have had to. So there's always that background issue about workforce. So that worries…that's the concern" (P3S1R04)

"I mean, the other thing as well when you do a pilot and they pull it is that that dampens people's enthusiasm for the next shiny new thing. So the GPs that were involved then, well, why should I put in my time and effort? […] The biggest impact of that was that it dampened the enthusiasm of the GPs for the next thing. The bunch I was working with were pretty cynical anyway and it didn't help in those quarters either. Whenever I tried to introduce something else after that, well, how long will this funding last for, how much do we commit to this, is it worth doing it? […] Circumstances at the time, because we were going into financial turnaround it just wasn't the right time, whereas we've got the backing of NHS England with funding and everything for more care home support now, so it's coming round." (P3S5R04)

Some initiatives to support care homes had lost staff and there appeared limited ways in which funds could be raised or rerouted due to standing contracts which could not be changed during the pandemic. There appeared only a finite time to get the changes embedded and funded as ongoing initiatives.

"We've lost three practitioners out of our care home support team and in the current climate, I'm sure you're aware, because GPs can't generate an income by QOF and we can't generate an income by PBR, although community we were always block, we can't actually transact anything new. Our commissioning colleagues can't decommission anything and equally they can't commission anything new from us whilst we're in this COVID pandemic" (P3S6R04)

At the time of the interviews all sites were still waiting for clarity about longer term funding which had been impacted by COVID-19:

"if I'm honest, for the practices, and we're still waiting for clarity on finance at a national level in terms of how the funding will work as we go through this financial year and into next financial year. So, I think it is something that is at risk, and I know in other parts of the country some PCNs have found it incredibly challenging." (P3S5R01)

Moreover, funding provided via the EHCH contract goes to PCNs. This makes it difficult to fund infrastructure and other developments which would support service development:

"we've had to apply for funding for IT support roles to, basically, pretty much go to, not every care home, but quite a percentage of our care homes to help them set up and get their IT sorted out so they can effectively do video consultations and the Wi-Fi and, you know, resetting passwords and that kind of really basic thing. But, again, that's an infrastructure element that's missing, so yes, and that sort of thing does take money, it needs a particular skillset and it needs to be resourced" P3S3R03

A disconnect between the end of the Vanguard programme, with its clear ownership and funding and the start of the roll out of the EHCH service by PCNs (most commonly supported by CCGs) was described by some sites. For example in site 3, in the interim period between end of Vanguard funding and EHCH service rollout, interviewees shared a sense of lost ownership and waning emphasis on care homes:

> "in terms of the EHCH what I felt that at the end of the Vanguard was that some bits were very nicely in place and were taking shape and other bits really didn't have any ownership within the CCG after the end of the Vanguard […]" (P3S3R03)

In site 5 GPs agreed with principles of the DES and that EHCH service framework were right, including the additional roles but the pace and resources to make it happen were of concern.

> *"the general feeling from the GPs that I've been working with across the areas, is actually they completely agree with the principles of the DES. […]The EHCH. They absolutely think it's the right thing. I don't think there's any question about that. I think their question is the pace that they've got to put it in, and also the resource to make it. I think that's their concern" (P3S5R05)*

In addition, some sites spoke about struggling to mainstream new services under the austerity constraints of healthcare systems when the Vanguard programme ended.

> *"But then the actual work of the Enhanced Health in Care... Obviously, it suffered from the reduction in the sort of seed funding that the Vanguard provided, and it was difficult then to mainstream in the context of austerity as well. And I think our CCG had a bit of a financial blip too. So, that didn't help"* (P3S4R02).

In some sites there was clear evidence of difficult financial constraints impacting on relationships within the healthcare system.

> *"In terms of other relationships around the system, I guess they kind of waxed and waned a little bit, depending on whether we've fallen out with each other or not lately, and there's been a bit of that…I mean, it's not helped by, obviously, the financial pressures that the local authority have been under, so ambitions that we had quite a few years ago, for developing carer services have really been stretched, as services have been decimated, basically. Older people's services, where we contributed to the grant with the local authority, all of a sudden we found we weren't grant and all those were cut. It's not exactly been strained, but it's not been conducive, however." (P3S2R02)*

Others emphasised a need for funding along with innovative collaborative working to enable preventative work requiring upfront investment and results seen only much later:

> *"I think it is about looking at resources across the system. Because if we don't, what we're going to be doing is really just continuing to offer reactive care. You know, somebody becomes acutely unwell, or there's a crisis, then we respond to that. We're very good at that but it's not enough. You have to look at population health, you have to look at being more proactive and prevention." (P3S3R02)*

There were some less positive views where respondents saw PCNs as being internally focused and not integrating to work as part of a local system. Some respondents highlighted the fact that PCNs tend to focus on care for their registered populations, in contrast to CCGs which are responsible for geographical populations:

> *"PCNs 'kind of' don't care what other PCNs are doing, they're doing their thing with their money because that's what they've been given. Whereas, CCGs, I guess, always did that for a registered population, didn't they, the overall registered population" (P3S6R03)*

In addition, PCNs received funding to employ additional staff, and this could be destabilising in a local health economy:

> *" I think the opportunity for them to draw down 100 per cent funding for some posts has obviously given them a funding stream that they didn't have sight of before. So, we have got some of them who've gone out to advert for dietitians, physios, pharmacists. And equally, because that DES supports them to draw down £120 per year per bed they're utilising, again, that funding to directly employ their own nurses. And that's not been without impact because the staff who were employed as our case managers in our own internal commissioned service to support care homes two of them have now given their notice in and are going to work for GPs at a higher band {…] I think as an organisation we've recognised that this approach, that, you know, is likely to be the first of many approaches if they're using this as a vehicle to fund services going forward, actually has the potential to destabilise the trust" (P3S6R04)*

Additional funding to care homes at the start of the pandemic was seen as important in facilitating the rapid changes required. However, some sites pointed to complexity and links to expectations (conditional funding) of accepting COVID-positive discharges and its impact on relationships.

> *"The fact that, during COVID, there was additional money given to social care to support care homes was really important. It's about confidence and we put a lot of effort into supporting care homes with infection control, expert support and PPE and things like that. So, you know, again it's all about relationships isn't it? So we want you to work with us, we want you to take patients who are discharged from hospital and we will help you by making sure that you have got the right infection control and the right equipment in order to protect your residents". (P3S3R01)*

In summary, 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 impacted on 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.

6.7 **Criterion 5: Communication**

Communication between all those providing care to people living in Care Homes was identified as an important issue.

The following quote illustrates the situation found in many care homes pre-pandemic:

> *"Communication for them [Care Home] is an issue…a lot of our care homes first of all don't have access to the real basic training for IT literacy, simple things like how do I get an nhs.net email, how do I do this, you know? so we put in a bid for support to all our care homes to do that, so that we as a system are supporting them, not in a patronising way but making sure that they're enabled to be able to communicate at a level with the primary care networks. There's no point in us saying we'll do a virtual*

ward round or whatever if the staff in the place don't know how to use a handheld device or whatever" (P3S1R02)

"[Clinical leads] are setting up groups, you know, communication lines, within each of the boroughs around care home management. That they are sharing best practice, that they're working closely with end of life care leads on, you know, advance care planning and getting the numbers right. They're doing listening as well. It's not just a one-way street, it's got to be about listening to what's important to care homes and building that into our plans" (P3S3R01)

The pandemic heightened the need for clear and effective communication and saw the development of daily communication both locally (e.g. between CCGs , PCNs and Care homes) and between national and local levels to have a clear and accurate idea of the current situation, allow clear planning and give unambiguous timely advice and guidance:

"The collaboration of practice working across the PCN has been quite a step change. So, locally in our [area] across the PCNs there's a nominated care home lead, they even have WhatsApp groups, you know, so their communication's improved. There's dissemination of information, particularly during COVID when we were trying to obviously work with our care homes much more closely. So, the collaboration of primary care has definitely improved care" (P3S3R04)

"At one point that was almost changing daily, and that's when we realised, you know, we can't keep sending out all these emails to care homes that were frazzled anyway, staff that were very, very worried and we were confusing them…" (P3S1R01)

The NHS capacity tracker first launched in 2019 was to provide a single data capture platform giving insight in to what support is needed most, and where. It is described as having comprehensive suite of reporting analytical tools that provide strategic and operational market oversight and intelligence at national, regional and local levels. It is supposed to allow rapid assessment of care vacancies across England to avoid delays in transfer and save time in reducing the number of calls made to find vacant beds. During the COVID-19 pandemic, Capacity Tracker was mandated by the government in order to provide valuable insight and give quick support to providers that were struggling with capacity. However, there were a lot of issues regarding accuracy of the data during the pandemic as systems, communications and relationships were tested to the extreme. It should be noted that the way capacity tracker was utilised during COVID-19, while related to the originally intended function, changed somewhat.

For example one site already had a local capacity tracker, so trying to introduce a new version meant an overhaul of existing good work:

"You know, for weeks and weeks, trying to get care homes to fill in two competing capacity trackers was, you know, pretty nonsensical. And it was only resolved when, effectively, a letter came from the department of health and social care that said it has to be the NHS one and social care money will go to care homes to make them do the NHS one… I haven't looked at the latest figures. Reasonably good compliance. I think the ADASS tracker probably had more compliance. People don't like the NHS tracker. We covered it in lots of layers of governance and passwords and, you know, made it very difficult for people to use. The ADASS tracker – not that I've tried to use either of them – but I'm told the ADASS tracker was just very, very easy to use." (P3S3R01)

Other sites had issues around gathering accurate and timely data which was not helped by the NHS Tracker as illustrated in Site 1:

"it shouldn't be underestimated just how difficult it is to get information about care homes, and how many beds, and who they're registered with. And so, it's something the CCG have, you know, we've been working with them for months just to get a list" (P3S1R04)

"There wasn't a central record of who we had registered and so where the CCG… they'd taken a simpler approach, they've said right we're looking at CQC registered homes and how many registered beds they have. And that doesn't…the registered beds don't always align to the reality of how many patients they have and so, I think, that's just to work out, you know, to try and simplify it. We worked with the CCG for months and they just didn't seem to have the information, there was something called the care home dashboard that occasionally some people got to see, and a lot of people didn't get to see" (P3S1R04)

The following quote illustrates some of the issues with technology (Tracker in this case) and monitoring and how it could impact on relationship building and partnership working:

"The element around the NHS capacity tracker has created enormous stress and strain because, a, of the time it takes them to report, but the fact that we then need to in essence check up on them, because the system isn't telling us what we need to do. So, our first assumption is, well, the care home hasn't done it, but actually, certainly I know over recent weeks, the local authority has done some really focused work with care homes to find out that, actually, the system is flawed. The care home is there in good faith putting their data in, but the system isn't picking it up, so it puts us in a difficult position in terms of being, you know, please don't shoot the messenger" (P3S3R03)

In summary, 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.

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

According to Nolte (2018), policy roll out depends upon the ability to adapt to local context and creatively integrate new systems or services with existing programmes. The EHCH service was rolled out against a shifting background of pre-existing initiatives, co-existing system changes and a great deal of uncertainty. In this section we consider the major types of contextual threats and opportunities and highlight the factors supporting or inhibiting adaptation and integration. These threats and opportunities are identified as: a rapidly changing and not yet stabilised wider healthcare system; local 'place' developments; the parallel development of PCNs; and the COVID-19 pandemic.

6.8.1 A rapidly changing and not yet stabilised wider healthcare system

Contextual issues

Since the FYFV (NHSE 2014) was published, the landscape of the NHS and its partners within the healthcare system has been changing. Over the recent past changes to the healthcare have been complex, multiple and encourage joint working at different levels in the system. The NHS Long-Term Plan explains three important levels at which decisions are made:

- **Neighbourhoods** (populations circa 30,000 to 50,000 people) - served by groups of GP practices working with NHS community services, social care and other providers to deliver more coordinated and proactive services, including through **primary care networks**.
- **Places** (populations circa 250,000 to 500,000 people) - served by a set of health and care providers in a town or district, connecting primary care networks to broader services including those provided by local councils, community hospitals or voluntary organisations.
- **Systems** (populations circa 1 million to 3 million people) - in which the whole area's health and care partners in different sectors come together to set strategic direction and to develop economies of scale.

A White Paper published in February 2021 (Department of Health 2021) proposed legislation to support the provision of more integrated care across these levels, with Integrated Care Systems established at the System level as statutory bodies. However, arrangements below this level have not been specified, other than continued investment in primary care services via PCNs. In particular, it is suggested that CCGs, which historically have usually covered populations of around 300-500,000 at what is now being called 'place' level, will merge up to operate at the level of the ICS. This leaves arrangements for collaboration between Local Authorities and service providers in Districts and Boroughs unclear. Our case study sites were grappling with this uncertainty whilst working collaboratively to establish and maintain improved services for care homes.

As well as this uncertainty, other factors were also in play in many areas between the end of the Vanguard programme and the implementation of the EHCH PCN DES. For example, in one site the acute Trust was in the process of being reconfigured, whilst another site was focusing upon the development of locally based geographical units with strong integrated links to District Councils. Several sites were affected by CCG mergers, occurring in anticipation of the requirement to increase the size of CCGs.

Impact of contextual issues and factors supporting mitigation

At the time of writing, the changes proposed in the 2021 White Paper are as yet incomplete although a draft bill has now been published. This means that EHCH services are being rolled out in the context of considerable uncertainty. This is particularly problematic with regard to:

- significant distraction amongst those working to operationalise an uncertain future system – this means that EHCH service roll out has not received the focus it might otherwise have done;
- difficulty in planning for the future, as individuals or organisations may not be in the same position in the future;
- adaptations required to deal with mergers and reconfigurations – service arrangements need to be adaptable to be compatible with new service configurations;
- Lack of clarity of layers in the system – overlapping statutory and non-statutory organisations, governance, oversight etc.

We found that coping with these uncertainties was supported by:

- the involvement of individuals with a good understanding of the local health and care economy who understand roles and responsibilities;
- senior-level engagement, including those involved in discussions about potential future configurations who are able to ensure that the needs of programmes are represented at relevant levels within these discussions;
- staff previously engaged with Vanguards now working at other levels within the system, facilitating relationships & providing support.

6.8.2 Meso-level context: local 'place' developments

Contextual issues

In addition to the wider uncertainty about the reorganisation of the NHS in response to the 2021 White paper, in many local areas reorganisations and reconfigurations are ongoing in order to establish more collaborative and integrated services. These arrangements are locally specific and may, for example, involve the establishment of so-called Integrated Care Providers. These networked structures bring together local community-based providers under collaborative governance arrangements. However, they have no statutory role and therefore no formal decision-making powers. At the same time, CCGs which previously operated at Place level acting as commissioners and service co-ordinators are being merged up to cover larger geographical areas, leaving something of a vacuum at Place level.

Impact of contextual issues and factors supporting mitigation

For Site 4 a new Integrated Care Provider model was proving helpful locally. Many of the local provider organisations were already working together, sharing risk and making joint decisions, providing a facilitative context for much of the local service development. Governance structures were in place, but under current legislation the Integrated Care Provider has no statutory existence or authority. This requires a more flexible way of working:

> *"Contractually and legally, the ICP is not, isn't an organisation, it doesn't have a leg to stand on. It operates purely on the basis of consensus and cooperation. Then once you've got that in your head and you realise that's the essence of it, you can still…those execs can still appoint somebody to run a programme on their behalf, it's still accountable for it, and they've still got to report to the ICP but they are running it on behalf of like a massive organisation, even though it isn't really an organisation. It's still can be done. But it's sometimes it's just about mind set". (P3S4R05)*

Working collaboratively at Place level was facilitated by initiatives implemented as part of the Vanguard programme or other local integrated care initiatives, such as compatible IT systems and data sharing agreements:

> *"the legacy work pre-vanguard and through Vanguard of all of our practices being on EMIS, data sharing protocols to share information between them has meant that integrated care across the PCN [and other footprints] has been that much easier because they've got that prehistory of working together and sharing across the piece anyway, a lot of that work has been fairly easy to build on" (P3S6R01)*

In some sites large providers such as those providing community services were seen as anchor organisations, often employing staff on behalf of PCNs to give stability and benefit the whole health and care system:

> *"So, we've worked really hard to reach out to Primary Care Networks to offer to be…I think the trendy term at the moment is the anchor organisation. We've developed service level agreements and our offer is that we would do obviously the recruitments, directly employ individuals, but they would be embedded or parachuted into Primary Care Networks but actually having those people work for us gives it an opportunity to potentially enrich those posts if we were going to be in a position to offer some sort of rotation, but also to offer the PCNs some resilience" (P3S6R04).*

Overall, we found across our sites that the roll out of EHCH services via PCNs required some sort of meso-level co-ordination and support. Historically this has been provided by CCGs, but as CCGs are merged to cover larger footprints and ultimately phased out, other formal or informal organisations are stepping in to provide this function. The exact configuration of such support varies locally, but

strong meso-level support acted as a mitigating factor in a rapidly changing context. Having stable personnel locally was helpful in this context, whilst staff turnover was problematic:

> *So, the joined-up commissioning is still an ambition but, as I said, it's dependent on people to drive it forwards that really want to do it, and that at the moment has halted from personnel changes." (P3S3R03)*

6.8.3 Parallel development of PCNs

Contextual issues

The provision of the EHCH service via newly formed Primary Care Networks brought with it some issues. Essentially, PCNs were forming and working out how they would organise themselves whilst at the same time taking on new responsibilities. Simultaneously, existing local collaborations established either as part of the Vanguard programme or by activity of local CCGs were required to adapt what they were doing to fit in with the new funding and administrative structures.

Impact of contextual issues and factors supporting mitigation

We found both positive and negative effects of the association between new EHCH services and the PCN programme.

Respondents in one site told us that, following the end of the Vanguard programme, developments had rather stagnated in their area, only to be stimulated again by the development of PCNs:

> *"So, the GP allocation has only happened this year because of the PCN DES, so we didn't make any progress with that after the Vanguard to when the DES came out… What happens now, which again I think is because of the DES, actually… there will be care home MDTs… so a person's case can be brought to that MDT for discussion around actually what might need to happen" (P3S3R03)*

However, others found it problematic. The contrast between Vanguard flexibility and the prescriptive nature of EHCH was highlighted, as it required changes to existing arrangements:

> *"Developing EHCH and PCNs in tandem has been good. However, the PCN initiatives has much to do and little flexibility, feels a bit like a production line at times"(P3S6R01).*

One of the potential mitigating strategies utilised by our sites was to try to emphasise the continuity between new services being developed by PCNs and what had gone before by, for example, using similar language. However, the inflexibility of the PCN process rendered this difficult:

> *"We had a few teething troubles with that initially because we wanted to downplay the primary care network nomenclature in order to keep going with [current integrated structures] and not confuse things. But it soon became apparent that because of government requirements and so on we had to talk about primary care networks and we had to set up primary care networks slightly differently"* (P3S6R01).

Areas which had not previously been Vanguards also found the introduction of a national top down approach difficult. For example in PCNS3 there was an existing care home scheme which provided more generous funding than is available via the DES. This caused some problems which were difficult to mitigate as there was no leeway to match previous funding arrangements.

In the Vanguard programme it had sometimes proved difficult to engage with GP practices; the PCN DES made this easier, as it provided a formal statement of the care that needed to be provided:

> *"So, one big thing that we struggled with during our Vanguard programme was the recognition of what good primary care support for the care homes and how important that was. And we struggled with the,*

sort of, lack of recognition about doing it well and the impact on…and the pressure on the primary care services to be able to do it well and I think that's being addressed somewhat now by having, you know, the PCN DES and the recognition that this is, you know, it is hard work to primary care and to community services" (P3S3R04)

However, the fact that PCNs were still at an early stage of development caused some issues:

"They [PCNs] are still forming, storming, norming, really, in that part of their development, really, and in adversity because there has been so much thrown at them" (P3S6R03)

"How much pressure there is at the moment on primary care networks to be continuing to respond to the COVID risk, to be continuing to screen their patients and potentially provide elements of hot and cold services, and bring in the requirements of the PCN DES, and think about some of the other stuff that's coming down through QOF and the requirement to identify their at risk groups. And so I think there is a fairly big pressure, I would say, on PCNs at the moment to be implementing what, in reality are some pretty big projects at a point where some of them are still very much forming relationships…some of the PCNs have taken this on no problem and others are really struggling. And I think that wider context is really significant" (P3S1R06)

Moreover, establishing an EHCH service is not necessarily straightforward, particularly in regard to the alignment of Care Homes to particular PCNs, as found in our PCN research. Ensuring equity between PCNs may be difficult, particularly if there is a geographical concentration of care homes in a particular area, and patients may not wish to change GP, causing complications with regard to ward rounds and data sharing.

In mitigating these issues, good local relationships and opportunities for PCNs to work together across a wide footprint could be helpful. Such supra-PCN forums provided support, opportunities to discuss problems and, if all else failed, the potential for mediation to resolve difficulties. This is addressed further in the next section.

6.8.4 COVID-19 pandemic (2020)

Contextual issues

Our fieldwork took place in the early stages of the COVID-19 pandemic which caused particular problems in care homes, with issues associated with supply of personal protective equipment, the discharge of infected patients from hospitals to care homes, availability of testing, provision of support to Care Homes remotely when in-person visits were difficult and the management of outbreaks in care homes. Deaths in care homes reached nearly 30,000 in the first 6 months of the pandemic (Morciano, Stokes et al. 2021), and residents were affected significantly by bans on family visits and the associated isolation. Care home staff were also affected, with rates of infection high (Ladhani, Chow et al. 2020).

Impact of contextual issues and factors supporting mitigation

The impact of the pandemic on care homes was overwhelming, affecting all aspects of care home operation alongside the provision of primary and community services to residents. In this report we do not focus in detail upon these devastating effects which have been widely reported and discussed elsewhere (Rajan, Comas-Herrera et al. 2020, Morciano, Stokes et al. 2021). Our focus is upon the impact of the pandemic on integration between the care home sector and wider health care services. From this perspective, for many, the impact was, in part, beneficial, as it increased the attention paid to a previously neglected sector:

"I think it would be absolutely right to say this has not had the kind of priority that it needed before COVID. But COVID has certainly accelerated the priority. And I think across [local area] we do have really good PCN engagement. We have care homes lead GPs for each borough and we have, I think now, a GP lead for every care home." (P3S3R01)

Very quickly in all areas care home support became remote (if previously face to face) which did cause some concern at least initially.

"we're still doing training on a weekly basis with the care homes, but we're going it via Teams, which some of the care homes are enjoying, but it's not the same as face to face, 'cause you can pick up so much more from visiting a care home, that just seeing the staffs' faces over the internet, as you can imagine?" (P3S2R03)

Interviewees described the pandemic crisis as speeding up EHCH implementation and care home support by unlocking systems which had previously been problematic, including governance requirements and data sharing. At the same time, the sense of facing a shared crisis cemented relationships and accelerated the development of trust. In most sites weekly crisis meetings across the health and care sector were quickly convened which included the issues faced by care homes and supporting them. There was evidence of collaboration across organisations and the quick removal of barriers to this, given that the whole system had a specific task. Virtual working was also seen as beneficial in reducing travel time, enabling longer meetings to discuss work and patients.

"The Enhanced Care Home team [an occupational therapist, a dietitian, a speech and language therapist, as well as the nurses and a team leader], you know, things have obviously changed because of COVID, and they're adapting to new ways of working, because previously part of their role was to go in on a daily basis, to these care homes and work with them. We've done things like, again, on the Enhanced Care Home Framework, best practice, things like having a poster, who to call first in the event of somebody having a deterioration or an exacerbation of their condition. And we've purposely put 111 at the very bottom, you know, 999, 'cause there are all these other services in the community that they should call in the first place." (P3S2R02)

Some clear benefits from changes in working practices caused by COVID-19 were identified, which included unblocking ways of working that would have got in the way:

"COVID ironically been very helpful. It's not been helpful in the progression of the programme in terms of what we thought we were going to do, but on the flip side of that we never had NHS mail and capacity tracker as tools that we were definitely going to use with enhanced health in care homes. They were preferable, but we had no mechanism to mandate their use. But COVID meant that the government needed very quickly a vehicle where they could communicate securely with the care homes, but also to understand their bed state" (P3NR01)

"It's allowed to work as a system to really accelerate some of the better things, so better relationships, understanding how they work as partners with us, how we can support people in care homes, how GP practices and the community can come together, how social prescribing is really important. So I think we've actually achieved an awful lot with a pandemic which is not a thing we would want to accelerate good practice but it certainly has focused us on working together" (P3S1R01)

The COVID-19 crisis was also seen to unblock access to data

"*it's accelerated those sorts of returns and people are more engaged in the process and just things are moving more quickly than they would have done otherwise, if COVID hadn't come along"(P3NR02).*

Thus, whilst the COVID-19 pandemic placed huge strain on the care home sector with devastating personal and professional impacts on staff, residents and families, in terms of service integration there were some beneficial effects in removing bureaucratic barriers to collaboration and

generating a sense of shared purpose. The factors supporting this were pre-existing strong relationships and the rapid establishment of meso-level (i.e. 'place') coordinative mechanisms such as regular meetings and shared access to IT systems and data. What is currently unclear is how these things will play out as the pandemic ends. In particular, whether the waiving of bureaucratic requirements will continue and whether systems put in place during the emergency will endure.

6.8.5 Summary

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 are set out in Table 2, and 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.

Table 2: summary of contextual challenges and mitigating factors

Contextual factor	Impact	Mitigating/enabling factors
Changing national context and potential system reconfiguration	• Distraction amongst those working to operationalise an uncertain future system – this means that EHCH service roll out may not have received the focus it might otherwise have done • Difficulty in planning for the future, as individuals or organisations may not be in the same position in the future • Adaptations required to deal with mergers and reconfigurations – service arrangements need to be adaptable to be compatible with new service configurations • Lack of clarity of layers in the system – overlapping statutory and non-statutory organisations, governance, oversight etc	• The involvement of individuals with a good understanding of the local health and care economy who understand shifting roles and responsibilities • Senior-level engagement, including those involved in discussions about potential future configurations who are able to ensure that the needs of programmes are represented at relevant levels within these discussions • Staff previously engaged with vanguards now working at other levels within the system, facilitating relationships & providing support
Meso-level system churn	• Establishment of locally-specific new collaborative structures, usually without statutory authority, requiring every area to work out specific ways of working together • Loss of meso-level organisation to support service developments • New geographical footprints may not accord with existing service configurations	• Specific organisations taking on a local leadership/support role – e.g. Community providers, local integrated care networks • Concrete arrangements to support collaborative working such as data-sharing agreements and access to it systems • Staff in place who understand the local area and can broker relevant relationships
Service development whilst PCNs in the process of being established	• New services layered upon old arrangements • Cemented the engagement of gps which had previously been problematic • Lack of flexibility due to the contractual model adopted • Services to be delivered by organisations at the very early stage in their development	• Strategic use of language to emphasise continuity. • Being allowed flexibility to adapt EHCH arrangements would have been helpful but not available • Support from meso-level organisations helpful
COVID- 19	The crisis facilitated collaboration by: • Allowing the removal of bureaucratic barriers to collaboration • Instilling a sense of shared purpose However, it also created many issues, including: • Loss of face to face interaction with clinical staff • Care Homes over-whelmed with guidance, not all of which was complementary • Devastating personal and professional effects on staff, residents and families	• Pre-existing strong relationships supported collaboration • The rapid establishment of coordinative mechanisms such as meetings and access to IT/data

6.9 **Criterion 7: Ongoing monitoring and timely feedback about progress**

The Vanguard programme as a whole was established with the intention that evaluation both locally and nationally would provide regular and rapid feedback as to progress.

In some sites this philosophy was continued into the EHCH service roll out, with monitoring systems for evaluation of EHCH included as part of wider monitoring policies. For example, in site 6 a county-wide 'Older People's Nursing and Residential Care Home Service Specification' (Dec 19) was developed at the ICS level (covering [multiple] CCGs and LAs) This was signed off at a [site 6] Board in March 2020. It sets the ICS wide context for developments and includes EHCH service requirements. It encourages a move from task based work and monitoring to an outcome based approach (30 listed outcomes). However, this was still to be implemented at the time of our fieldwork.

In Site 2, the EHCH Team initially covered a few of the care homes, where they monitored attendances to hospital and looked for those that could have been prevented and supported homes with training. This has expanded with the arrival of the pandemic and allowed the team to develop after better reflection on what was working well or needed to be changed:

> *"As I said before, although COVID's been a really bad time, for us as a team, it's really given us time to just step back a little, and look deeper into issues, and highlight them, and given us time to work towards improving care in these areas. And the team's drastically changed in the last, say, three to four months, but all for the better, and we'll definitely be staying in place. […]." (P3S2R03)*

In Site 3, quality assurance was less prominent at the planning stage, but roles were extended/added as a reaction to COVID-19.

> *"if we hadn't had COVID this wouldn't be the case, but my care home role], where we joined to be [ICS], so this is obviously a result of NHS policy to change structures, my role wasn't in the new structure because it was unique to [Vanguard] and it couldn't be replicated in the other CCG. So, in essence, it was removed, but because of all of the work around care homes that had to happen because of COVID the CCG has recognised that some person needs to have a lead role for care homes within the CCG" (P3S3R03)*

In regard to emergency admissions, the Enhanced Care Team in Site 2 went in to discuss with staff particular problems e.g. with continual UTIs as a reason why they're going in, pointing them to look at hydration and nutrition; similarly with falls. They claimed to have had some excellent outcomes from this team, with reduced admissions into hospital within the first six months.

> *"But one of the wins we had was actually, the care homes, every time they called an ambulance, had to complete an RCA, and nothing elaborate, but to get them to start thinking about the reasons why the patient went into hospital in the first place, and getting them thinking, could they have done anything differently?" (P3S2R02)*

They had also initiated daily virtual meeting with PCN GPs which gave timely clarity and allowed review:

> *"Every morning we have, now this is a new thing, we have a meeting with those GPs every single morning, so we've got the opportunity, if any problems have arisen in any care homes that they cover, we can discuss it with them… It's our team, the GPs, the Care Home Nurse Practitioners from [name of place] Clinical Hub, and then the ANPs from those GP surgeries… We've only done it for about two months now, but it's made a massive difference, 'cause normally, if we've issues we've got to chase GPs, or, you know, and everybody's busy. But we've just got that specific time now where we can just have a catch up, and things are sorted much quicker. " (P3S2R03)*

In Site 1 there has been alignment between the CCG and Care Homes, who also carry out a monitoring role:

> *"And then the CCG care home nurse specialists…I can phone [name] and say, care home x, we've discussed this at our meeting today, at our MDT, because we've noticed there have been four A&E attendances in the last month with falls. And then they would go and speak to the home and just check about training and things" (P3S1R03)*

We asked about information and guidance about the EHCH service implementation and despite sites saying the introduction was prescriptive, some would have liked more guidance and to be able to link with others to see what was working well.

In Site 2 we were told that the Enhanced Care Homes Team Leader had gone through the framework to either cascade the info or work on what can be improved. This happened as often as time permitted a review of the documentation.

> *"I think, well since I've taken over, I know the Enhanced Care Home Framework inside out, and we've just tried to adapt our team, to make sure that we're meeting the needs of that fully, or as close as we can." (P3S2RO3)*

However, the Enhanced Care homes Team would have liked to link with other local areas, to see what they are doing and share best practice. It was unclear when this might be possible due to Covid restrictions at the time.

> *"Yeah, definitely, I think all areas have probably done things very differently, and we all have a lot to learn from each other. We have linked in with the frailty scoring tool that's going to come out. The lead for that, she covers loads of PCNs and lots of different catchment areas, so she's already fed back to me that areas are doing things very differently, and a lot of areas haven't got a team like we've got in place, which is good to know that we are doing some good work. So yeah, I think, following all this, it would be good to link up and just share what we've been doing, 'cause we can tweak what we're doing then, and bring good ideas from other areas, to help improve our service." (P3S2RO3)*

The introduction and roll out of the EHCH service was inextricably linked with the arrival of the COVID-19 pandemic. The sites at the time we interviewed them had not yet had time to pause, reflect, assess impact and monitor the changes for either the EHCH service or wider service provision and delay. This was illustrated by the lack of documentation that the sites were willing or able to share with us. All respondents were very aware of the importance of learning from the experience of working under COVID-19 and many did not want their areas to slip back into ways of working which pre-dated the pandemic. For example, bureaucracy, lack of data sharing, working in silos etc.

> *"I just think if we don't learn and embed from this, it will be an absolute shame and a disaster because the opportunities that this has given us, to really be a proper…everyone talks about an integrated system…we're not, but this would really give us a chance to be an integrated system and be a collaborative system and I hope the ICS and the ICP keep that within them and drive that forward, I really do" (P3S1R05)*

However, sites appeared keen to learn and Site 6 for example, ran a local exercise to find out the positive / negative things from COVID impact and capture learning for the future. Two main reasons given for this:

> *"we wanted to reflect back on the great work that had been done, we wanted to sing people's praises. Capture those things that mightn't have some ongoing work to do and we needed to start to think about which of those might need some resource behind them, be it money or people just to help continue them*

on and those which might represent a significant variation which would normally have given rise to consultation or at the very least some engagement" (P3S6R01).

Following the evaluation they came up with approximately 50 initiatives / adjustments that had been beneficial including process related e.g. less travel, more use of electronic communication, quicker discharge processes, quicker decision making etc.

In summary, while 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.

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

In addition to monitoring and feedback about implementation progress, Nolte (2018) suggests that demonstration of effectiveness is also important in ensuring the scalability and sustainability of pilot innovations. This is something which has not been prominent in the Vanguard programme as a whole. However, there is some evidence that the EHCH service model (alongside associated additional funding) was successful in reducing the growth rate of emergency admissions to hospital, although there was no effect on length of hospital stay (Morciano, Checkland et al. 2020). There was no published evidence of cost-effectiveness of the programme, and no economic case for the roll out of EHCH services via PCNs has been made nationally.

At the time of the interviews in site 4, they were undergoing a review due to overlap of services (resulting from multiple initiatives including the Vanguard), introduction of EHCH services and COVID-19.

"Across the Council, the CCG and [named] Hospitals NHS Trust, there are a number of funded initiatives that are currently supporting care homes or system processes that interface with care homes. Based on feedback and evaluation, we believe there are opportunities to reshape and remodel some of these to improve their effectiveness. We also feel that a better system level shared understanding and ownership of care home support initiatives will result in better system outcomes". (Site 4 Joint Care Homes Strategy 2020-25 p11)

Respondents in Site 5 suggested that what is covered under EHCH service is a lot of the work that areas were doing under the Vanguards. The specification had strengthened that and should make sure that everybody's delivering to the same level, through robust monitoring (which they didn't really have before).

Services in many of the sites changed quickly where appropriate from being face to face to online to be able to continue to support the care homes. For example in Site 2:

"[named initiative] is a new one that we're going to use, in line with the DES, so if a home aren't happy for us to have face to face, and don't feel that we need to go in and review residents, we can use [named initiative]. So, we can still have a discussion with the resident, but via technology instead." (P3S2R03)

"So, in terms of education and training, we've done this in a different way during COVID, which I think included the remote video webinars, and a success has been working with the local authority. We've been having daily meetings, these are now twice weekly, but we're working in tandem with them, and, you know, doing joint working on education training programmes, and webinars […] You can imagine how many technical problems there were. But overall, kind of loads of successes." (P3S2R02)

In site 2 they could highlight achievements against national targets e.g. admissions to hospitals, and claimed to be able to trace it to having been involved with the Vanguard previously:

"So, within the sort of first six months, we actually had some excellent outcomes from this team, with reduced admissions into hospital. So that gave the opportunity then, to go back to our Commissioning and Policy Development Committee to say look, you know, we need to substantiate and embed this team on a permanent basis. So, that's been a success, and now they are fully part of that clinical hub, working alongside, having daily meetings with the other members of the clinical hub, so as well as the other advanced nurse practitioners and care home nurse practitioners, we also have long term condition nurses, and they've come under different names over the years, community matrons and so on, but essentially they focus on those patients who have got long term conditions, and are complex and get referred from primary care, or through the hospital, through multiple admissions." (P3S2R02)

In some Sites there was evidence of them having piloted initiatives associated with the EHCH service at a small scale before they were rolled out further to gain proof of concept before investing more funding, time and staff. For example In site 1, a pilot to support end of life care for care homes during the pandemic ran, which allowed more people to die in their place of choice:

"We set up a pilot for care homes anjd people in their own homes during COVID for end of life support out of hours because we did have a team that would support people in hours, but we realised what a big issue COVID especially was, with people deteriorating very quickly and we didn't want them being conveyed to A&E in the last hour of their life… we saw a dramatic reduction in conveyances for end of life and more people dying in the place that they wanted to die" (P3S1R01)

In Site 2 a pilot to encourage the practices to refer residents into the 'Clinical Hub', as a first point triage and pathway service was being undertaken.

"So in terms of the clinical, the next steps, I mentioned this is absolutely integral to our new organisation and the development, so we've just started a pilot, best proof of concept, to get the practices to refer into the Clinical Hub, where you'd be triaged, rather than going directly to the Assessment Unit. We're just doing a small scale to begin with, working with one practice, then it's going to be a few practices within the PCN, and then the entirety of the PCN. Essentially, the Hub will triage them, and we're going to work closely with the hospital, so that we can have this sort of three way consultation with the on call consultants, to discuss patients, do they really need to come into hospital, can we arrange a hot clinic, an early outpatient appointment, and have that discussion as a way of obviously preventing unnecessary admissions to hospital." (P3S2R02)

Informants in Site 2 claimed that the Vanguard process enabled them to test out (pilot) new services, because of the resources to do that, and be able to demonstrate that they work. Informants suggested that they may have got so far without being involved in the Vanguard process, but wouldn't have got far enough.

In summary, whilst there is some evidence that the ECH Vanguards were partially successful in reducing emergency hospital admissions, 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.

6.11 **Summary: scaling and spreading of EHCH services**

Table 3 sets out our findings against Nolte's criteria. We found that these criteria were useful in understanding the roll out of the EHCH service. They drew attention to some of the factors supporting roll out, and highlighted the advantages associated with previous Vanguard status. It is noticeable that these advantages accrued to all our Vanguard sites, not just those who had previously implemented EHCH services. These advantages revolved around the trusting relationships developed during the Vanguard programme.

Table 3: summary of programme scale and spread against Nolte criteria

Criterion	Manifestation in research sites	Additional issues
Criterion 1: Structure that is adaptive and flexible, with structures that support devolved decision making	The EHCH specification had to be implemented alongside existing services and previous initiatives. This required adaptation	• Adaptation supported by good, trusting relationships, and previous Vanguard experience was seen as having been helpful in this • Removal of bureaucracy associated with pandemic helpful
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	EHCH roll out took place in a complex and changing system, in which leadership roles unclear, changing or developing	• Common purpose and shared vision important, and was facilitated by previous Vanguard experience • Changing role of meso-level organisations (eg CCGs) potentially problematic
Criterion 3: Early and widespread stakeholder involvement, including staff and service users	Gaining widespread engagement from all professional stakeholders in facilitating the roll out of the EHCH DES was seen as important. However, exactly who the relevant 'stakeholders' were was locally specific and tended to be driven by previous initiatives and ongoing relationships. 'Boundary spanners' who were locally respected and able to work across sectors were particularly important.	• Where 'buy in' not strong, monetary incentives were used • Service user engagement negligible.
Criterion 4: Dedicated and ongoing resources, including funding, staff, infrastructure and time	Additional resources provided by the Vanguard programme had supported service developments. There are some resources available for EHCH roll out via PCNs, but these are usually less than those provided by the Vanguard programme. This caused some problems	• Funding needs to be stable & long term • Funding for EHCH roll out via PCNs is inflexible & therefore less useful
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 support communication (eg capacity tracker) helpful, but sometimes clashed with local systems
Criterion 6: Adaptation of the innovation to the local context and integration with existing programmes and policies	See table above	
Criterion 7: Ongoing monitoring and timely feedback about progress	Whilst monitoring EHCH DES progress was seen as important, how sites approached this, and how much monitoring was already taking place differed significantly across the case study sites.	• Previous experience as a Vanguard supported a culture in which monitoring seen as important • The need for speed in the context of the pandemic limited opportunities to reflect
Criterion 8: Evaluation and demonstration of (cost-) effectiveness of the innovation being introduced, including assessment of health benefits.	Whilst there is some evidence that the EHCH Vanguards reduced the growth rate of hospital admissions, other metrics showed no improvement and there is no evidence that the service approach is cost-effective	• Sites were aware of the need to demonstrate effectiveness, but their ability to do so was limited

6.12 **Factors and issues not captured using Nolte's criteria**

Having analysed our data through the lens of Nolte's (2018) criteria affecting the successful scale up and spread of pilot innovations, we considered issues arising which were not captured by the framework.

Firstly, in keeping with its status as a cross-sectoral policy, the roll out of the EHCH service occurred in a complex provider landscape which includes small scale private providers. This brings with it complexities around sustainability and market viability. A recent report from the National Audit Office (2021) suggests that COVID-19 focussed attention on social care as never before, highlighting existing problems with social care and emphasising significant gaps in understanding of the market.

As might be expected having been developed with reference to European innovation initiatives, Nolte's criteria in general assume a stable structure of providers, underpinned by state investment. The Care Home market in England is considerably more complex than this, with state-funded residents heavily subsidised by their self-funded counterparts (Melanie Henwood, Stephen McKay et al. 2018) and some complexities associated with engaging with new initiatives, including who is liable to pay for new equipment, for example. This respondent highlighted these issues:

> *"we're doing quite a bit of work with both local authorities to make sure that the regulated care sector is stable. It was challenging pre-COVID to make sure that both care homes and the domiciliary care sector were robust and we've got a lot of challenges there both financially and probably because of finance in quality terms. […] We were starting to work with the local authorities on that. COVID, again, has just magnified just how…the challenges around the stability of the sector. It's probably more that, that we're doing on the whole and linked into that and making sure that things are done." (P3S6R01)*

This leads onto a second issue arising out of the associated regulatory system. Care Homes' interaction with the NHS has historically been structured around issues of quality of care, often arising out of reported concerns and requirements to be inspected. Relations could become strained where the differentiation between offering support and monitoring / policing was not clear to the Care Homes. On occasion in our case study sites this particular dynamic could generate tensions, with care home staff reluctant to engage:

> *"Some of the homes I've contacted, I almost felt a little bit like a cold-calling double glazing salesman, saying I'm from the NHS, you know? So it's about explaining properly and following up with letters of correspondence so they realise we're not just some cold-caller that's first of all trying to inspect them, but secondly want something from them" (P3S1R01)*

Thirdly, the EHCH service roll out was beset with questions as to ownership, governance and roles, issues which do not necessarily come to the fore using Nolte's framework. In essence the implementation of EHCH services in a shifting landscape of imminent or partially completed reconfigurations meant that the issue of who took responsibility for what was very important. In Nolte's framework the importance of leaders in formal positions who are committed to change is highlighted, but in our situation of shape-shifting organisations and fluid responsibilities we found that it was equally important to have individuals with a clear vision of the local landscape and the appetite and operational leeway to take personal responsibility for ensuring that things happened, regardless of whether or not they held formal responsibilities in that area. This is a condition which it is difficult to legislate for or to enable, but we found some suggestion that a previous history of Vanguard working was helpful in engendering this type of individual action. Moreover, in a situation where the formal responsibilities of individual organisations are in a state of flux, there is a danger that necessary actions might get forgotten. We found that early attention to allocating

responsibilities and clearly delineating roles was valuable. These issues were particularly important as the EHCH initiatives require collaboration between sectors under very different pressures and under the direction of different arms of government. Clear communication between Local Authority representatives (under pressure due to shrinking budgets) and NHS staff (under pressure because of rising demand and the anticipation of imminent reorganisation) was key to successful roll out.

Linked to this, we found that relationships and alliances could be fragile and easily disrupted by changes in focus. Where partnership working stretches across sectors, priorities may differ, and considerable work is required to maintain successful co-operative working. For example, in Site 4, after the Vanguard ended the model for the Care Home Support Team was refocused upon supporting discharge from hospitals to care homes. The Care Home Team became part of the wider elderly care and frailty support work, reducing the perceived priority given to Care Homes. This had a negative effect on some relationships built up with the homes. Eventually this decision was reversed, but trust had been affected:

> *"They went to a, sort of, Supported Discharge Team, more than a Care Home Support Team. Which had the negative effect of destroying all the relationships the team had already established. But then the, sort of, amount of effort they needed to be put in to do that shouldn't be understated. The Care Home sector has, for a long time, felt cast aside, not as important, and COVID itself has only, sort of, exaggerated that image. So they're naturally quite suspicious…or not suspicious, but wary of these new programmes come along […] they were lacking direction in terms of what they're actually trying to achieve"(ID P3S4R01)*

This suggests that the spreading of initiatives that cross sectors need sensitivity to the needs of the different sectors. This may be complex if the roll out is orchestrated and funded by one sector.

Finally, we would emphasise the importance of geographical footprints and definition of what constitutes a meaningful local geography in orchestrating the roll out of innovations. Whilst this aspect is to some extent captured by Nolte's (2018) criteria of programme adaptability and integration within a specific context, our study suggests explicitly considering local geography as part of this will pay dividends. Most modern health and care systems have been subject to repeated rounds of reform and embody a mix of local and national previous initiatives. Moreover, the available menu of potential innovations in health and care reform are fairly limited, with many previous initiatives centring around attempts to make care less fragmented and more coherent. As such, any new initiative such as EHCH services will come up against the legacy of previous initiatives, which will often have been implemented across different footprints and involved slightly differing casts of individual and organisational actors. Whilst we would concur with Nolte's emphasis on the need to incorporate new initiatives with those previously implemented, we would modify this by highlighting the fact that 'local context' is not static or fixed. Thus, new initiatives may require *the adjustment of perceptions of what constitutes local context* alongside adaptation to accommodate previous initiatives.

7. DISCUSSION AND CONCLUSIONS

In this section we bring together our findings to address our research questions:

- How did the Vanguard pilots feed into the development of the EHCH new 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?

7.1 EHCH services as a legacy of the Vanguard programme

Whilst many previous Vanguard areas would probably claim that their experience in the programme is influencing their development as Integrated Care Systems and in their local integration programmes in 'Places', it is only in the EHCH service roll out that we see the original purpose of the Vanguard programme in defining 'products and frameworks' which could be 'straightforwardly spread' playing out (NHS England 2014)

Our national level interviews suggested that the Vanguard ECH 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 Vanguards (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. Indeed, whilst the Vanguard programme included a well-funded and comprehensive support programme, the roll out of the EHCH service via Primary Care Networks is occurring via a contractual mechanism, with guidance focused upon setting out best practice rather than providing guidance for implementation (NHS England 2020). 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 practise, 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.

7.2 **Supporting and enabling the scale and spread of the EHCH service model**

Using Nolte's (2018) criteria, we have considered the factors affecting the wider roll out of the framework for EHCH services developed via the Vanguard programme. Broadly these fall into two groups: the characteristics of the local area in which roll out occurred; and the design of the service(s) being rolled out. We found that, in terms of providing a 'receptive context' (Pettigrew, Ferlie et al. 1992) for roll out, previous experience as a Vanguard was helpful, as it provided a legacy of relationships and trust which supported the development of the new services. In particular, we found that the presence of individuals with a good understanding of local organisational realities and strengths/weaknesses was helpful, alongside local leaders with experience of working across organisational and sectoral boundaries. However, it was also necessary to have clarity over which organisation was responsible for what; local meso-level organisations (e.g. CCGs) able to broker relationships across sectors were helpful in this regard. Alongside this, effective communication and stakeholder engagement were very important, particularly when dealing with a fragmented landscape of small providers. Notably we found little engagement with clients or the public, but it is possible that this was influenced by the impact of the COVID-19 pandemic. All new initiatives are implemented in complex contexts where legacies of previous initiatives exist alongside shifting organisational boundaries and varying geographical footprints, and these can be of decisive importance in determining the success of wider roll out.

These complexities mean that initiatives are easiest to roll out where flexibilities exist for adaptation to local environments. It is here that the EHCH service programme was potentially deficient, in that the roll out occurred via a fixed contractual model which was designed around the needs of a single sector – primary care (Checkland, Hammond et al. 2020). This limited the extent to which local areas could ensure that new services fitted well with their existing service models. Resources associated with the initiative to be rolled out are clearly important, and our study suggests that careful design of the funding model is essential. Where previous initiatives have existed, we found that it is possible for even well-funded new services to be problematic, as they may disrupt a delicate status quo. Problems may occur when funding for the new initiative are less than those associated with the

relevant pilots, or when rules associated with new funding are incompatible with what went before. Our interviews and comparison between our previous Vanguard sites and the PCN sites which had not previously been involved with the Vanguard programme suggested that all Vanguards felt themselves to be at an advantage because of their previous experience, with strong relationships and experience of working in more flexible ways both seen as helpful. However, previous ECH Vanguard sites may have been at a disadvantage, as funding for the new service was less generous and more targeted, requiring some Vanguard initiatives regarded as successful to be stopped or provided via different mechanisms. ECH Vanguards had considerable latitude as to how to develop their services. This meant that leadership and oversight of the services was variable between sites, with potential lack of clarity over who was actually responsible, especially once the Vanguard programme formally ended. The new PCN EHCH service, by contract, provides clarity over responsibilities. This increased clarity may be useful in establishing who is responsible for what, but a highly determined service specification does not necessarily allow the new services to build upon existing local relationships and alliances (Coleman et al 2020). Thus it would seem that a delicate balance is required between clarity and clear accountability, alongside some flexibility and opportunities for local adaptation.

Nolte (2018) emphasises the importance of monitoring, feedback and evaluation in supporting the scale up and roll out of new services. In our study such processes were recognised to be important but were rudimentary at best, with the COVID-19 pandemic clearly important in this regard. The use of a contractual model for resource allocation seems likely to focus attention on measuring those things used to allocate funds, rather than wider focus upon quality or outcomes. Nolte (2018) suggests that successful roll out is more likely to occur when the service being rolled out has been shown to be cost effective. The Vanguard ECH programme has been shown to have been effective against a single metric (reduction in the rate of growth of emergency admissions (Morciano, Checkland et al. 2020, Morciano, Checkland et al. 2021) but there has been no estimation of cost-effectiveness. Nevertheless it has been rolled out, suggesting that a national programme backed by a contract and associated funding is not disadvantaged by lack of evidence as to its overall value.

The roll out of the EHCH model was significantly affected by the COVID-19 pandemic, which required rapid adaptation, different types of support and placed considerable additional strain on those involved. However, we would argue that, whilst this will have affected what happened locally, the fundamental issues which supported successful adaptation were similar to those supporting collective action more generally. As such, COVID-19, whilst important, has highlighted existing issues rather than created completely new challenges.

7.3 **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 ECH 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 in table 4.
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Table 4: 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.	• 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 ECH 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	• 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	• 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	• 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	• Which individuals locally will drive roll out? • Which organisations will provide support? • Who is accountable, for what?	The shift from ECH Vanguards to PCN-led EHCH service roll out entailed a shift in responsibilities from a shared model across a Vanguard footprint to a PCN (ie general practice)-led approach. Organisational churn resulted in some ambiguities.

7.4 **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.

7.5 **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 ECH 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.

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