



## National Evaluation of the Vanguard New Care Models Programme

### Report of qualitative case studies: understanding system change

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# Executive summary

## ***Introduction and background***

This report forms part of a wider evaluation of the National Vanguard programme, funded by the NIHR Policy Research Programme and taking place between 2017 and 2021. The aim of this national evaluation is to explore the implementation and impact of the Vanguard New Care Models programme. This study forms part of a wide-ranging evaluation for the programme, which incorporated internal evaluation by the NHS England Operational Research and Evaluation team, locally commissioned evaluations of each Vanguard as well as this independent evaluation. Our study was conceived as an evaluation of the programme as a whole – i.e. it was our intention to not only explore how local areas made changes, but also to understand in depth how the programme as a whole operated, including the national support programme which ran from April 2016-March 2018. We have focused throughout on understanding how national policy initiatives and local contextual conditions intersect, in order to explore more widely how national policy is interpreted and implemented locally and the factors that affect this. The focus was on the evaluation of the Vanguard programme as a whole, set against the original aims, not the individual interventions being introduced locally. Our study is underpinned by an understanding of the policy literature, notably: the importance of history in determining how national policy is interpreted and implemented locally (Coleman et al., 2010; Pope et al., 2006); the interplay between ‘bottom up’ and ‘top down’ approaches to policy implementation (Barrett & Fudge, 1982; Matland, 1995); and the complexity in determining what constitutes policy ‘success’ in any given situation (Marsh & McConnell, 2010; McConnell, 2010).

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

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

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

## ***Study aims, objectives and research questions***

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

- **RQ1:** What is the programme of change in this case study site?
  - What has the local Vanguard programme involved, and what is the underlying causal logic assumed?
  - What methods of co-ordination have been developed and used to support the change programme at both frontline and organisational level?
  - What has changed so far in service operation and delivery, and what further changes are planned?

- To what extent do local actors believe that new ways of doing things have been normalised?
- What outcomes are claimed?
- **RQ2:** What have been the drivers of change in this case study site?
  - What sources of authority (including national, regional and local levels) have been successfully mobilised, by whom and under what conditions?
  - What social skills have been used to support change, by whom, at which levels and under what conditions?
  - What has been the impact of exogenous factors originating at local, regional and national level?
- **RQ3:** Looking across the case study sites, what are the common factors at local, regional and national levels (including sources of authority, social skills and exogenous factors) underpinning (perceived) successful implementation of Vanguard change programmes, and what factors have prevented or hindered progress?
- **RQ4:** To what extent can particular claimed beneficial changes in outcomes be related to these factors?

### ***Theoretical framework***

The Strategic Action Field (SAF) framework (Moulton and Sandfort 2017) is a useful way of thinking about policy implementation, which takes account of the multiple levels which influence how a particular policy is implemented.

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

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

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

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

### ***Methods***

For this phase of the project, a qualitative case study approach was adopted to explore, in depth, the processes and experiences of participants directly involved in implementing and operating the Vanguard programme (2015-2018) at the local level. During the summer 2018, we selected six case-study sites, from the 50 New Care Models Vanguards that operated in England from 2015-2018, to study in depth and gain an understanding of their journey to devise and implement new models of care: two Multispecialty Community Providers (MCP) Vanguards, two Integrated Primary and Acute

Care Systems (PACS) Vanguard and two Enhanced Health in Care Homes (EHCH) Vanguard. We focused on these 3 model types to allow wider conclusions to be explored about the opportunities and challenges around the 3 approaches and to try to meaningfully inform the wider roll out of the Vanguard models. Choosing two case studies from each of these three Vanguard types gave us the best opportunity to explore different approaches whilst maintaining sufficient depth to provide meaningful explanations for what we saw. We made sure we have a reasonable geographical spread of Vanguards around England (2 North, 2 Midlands and 2 South), looked at progress to date and issues the Vanguards were trying to solve (informed by logic models and local evaluations).

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

## **Findings**

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

### **Programme of change**

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

- We found no clear pattern of differences between the three types of Vanguard. Whilst EHCH Vanguards differed slightly in their scope (focusing upon care home populations rather than the population at large) the types of initiative implemented in EHCHs were very similar to those introduced in the other types of Vanguard.
- Whilst a number of sites had a compelling over-arching narrative about what they were trying to achieve and the way in which they intended to achieve it, it is hard to distil from these anything which might, in the longer term, develop into a 'new model' of care which could be straightforwardly codified and implemented elsewhere. Each of the approaches developed in our sites were locally specific and built upon existing initiatives
- The Vanguard programme was generally perceived as providing an opportunity to obtain additional funding to support and build upon local initiatives which were seen as having potential. Better integration of all kinds (between primary, community and secondary care, between statutory and voluntary services, and between health and social care services) was, in all of our areas, seen as an obvious and desirable objective and the Vanguard programme was an opportunity to pursue this.
- Finally, all of our sites followed a similar trajectory, with the short term nature of the programme perceived as problematic. In the initial stages, the substantial additional funding provided was welcome and used to support a wide variety of initiatives. However, as we documented in our interim report (Checkland et al 2019), funding was not secure, with some sites not receiving funding for year two or year three, based upon performance metrics which had not been stated at the start. Moreover, whilst many of the initiatives were locally perceived as having been successful, few (if any) were cash-releasing, meaning that many had to be scaled back or stopped when the additional funding ended. Staff were appointed or seconded to support Vanguard initiatives, but once the funding ended many of these roles disappeared. Some initiatives were absorbed into 'business as usual', but many were not.

### **Perceptions of Vanguard outcomes and success**

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

- These largely centred on the benefits of working together across boundaries, with frequent references to increased trust.
- The processes associated with the Vanguard, particularly in the early stages, engendered a feeling of exceptionalism, in turn generating enthusiasm and engagement.
- The additional funding associated with Vanguards was very important, and this is particularly evidenced by the post-Vanguard trajectory in which many initiatives were abandoned and downgraded as the additional funding ended.
- Most initiatives represented incremental improvements in local procedures and approaches to care rather than anything which might be identified as a 'model' of care.
- We found very limited evidence of scaling or spreading of Vanguard initiatives. Where this did happen it was usually either limited individual schemes (such as the care home initiative designed to facilitate communication between hospitals and care homes) or regional spread of a service or service model (e.g. MSK services, MDTs). This type of spread was supported by the transfer of relevant staff to posts within STPs/ICSs, and it was hampered by the lack of additional funding.
- This limited evidence of spread of Vanguard initiatives contrasts sharply with the programme goals and with the ambitions set out in each areas' initial 'value propositions'.
- The exception to this rather limited picture of impact is the EHCH model, elements of which are to be rolled out via Primary Care networks<sup>1</sup>. This largely reflects the much more limited scope of the EHCH model, and the fact that care homes were relatively neglected in terms of health care initiatives prior to the Vanguard programme. However, it is important to note that even in our care home sites some of their initiatives were downgraded or ceased following the end of the Vanguard programme due to lack of funding. Additional funding is likely to be an important determinant of whether or not this initiative endures.

### **Drivers and enablers of change in case study sites**

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

#### Sources of authority

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

- Whilst the exact pattern of particular sources mobilised differed between our sites, all regarded the 'badge' of belonging to the national Vanguard programme as an important source of political authority, at least initially.
- All sites used an initial narrative focusing upon an economic crisis (often verbalised as a 'burning platform') as a source of authority to justify significant changes in local services, whilst additional funding was important both for its own sake and as a marker of esteem.
- The values underpinning the programme as a whole – including support for local innovation, focus on collaboration and emphasis on providing value to local populations - chimed clearly with the public service ethos present in all of our sites, and in all sites the programme carried a strong moral tone.

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<sup>1</sup> [https://www.engage.england.nhs.uk/survey/primary-care-networks-service-specifications/supporting\\_documents/Draft%20PCN%20Service%20Specifications%20December%202019.pdf](https://www.engage.england.nhs.uk/survey/primary-care-networks-service-specifications/supporting_documents/Draft%20PCN%20Service%20Specifications%20December%202019.pdf)

- New norms of collaboration were prominent as mobilised sources of authority, often contrasted against the ‘bad old’ norm of competition. However, existing NHS legislation could be problematic in this context, with procurement rules, for example, militating against collaboration at times.
- The use of data and data analysis as a source of authority was not necessarily expected, and carries with it an important ambiguity and tension between robust evaluation of actual impact versus demonstration of impact for local and national political purposes.
- What runs through all of our sources of authority was the local creation of a compelling story, containing many of these elements: the establishment of a sense of crisis and pressing need for change; a narrative about why this particular area had been singled out or was recognised as being ‘special’; a moral case for why this particular change was required; and a road map or vision as to what was going to be done.

### Social skills

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

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

### Exogenous shocks

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

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

Whilst the final end of the programme was clear from the outset, the cessation of the programme and cessation of funding were experienced as shocks by our case study sites, in part, perhaps,

because they anticipated that there would be some sort of follow on initiative. However, after the end of the programme the focus shifted to Integrated Care Systems, and there was no systematic attempt by NHS England to link ex-Vanguards into the ICS programme.

## ***Discussion and Conclusions***

### **Summary of findings**

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

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

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

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

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

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

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

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

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

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

### **Understanding major system change.**

We initially highlighted the insights into major system change provided by Best et al (2012) and Turner et al (2016b). In this section we explore these normative claims, and consider how our insights might modify or expand them. Turner et al suggest that: leadership requires system-wide authority to align stakeholders; feedback loops and other tools such as financial incentives are required; whilst history is important, such local contextual factors may limit the ability of a local area to learn lessons; stakeholder engagement needs to be broader than just clinicians; and there may be tensions between different stakeholders' interests.

We also found that each of our sites offered a complex and fluctuating picture of interwoven factors, including: individuals with particular positionality and agency; historical accretion and sedimentation of previous initiatives (Coleman et al., 2010) and locally specific structures and processes. Importantly, our study suggests that exactly what constitutes an important or relevant local contextual condition to be 'managed' may not be obvious until initial action has been taken. This is in keeping with the work of Weick (1995), who highlights the importance of action in allowing retrospective sensemaking about any given situation. The Vanguard programme interacted with this local complexity, supported by its associated political and economic authority, and its consonance with public service beliefs and values.

Our study therefore offers a further elucidation of the theories offered by Best et al (2012) and Turner et al. (2016) in two ways. Firstly, our study suggests certain aspects of local context which made the environment a receptive context for change (Hunter et al., 2015; Pettigrew et al., 1992). In particular, we found that having individuals championing change who had a significant history within a local area was helpful. Such individuals had garnered trust through previous roles and responsibilities, and were able to leverage that trust to support the Vanguard programme. Inevitably in any health and care system individuals will move between roles and across geographical areas, and it is often considered that mobility and experience of multiple roles is useful in advancing in a chosen career. However, our study also suggests that investing in staff in situ, valuing their longevity and their deep knowledge of a particular context may bring dividends, as such people can, if



engaged and involved, be powerful agents of change. Similarly our study suggests that the ability and willingness to seize opportunities was very important. This implies a system architecture which encourages local managers to be alert to potential opportunities and to feel empowered to act when such opportunities arise. This in turn suggests that a supportive approach to risk taking, in which performance management processes reward and encourage activity beyond narrow role specifications, may be valuable. Whilst in some ways the Vanguard programme was an unusual one (in particular it was unusually well-funded and supported), in others it was quite typical of health system policy programmes, in that it was announced with a very short timeframe for application and it grew out of previous similar initiatives. Our study suggests factors which may make systems more able to respond to such initiatives, including nurturing a stable cadre of engaged and knowledgeable staff, and setting up performance management and other systems which reward initiative and willingness to take calculated risks.

Secondly, our study suggests features of change programmes which may facilitate engagement. Turner et al (2016) highlight the need for 'system wide authority'; our study has shown the different types of authority that can be mobilised. Political and economic authority were very important, but so too was the authority arising out of the consonance between the beliefs and values embedded in the programme, and those common in public organisations and espoused by local actors. This consonance was a vital element in the Vanguard programme. Similarly, the strong supportive structures put in place – including the role of the account managers – were important in initiating and maintaining the programme, with meso-level encouragement and recognition from someone outside the local area seen as a very important element promoting engagement.

In summary, our study confirmed some of the findings of Turner et al (2016) but also elucidated some additional contextual factors which were important in supporting local change initiatives. We have also highlighted some features of the Vanguard programme which facilitated engagement.

### **Lessons for policy.**

Most Vanguards operated at a population scale of around 200-300,000. The NHS Long Term Plan (NHS England, 2019) designates this level as 'place' in the developing system, but provides no details as to what is envisaged as occurring at this level. Focus is now upon ICSs (covering 1-3 million population) and local 'neighbourhood' Primary Care Networks (PCN), covering populations of 30-50,000. Considering our case study findings, a number of lessons may be transferrable to these different levels. All of these factors may be equally as important at 'system' and 'neighbourhood' level as we found them to be at 'place':

- The value of a compelling narrative in establishing the nature of the problem and a case for change;
- The value of local knowledge and experience;
- The need for trust;
- The need for support for risk taking and flexibility in roles;
- The importance of finding a narrative that chimes with existing beliefs and values.

There may also be some issues in this transfer, arising out of the nature of the different levels. Our study suggests a need for a more considered transition from one policy to another. Lessons from the Vanguard programme may have been incorporated into the programme for Integrated Care Systems, and elements of the EHCH Vanguards are being explicitly rolled out via PCNs, but there does not appear to have been a systematic approach to such learning, at least in public. The Vanguard programme was well-funded, supported and evaluated, and it would be a missed opportunity if the rich experience gained in the programme was not used to support ongoing policy development.

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## 1 Chapter 1: Introduction

This report forms part of a wider evaluation of the National Vanguard programme, funded by the NIHR Policy Research Programme and taking place between 2017 and 2021. The aim of this national evaluation is to explore the implementation and impact of the Vanguard New Care Models programme. This study forms part of a wide-ranging evaluation for the programme, which incorporated internal evaluation by the NHS England Operational Research and Evaluation team, locally commissioned evaluations of each Vanguard as well as this independent evaluation. Our study was conceived as an evaluation of the programme as a whole – i.e. it was our intention to not only explore how local areas made changes, but also to understand in depth how the programme as a whole operated, including the national support programme which ran from April 2016-March 2018. We have focused throughout on understanding how national policy initiatives and local contextual conditions intersect, in order to explore more widely how national policy is interpreted and implemented locally and the factors that affect this. The focus was on the evaluation of the Vanguard programme as a whole, set against the original aims (testing new ways of working and developing models), not the individual interventions being introduced locally. This was the focus of the local evaluations commissioned by the 50 Vanguards (Wilson et al 2019). Our study is underpinned by an understanding of the policy literature, notably: the importance of history in determining how national policy is interpreted and implemented locally (Coleman et al., 2010; Pope et al., 2006); the interplay between ‘bottom up’ and ‘top down’ approaches to policy implementation (Barrett & Fudge, 1982; Matland, 1995); and the complexity in determining what constitutes policy ‘success’ in any given situation (Marsh & McConnell, 2010; McConnell, 2010).

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

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

It is the third phase of the study we are reporting here. We have used qualitative case study methods in order to explore in depth the factors that affect whether and how local initiatives are implemented in response to national policy. Our initial conceptualisation of the Vanguard programme acknowledged that the programme included and required action at three levels: national (macro) level, at which policy is made and support is orchestrated; meso level, at which Vanguard initiatives must compete for attention and implementation effort with other initiatives across a local health and social care economy; and micro level, where local actors must interpret policy and adapt it to their local context. It is important for future policy initiatives that we understand how national policy, regional priorities and local context combine together to generate specific local activity, and it is this that is addressed in this report. We therefore adopted a theoretical framework (the Strategic Action Field [SAF] framework, see Chapter 3 p18) designed to interrogate these three levels, acknowledging the fact that:

*‘...implementation actors—be they policymakers, public managers, service providers, funders, or direct service staff— work within bounded social settings. They employ social skill to interpret and adjust a public service intervention in ways that build common understanding and reconcile competing sources of authority to enable collective action. Different social dynamics across Strategic Action Fields lead to variations in how*

*interventions are brought into practice, which, in turn, can contribute to variations in the outcomes in the system and for the target population. (Moulton & Sandfort, 2017 p145)*

In this report we use this framework to explore in depth the experience of local Vanguard areas as they sought to implement new ways of providing services for their populations. Our data collection occurred at the end of the Vanguard programme, allowing us to both look back at what had been achieved and the factors which had influenced this, but also to explore what happened next. We have also considered the question of what 'success' for the Vanguard programme might constitute. As we have previously discussed (Checkland et al., 2019) the programme was initially intended as a pilot programme, which would result in the generation of 'standard approaches and products' (NHS England, 2015 p4) which it was intended would subsequently support the rapid roll out of new approaches to providing integrated care to populations. However, as we documented in our earlier report, this development of clearly defined 'new care models' which could straightforwardly be rolled out elsewhere did not happen. Moreover, the Vanguard programme itself was, in its latter stages, somewhat over-shadowed by the development of Sustainability and Transformation Partnerships (STPs) and subsequently Integrated Care Systems, covering populations of 1-3 million (Checkland et al., 2019, Coleman et al. 2020). These larger-scale partnerships are intended to offer a framework within which large scale commissioners and providers can work together to develop more integrated approaches to care provision. Meanwhile, at more local levels Primary Care Networks (PCNs) are being developed, covering populations of 30-50,000 and providing a nucleus around which local community service and other providers will begin to collaborate and work together more effectively (NHS England, 2019). Vanguards typically fall between these two geographical scales, operating across populations of 2-300,000. Whilst the Vanguard programme is explicitly referenced within the NHS Long Term Plan as providing 'tests' of alternative models which underpin the development of these new initiatives (NHS England, 2019 p13), it remains unclear exactly what this means, or how lessons learned from the Vanguard programme have been incorporated into the ongoing plans for the developing system.

Our report thus focuses on the operation of Vanguards within their specific social settings, using the Strategic Action Field framework as a lens to, for example, explore how socially skilled actors mobilised support and accomplished change, alongside a broader analysis of whether and how Vanguard initiatives have developed and informed wider system change following the end of the programme. From this we attempt to draw some lessons for large scale policy-driven system change more generally. This report does not focus upon quantitative outcomes associated with the Vanguard programme. These will be addressed in a later report, as well as in academic papers in preparation.

What follows is divided into 5 chapters. Firstly we set out a brief overview of the Vanguard programme and summarise our research to date. Next we explain our theoretical framework, before describing the methods used in this part of the study, including our research questions. We then set out our findings, addressing each research question in turn and considering the different elements of the Strategic Action Field framework. We finish with a discussion section which pulls together our findings and considers what might be the broader lessons for policy-driven change programmes.

## 2 Chapter 2: The Vanguard programme

### 2.1 Introduction and background

The Five Year Forward View (FYFV) (NHS England, 2014) described a vision for the future development of the NHS focussing upon new ways of working to improve care delivery rather than upon structures, aiming to break down barriers between different organisations and care sectors. It was suggested that Vanguards would 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 repeated elsewhere.

The FYFV also backed “diverse solutions and local leadership” and at the national level developments were to take place to facilitate the emerging policy environment and support Vanguard teams. According to Turner et al (2016a p1) “the strategy for introducing NCMs was simultaneously driven by the pressure to contain costs, improve care and deliver services closer to home through integrated models”.

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

**Table 1: Types of Vanguard**

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

Our initial study identified the following goals underlying the Vanguard programme (see Checkland et al 2019, chapter 3):

- To test out approaches to integrating care across organisational boundaries;
- To test out approaches to implementing these new ways of working, including overcoming relevant barriers and exploring ways of supporting innovative activity;

- To use the learning derived from the development of the models to develop replicable care design frameworks and ‘standard approaches and products’ which could then be adopted by other areas;
- To use the learning from the implementation of the models to develop common approaches to implementation that could themselves be spread alongside the developed models.

In addition, and in order to support the implementation of and learning from the 50 Vanguards, an extensive support programme was established, led by NHS England. This support included an evaluation programme, of which this study forms part (see Checkland et al 2019 Chapter 4 p40-56 and Appendix A).

## **2.2 Our research to date**

Commissioned by the NIHR Policy Research Programme 2015-2021, our study aimed to investigate the effects of the Vanguard programme on the NHS, including its local organisations, wider partnerships and service users. We have focused largely on PACS, MCPs and EHCHs. There are three over-arching objectives:

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

As mentioned in chapter 1, our evaluation consisted of four phases commencing with an initial scoping phase followed by a synthesis of the findings from local evaluations. A third phase of primary data collection uses case study methods to explore in depth the experiences and outcomes of a sample of Vanguards, alongside a national evaluation of outcomes. A final phase will synthesise the findings. Alongside the case study phase set out in this report, we have carried out the following:

### **Scoping**

For this initial phase we started the process of synthesising available information, and initiated the development of a database which has been providing a dynamic resource for subsequent phases. This allowed us to identify commonalities between different Vanguards, and begin the process of making comparisons and establishing important themes to be followed up in more detail through the remaining phases.

### **Understanding the national and regional context**

The aim of this phase was twofold: to understand in more detail the development of, intentions underlying and activities associated with the national support programme; and to understand the way in which national regulators have engaged with the Vanguard programme.

From our national (reported in Checkland et al 2019, Billings et al 2019, Coleman et al 2020) and regional (Laverty et al 2019) level interview accounts during 2017/18 we built an overarching narrative of how the programme was developed and operated, identifying the different elements such as enabling streams, logic modelling and evaluation. We then considered what had worked well (facilitators) and not so well (obstacles) across the support programme. Finally we conducted an in-depth analysis highlighting cross-cutting themes identified in the data gathered – this is summarised in our previous executive summary (see Appendix A).

### **Evidence synthesis**

Each Vanguard was funded and required to commission a local evaluation of their work. We conducted an evidence synthesis of these evaluations (Wilson et al., 2019) alongside interviews with a sample of evaluation leads to assess the commissioning, impact and findings of the locally commissioned evaluations. The synthesis summarised a significant grey literature of 108 local evaluation reports. This review represents the only comprehensive mapping of what was commissioned and conducted and may serve as a key resource for researchers and policy makers, both within the NHS and internationally.

### **Early quantitative analysis**

Our initial project proposal included a modelling phase to explore what impacts might be expected from the programme. However, we were able to obtain early access to outcome data, and so instead conducted an econometric evaluation of outcomes associated with the programme. We demonstrated a modest slowing of the growth of emergency admission rates in Vanguard sites, occurring in year three and mainly concentrated in the Care Home Vanguards. These findings have been submitted to an academic journal for publication.

Refer to Appendix B for diagrammatic representation.

### **Research findings from early phases of the research**

Those we interviewed, at the national level in 2017/18, praised the support programme for being genuinely 'bottom up' and facilitative, with the generation of significant local engagement and enthusiasm frequently remarked upon. However, senior managers acknowledged that the aspiration to generate replicable 'models' of care which could straightforwardly be 'spread' more widely was not achieved. At the time of writing our previous report (Checkland et al 2019), no contracts had been let to new forms of provider organisation based upon new care models.

Our work with national level informants (Checkland et al. 2019, Coleman et al 2020) suggested a number of lessons for future policy implementation, as well as some issues which required following up at local level in order to understand in more depth how they were experienced (See Appendix A). In relation to policy implementation design, when the desired outcomes are unclear, we suggested a more cautious approach would be helpful. This could include an initial assessment of relevant evidence relating to proposed interventions alongside subsequent careful assessment of how far particular service interventions have been beneficial, with what would be most likely to yield products to support wider roll out as outputs. However, we also cautioned that this approach would not have been compatible with the desire to rapidly demonstrate progress.

From our work at the macro (Checkland et al. 2019, Wilson et al. 2019) and meso levels (Lavery et al 2019) we concluded that: the programme had failed to develop distinct 'new models of care'; that the rapid shift to the next new policy (in this case STPs and ICSs) resulted in a failure to engage fully with the lessons emerging from NCM (Vanguards); and the speed of the programme and premature ending were potentially problematic (Billings et al. 2019).

In terms of the local evaluations, we concluded that a significant amount of money was spent on commissioning and conducting multiple local evaluations, but each was relatively small scale and context specific. We suggest that future evaluations of large scale service change should continue to consider multi-faceted strategies but perhaps with less prescription of what should be explored in depth at the local level.



### **2.3 Summary**

From our analysis so far, we conclude that the Vanguard programme was a complex, multi-faceted and well-funded policy pilot programme. The initial phases of our study explored in depth the macro-level of policy implementation, exploring the programme goals, the infrastructure put in place to meet those goals and the extent to which they had been realised. From this, we drew out a number of lessons and issues relevant to policy implementation and have reported these. These early phases of research also highlighted an important tension: the programme explicitly embraced a permissive approach which aimed to foster bottom up learning and development, and this was important in engendering enthusiasm and engagement. However, it also made the intended goal of developing standard models and templates, which could be spread elsewhere, more difficult to achieve and caused considerable difficulty for local actors in defining what each Vanguard was actually doing and accomplishing.

Whilst the Vanguard programme itself has ended, ongoing NHS policy, including the NHS Long Term Plan (NHS England, 2019), requires local areas to work in ways consonant with the principles underlying the Vanguard programme. This includes working across geographical areas to manage the health of populations; collaborating across boundaries between primary, secondary, community and social care; and facilitating multidisciplinary approaches to patient care. It is therefore important to understand how changes were made by Vanguards, the factors which supported them and the things which made change difficult to achieve, as these will continue to be relevant as the Long Term Plan is implemented.

To explore these issues further, we undertook case studies in six Vanguards. In the following sections of this report we set out the theoretical approach that we took in these case studies, the methods we used and our findings. We then bring these findings together in order to offer more general insights into the implementation of integrated care approaches.

## 3 Chapter 3: Theoretical Framework

### 3.1 Understanding large scale system change

The Vanguard programme was a multifaceted and multi-layered programme which was a flagship policy programme for the NHS as set out in the Five Year Forward View (NHS England 2014). Local action and programmes were therefore lent authority by their association with this formal policy driver, as well as being underpinned by supportive activity at both national and regional levels. Vanguard pilots were set up to cover significant geographical populations and required collaboration across a broad range of organisations, including CCGs, primary, secondary and community service providers and Local Authorities. New services were introduced, new governance and co-ordination structures were set up and improvements in population health and system efficiency were expected. The programme thus fits the definition given by Best et al of what they call ‘large system transformation’:

*Large-system transformations in health care are interventions aimed at coordinated, system wide change affecting multiple organizations and care providers, with the goal of significant improvements in the efficiency of health care delivery, the quality of patient care, and population-level patient outcomes (Best et al., 2012 p421)*

In exploring the operation and impacts of the programme at local level we therefore required a theoretical framework which would allow us to understand not only the local issues affecting the ability of local actors to initiate and sustain change, but also how national and regional support and policy drivers interacted with local context.

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

- Blend designated leadership (i.e. formal leadership) with distributed leadership (i.e. opportunities for individuals to take ownership of aspects of a programme);
- Establish feedback loops;
- Attend to history;
- Engage physicians;
- Include patients and families.

They emphasised that the operation of each of these rules is context dependent, such that it will never be possible to identify ‘one best way’ to implement large scale change. However, they suggest some relevant ‘mechanisms’ underpinning each of these rules which may operate in different contexts. This framework is largely focused at what we have called the ‘micro’ level: i.e. the factors within local health systems which support or inhibit change occurring. Turner et al (2016) later applied Best et al’s (2012) framework to a study of large scale system change in the UK (implementation of new models for stroke care in the NHS in London and Manchester). They concluded that Best et al’s framework is of value in understanding such programmes, but suggest a number of ‘adaptations’ to their rules. See Table 2 below.

**Table 2: Rules for major system change in health services (adapted from Turner et al 2016)**

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

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

Neither the Best et al (2012) nor Turner et al (2016) frameworks take account of the macro level which includes national policy objectives, and the architecture established to implement that policy, alongside the broader context within which other (potentially competing) policy objectives are embodied in and pursued by organisations with statutory authority and duties. Such factors are often conceptualised as constituting a static or background 'context' within which local actors operate; it is our contention that this is unhelpful, as it denies the dynamic and changing nature of policy, and fails to take account of the fact that national policy and local implementation continually interact and influence one another (Ettelt et al., 2014, Checkland et al., 2019). Therefore, for our research we have explored these interacting levels: macro level, including the policy, the implementation support programme and the national regulatory/legislative framework (See Checkland et al 2019); meso level, including the interactions across local health economies & STPs / ICSs; and the micro level, including the implementation of specific interventions in a specific locality (See Laverty et al 2019).

In order to understand these complex and interacting levels, we required a more detailed theoretical approach which went beyond the descriptive summary provided by both Best et al (2012) and Turner et al (2016) to understand the mechanisms by which the posited 'rules' may act. In particular this requires a theoretical lens which provides insight into the operation of the concepts raised by the framework. For example, Turner et al raise the question of political authority, and suggest that this may be required to support changes to the status quo. However, their framework provides no

tools beyond the descriptive to understand how such authority might be garnered or used. Similarly, they highlight mechanisms to support behaviour change such as incentives, but do not provide insight into how different mechanisms might be required in different contexts and how leaders might make decisions between potential mechanisms. In the next section we set out the rationale for choosing the Strategic Action Field framework posited by Moulton and Sandfort (2017) as our chosen approach.

### **3.2 Understanding local action in a wider context**

Both Best et al (2012) and Turner et al (2016) provide valuable descriptive summaries of the factors which may operate when local systems seek to implement significant changes to services. Such descriptive analyses are of value in supporting local leaders by drawing attention to the factors which could usefully be considered when initiating change programmes. However, in order to understand the complex interactions seen in the Vanguard programme between national policy, regional context and local action, other theoretical tools are required. In particular, it is necessary to be able to interrogate the mechanisms by which the agency of local actors is enabled or constrained, and explore how and why factors which are decisive in one context fail to generate change in an apparently similar context.

To some extent these questions raise the most fundamental sociological issues related to the interaction between structure and agency. A neo-institutional lens would focus upon the institutional structures of rules, norms and beliefs and cultural-cognitive frames which constrain or enable particular courses of action (W. R. Scott, 2008b). However, as Archer (2005; 2000) has explored, such analyses tend to neglect or downplay the possibility that particular actors, at particular moments in time, may act in ways which go beyond the institutional constraints to which they are subject. Leadership studies (Day et al., 2014) have sought to address this by considering and researching the particular traits and modes of behaviour which enable individuals to act in these ways, and both Best et al and Turner et al highlight aspects of leadership as being of importance. However, our focus is upon the interaction between structures in their broadest sense – including local, institutionally derived constraints and wider national-level contextual conditions – and the local action required to achieve change. Whilst leaders and leadership may be of importance, the shift in leadership studies towards more inclusive concepts such as ‘distributed’ leadership (Fitzgerald et al., 2013) highlights the poverty of explanations which posit heroic action by individuals in any given situation. Sensemaking (Weick, 1995, 2001) provides a slightly different lens through which to view organisational change, highlighting the collective social interactions by which organisational actors appreciate, understand and act within their particular environment. Of importance here is the influence of previous experiences on how new information is understood, and the importance of action in generating new understandings which may transcend institutionally entrenched ways of viewing the world.

In considering how to explore and understand the ways in which the Vanguard programme was appreciated and responded to by local actors we therefore sought a theoretical approach which would allow us to explore the local institutional context within which change was occurring, the ways in which local actors responded to the imperative to change within their particular institutional context and the broader institutional framing of the programme. In this case that framing included its importance as a ‘flagship’ national programme, supported by significant funding and a well-funded support structure. Sensitised by our understanding that collective sensemaking requires and feeds upon action (Weick, 2003), we sought a framework which took action seriously, including its antecedents and its effects.

Moulton and Sandfort (2017) suggest a framework for understanding policy implementation which brings together institutional understandings of context and a focus on social action. They derive their framework from the work of Fligstein and McAdam (2011) on strategic action fields. This work posits the construction of a meso-level social order between organisational units, and argues that this constitutes a 'field' within which competing (or collaborating) organisations jostle or negotiate for position, resources or even survival. This framework has been used extensively to explore inter-organisational relationships across a variety of sectors. For example, Chen (2018) explores how competing non-profit making organisations respond to exogenous shocks, suggesting that such organisations are more likely to focus upon meaning making and positioning amongst peer-organisations than to challenge the source of threat. Raaphorst and Loyens (2018) use Fligstein and McAdam's framework to shed light on the social dynamics between public sector actors in organisations charged with moving from a competitive to a collaborative approach to their work, highlighting the concrete mechanisms by which front-line workers negotiate the challenge of collaborative working across professional boundaries. The essential insight here is that, whilst neo-institutionalist approaches (Di Maggio & Powell, 1983; Scott, 2008a,b; Scott & Christensen, 1995) can explain much about observed patterns of organisational change, the specific response within any given organisation will depend, to some extent, upon the agency of individual actors, albeit constrained and shaped by institutional field-level forces. Regulatory, normative and cultural/cognitive institutional 'pillars' (W. R. Scott, 2008b) act upon individuals and groups who individually and collectively 'make sense' of what is happening via social processes (Weick et al., 2005).

Moulton and Sandfort (Moulton & Sandfort, 2017; Sandfort & Moulton, 2019) apply this insight to policy implementation, developing a framework which, they argue, is '*able to encompass multiple theoretical perspectives, including complexity theories, organisational theories, economic theories, and theories of human behaviour*' (Moulton and Sandfort 2017 p144). They suggest that implementation occurs in systems:

*We conceptualize these systems as multilevel strategic action fields (SAFs) that form around a public service intervention. Rather than starting with a formal policy (Gormley, 1986; Ingram & Schneider, 1990; Matland, 1995; Mazmanian & Sabatier, 1989; Pressman & Wildavsky, 1984), a policy problem (Elmore, 1980; Hjern & Porter, 1981), or institutional setting (Berman, 1981; Lipsky, 1980; Milward & Provan, 1998; Selznick, 1949), our approach begins with a public service intervention—investigating how ideas about creating change in the target population are institutionalized into a set of processes and methods of coordination purposively intended to bring about that change.(Moulton & Sandfort, 2017 p144)*

They explicitly reference structuration theory (Giddens, 1990), and highlight the importance of change over time, arguing that:

*Human agency in changing structures is simultaneously informed by the past (observing what was viable), oriented toward the present (understanding current conditions), and anticipating the future (imagining alternative possibilities). (Jodi Sandfort & Moulton, 2019 p7)*

Sandfort and Moulton (2015) have previously used the metaphor of water running through a natural three-layered water filtration system to illustrate how a new policy or public service innovation flows through a multi-level system during its implementation process (Høiland & Willumsen, 2016). Elements of the system include: a policy field at the macro-level, consisting of a bounded network of organisations carrying out the particular policy; an organisational field at the meso-level, where the

policy is authorised and operationalised; and a front-level field consisting of the micro-level where the implementation system interacts with the target group to carry out the innovation, specifically through the front-line staff in their everyday practices and interactions. According to Sandfort and Moulton (2015) there are unique social structures at each level which work like filters and shape the innovation as it passes through. This fits well with our conception of the Vanguard programme, with local action shaped by local, regional and national-level action.

One of the concepts used in the framework is the 'socially skilled actor'. This provides a more nuanced and theoretically interesting approach than simply focusing upon 'relationships' and 'leadership', as it opens up concrete questions about how relationships are developed and what leaders actually do.

*In our framework, implementation actors—be they policymakers, public managers, service providers, funders, or direct service staff— work within bounded social settings. They employ social skill to interpret and adjust a public service intervention in ways that build common understanding and reconcile competing sources of authority to enable collective action. Different social dynamics across SAFs lead to variations in how interventions are brought into practice, which, in turn, can contribute to variations in the outcomes in the system and for the target population. (Moulton & Sandfort, 2017 p145)*

The ontological assumption underlying the framework comes from symbolic interactionism, and holds that humans seek meaning and identity construction in social interactions. 'Social skill' is defined as: "the ability [of an actor] to induce cooperation by appealing to and helping to create shared meanings and collective identities" (Fligstein & McAdam, 2012, p. 46, Moulton & Sandfort, 2017 p146). Moulton and Sandfort posit that, whilst change can be initiated and induced by exogenous 'shocks', such shocks will be interpreted and framed by existing local actors. Hence, the outcome of such things is unpredictable and locally specific.

They go on to apply this framework specifically to the implementation of public service interventions. Their first useful enhancement is to argue that examining implementation of any public service intervention requires that intervention to be defined. This is obviously, difficult – as shown by the difficulty both local actors and our research team (in phase one of the study) had in defining what each Vanguard is actually doing. Moulton and Sandfort overcome this difficulty by specifying four elements which define any intervention. These are set out in **Table 3** below.

**Table 3: Elements of interventions (adapted from Moulton and Sandfort 2014)**

Element	Definition	Potential example in Vanguards
Processes of change	What is to be changed, and what is the underlying causal logic assumed?	Logic models setting out local programme of change
Methods of co-ordination	What tools are used to implement the particular local processes?	Funding models used to support MDTs, the co-location of services etc.
Changes implemented	What new processes are put in place, and do they become normalised/routinised?	Successful implementation of new services
Changes to outcomes	What changes do target group experience?	Improved outcomes associated with new services

The key assumption in this framework is that the same initiative implemented in two different places will vary according to the local SAF framework, because the change will be interpreted differently by those involved. Thus, for example in the context of new care models, a multi-disciplinary team (MDT) in site 1 might look quite different to one in site 2 because of differences in both what is seen as normal or acceptable and what is available, or GPs in one area might refuse to attend without being paid whilst GPs in another area might see it as an important facet of their job. How an MDT is enacted will therefore arise out of the complex interactions locally, including the behaviour of skilled actors trying to make the change happen. This suggests a uniqueness in local conditions and implementation which in turn makes knowledge transfer and spread/scale of such initiatives extremely difficult, suggesting that ‘standard approaches and products’ (NHS England, 2015 p4) will always be difficult to develop.

The next stage is to focus upon the different scales. The SAF framework assumes three broad scales as being relevant – national policy, inter-organisational, including the interaction with other policies across an area, and front-line enactment – the changes which are actually implemented. The argument is that local implementation will be shaped by the interaction between things happening at each of these levels. For example, national policy guidance might be interpreted locally in specific ways, with regional authorities providing specific incentives or support. On the other hand, locally specific conditions and history might mean that particular interventions have more or less local traction, or require local adaptation.

Finally, the framework identifies three categories of factors which are called ‘drivers of change or stability’. These are:

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

On ‘sources of authority’, they argue that:

*Within the SAF framework offered here, it is the role of actors with social skill to activate, resolve, and interpret signals from diverse sources of authority to create collective understanding for action around the public service intervention. (p154).*

They identify four broad categories of sources of authority:

- Political authority - Political authority defines what is legally permissible, establishes mandated processes, stipulates which public institutions are vested with legal responsibilities, and delineates hierarchical governance relationships between fields;

- Economic authority – incentives, contracts, payments;
- Norms – appeals to ‘best practice’ or training offered to make particular changes;
- Beliefs & Values – shared cognitive beliefs about what should happen, what will be effective etc. – often informed by past experiences.

Sources of authority appear as rationales to act, with individuals saying, for example, ‘we did this because...’. However, it is important to understand that sources of authority are not objective – they are mobilised in particular ways in particular settings – and exactly which are mobilised in what way will depend upon the characteristics of the field. This provides a theoretical explanation for the observation that supposedly objective rules are interpreted differently in different areas Allen et al 2017

Moulton and Sandfort (2017) suggest that social skills, as defined above, help to answer the question ‘what sources of authority get activated’ – they offer interpretations, frame issues etc. in order to ‘make sense’ of complexity in fields. Socially skilled actors are boundary spanners, interpreters and mobilisers. Relationships will be relevant, as groups of actors who know each other well and have worked together will have developed collective interpretations which then support them in mobilising/using particular sources of authority. ‘Leaders’ are the socially skilled actors, but this framework moves beyond the truism that sustained change requires ‘strong leadership’ to ask ‘what did the leaders do in this particular situation?’. Moreover, it enables a deeper interrogation of Best et al’s (2012) injunction to ‘blend designated and distributed leadership’, suggesting that ‘leaders’ of all kinds must be able to mobilise sources of authority in a skilled way, with position (i.e. designated leadership) interacting with individual skills to support or inhibit the exercise of that leadership.

Exogenous shocks form the final building block in the framework. Essentially it is argued that exogenous shocks – such as the creation of the New Care Models programme, an economic crisis, legislative change reorganising the system – will be interpreted and utilised in locally specific ways.

Putting it all together, Moulton and Sandfort argue that:

*Field actors utilize social skill to re-frame what is perceived to be legitimate practice for public service interventions, leveraging existing authority sources in new ways, facilitating the creation of additional sources of authority, or capitalizing on exogenous shocks to create new authority for action (Moulton & Sandfort, 2017 p156).*

This framework has been used in policy studies, with, for example, Hoiland and Willumsen (2016) using the SAF to explore the implementation of a work inclusion policy in Norway. They argue that, in order to understand the outcome of implementation in different contexts it is necessary to understand both the contextual conditions at multiple levels within the system and the ‘practical everyday work situations’ (p2) of front-line workers charged with implementation. Similarly, Stanczyk et al (2018) explore the variable implementation of welfare reform in California, using the SAF to understand in more depth how different local areas made decisions about how to implement the policy.



### **3.3 Applying the SAF to the Vanguard new care models programme**

In our original project proposal we posed three general research questions for the case study phase of the research:

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

RQ2: How do Vanguards interact with other policy initiatives such as Integration Pioneers and Sustainability and Transformation Partnerships/Integrated Care Systems?

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

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

RQ1: What is the programme of change in this case study site?

- What has the local Vanguard programme involved, and what is the underlying causal logic assumed?
- What methods of co-ordination have been developed and used to support the change programme at both frontline and organisational level?
- What has changed so far in service operation and delivery, and what further changes are planned?
- To what extent do local actors believe that new ways of doing things have been normalised?
- What outcomes are claimed?

RQ2: What have been the drivers of change in this case study site?

- What sources of authority (including national, regional and local levels) have been successfully mobilised, by whom and under what conditions?
- What social skills have been used to support change, by whom, at which levels and under what conditions?
- What has been the impact of exogenous factors originating at local, regional and national level?

RQ3: Looking across the case study sites, what are the common factors at local, regional and national levels (including sources of authority, social skills and exogenous factors) underpinning (perceived) successful implementation of Vanguard change programmes, and what factors have prevented or hindered progress?

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

### **3.4 Summary**

The Strategic Action Field (SAF) framework (Moulton and Sandfort 2017) is a useful way of thinking about policy implementation, which takes account of the multiple levels which influence how a

particular policy is implemented. It also allows us to move beyond the need for 'good leadership' to explore, via the concept of 'socially skilled actors', exactly what is done by whom in making change happen. However, the framework as devised by Moulton and Sandfort focuses upon the implementation of defined interventions. The Vanguard programme, by contrast, comprised a suite of ill-defined interventions, different across the different Vanguard 'model' types (MCP, PACS, EHCH). We will therefore apply the SAF framework to our Vanguard case study sites, and then reflect upon if and how it might need to be modified to understand policy-driven system change where interventions are not necessarily well defined. In our final discussion we will consider the SAF framework in the light of the broader literature relating to major system change, and consider how insights from the framework might align with or further elucidate the 'rules' for major system change proposed by Best et al (2012) and Turner et al (2016).

## 4 Case Study Methods

### 4.1 Study design

A qualitative case study approach was adopted to explore, in depth, the processes and experiences of participants directly involved in implementing and operating the Vanguard programme (2015-2018) at the local level. The focus was on the evaluation of the Vanguard programme as a whole, set against the original aims, not the individual interventions being introduced locally. During the summer 2018, we selected six case-study sites, from the 50 New Care Models Vanguard that operated in England from 2015-2018, to study in depth and gain an understanding of their journey to devise and implement new models of care: two Multispecialty Community Providers (MCP) Vanguard, two Integrated Primary and Acute Care Systems (PACS) Vanguard and two Enhanced Health in Care Homes (ECH) Vanguard. We focused on the 3 model types to allow wider conclusions to be explored about the opportunities and challenges around the 3 approaches and to try to meaningfully inform the wider roll out of the Vanguard models. Thus, for example, we were able to explore approaches to primary care engagement across the three types of Vanguard, drawing wider conclusions relevant to all community-based interventions. Choosing two case studies from each of these three Vanguard types gave us the best opportunity to explore different approaches whilst maintaining sufficient depth to provide meaningful explanations for what we saw (Segar *et al.*, 2015). In addition we made sure we have a reasonable geographical spread of Vanguard around England (2 North, 2 Midlands and 2 South) and looked at progress to date and issues the Vanguard were trying to solve (informed by logic models and local evaluations). Urgent and Emergency Care and Acute Care Collaboration Vanguard were excluded due to their very different focus (Emergency / acute care) and are covered in other work within the wider research.

Between October 2018 and July 2019, the research team carried out a series of focus groups and interviews with a variety of respondents at six case study sites. Interviews were a mix of face-to-face or telephone: most on a one to one basis, but at several sites joint interviews conducted with 2 participants were also included. Four focus groups were conducted face-to-face and facilitated by at least one researcher: two of these involved professionals and were conducted at the outset; and two involved PPI contributors (including professional, voluntary sector and public members) and were conducted at the conclusion. Group size ranged from 3-8 participants (see Table 4). We were led by the sites given their preferences to undertake either an initial FGD plus interviews vs a series of interviews. Two sites (2 and 5) choose to participate in an initial group discussion for professionals providing a broad overview of views. The two sites where PPI contributors were involved (again 2 and 5) had established PPI groups who preferred to speak to the researchers as a group rather than as individuals. This was accommodated into our data collection.

A total of 80 respondents participated at these Vanguard sites, including current and past representatives from Clinical Commissioning Groups (CCG) provider organisations, local authorities, voluntary sector organisations, Vanguard programme leads, frontline staff and patient/public contributors. 1 NHS employee participated in both an interview and a focus group.

**Table 4: Case study respondents**

<b>Respondent type</b>	<b>Numbers interviewed</b>	<b>Numbers in focus groups</b>
NHS employees (current / past)	48	14
Local Authority	4	-
Private/Community/Charity sector	9	1
Public contributor	1	4

Separate interview/focus group topic guides were developed for different groups of respondents (initial key informants, professionals/managerial, frontline staff and those involved with patient and public involvement (staff and public)). Each was semi-structured and used to guide conversations, enabling respondents to share their unique stories and experiences, which helped to understand the different roles and responsibilities, key influences and implementation of the programme over time. The relatively small number of Local Authorities is a reflection of the fact that, notwithstanding the formal commitment within the Vanguard programme to integration between health and social care, in practice in our sites there was very little formal involvement of Local Authorities.

Focus groups and interviews were recorded and transcribed verbatim, followed by a thematic analysis using a coding schedule developed by the team based on previous literature and our previous work on Vanguards (Checkland et al 2019) using NVivo software. Broad thematic themes included: Establishment (history, relationships, organisational roles etc.); Vanguard substance (services, change over time, scale etc.); Implementation (narrative, regulation, facilitators / obstacles, permissiveness etc.); Funding (national, local, timing, allocation rules etc.); Performance (local / national metrics, local evaluations, logic models etc.); Next steps (scale and spread, STPs/ICSs, funding etc.); and the SAF framework (sources of authority, social skills, exogenous shocks etc.). To preserve anonymity, each respondent was given a unique ID number. Ethics approval for this evaluation was obtained from the University of Manchester (Approval Number: 2018-4359-6573).

As set out in the previous section, we addressed four groups of research questions:

RQ1: What is the programme of change in this case study site?

- What has the local Vanguard programme involved, and what is the underlying causal logic assumed?
- What methods of co-ordination have been developed and used to support the change programme at both frontline and organisational level?
- What has changed so far in service operation and delivery, and what further changes are planned?
- To what extent do local actors believe that new ways of doing things have been normalised?
- What outcomes are claimed?

RQ2: What have been the drivers of change in this case study site?

- What sources of authority (including national, regional and local levels) have been successfully mobilised, by whom and under what conditions?

- What social skills have been used to support change, by whom, at which levels and under what conditions?
- What has been the impact of exogenous factors originating at local, regional and national level?

RQ3: Looking across the case study sites, what are the common factors at local, regional and national levels (including sources of authority, social skills and exogenous factors) underpinning (perceived) successful implementation of Vanguard change programmes, and what factors have prevented or hindered progress?

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

These questions informed our topic guides and guided our analysis.

## **4.2 Sampling criteria**

Taking a pragmatic approach, we purposely selected and recruited six case study sites from the 50 New Care Models Vanguards that operated in England from 2015-2018. We invited examples of each type of Vanguard (MCPs, PACS and ECH) to participate until we had recruited two of each, ensuring a geographical spread across England, which we felt could represent the contrasting sizes, experiences and potential across the Vanguard programme – as identified and informed by published data and intelligence from NHSE. We used a systematic approach whereby two of the research team (AC / JB) contacted potential sites, initially via email, to identify relevant individuals to speak to; conducted telephone recruitment conversations; and made site agreements with these. Formal recruitment was completed via initial focus group discussions (sites 2 and 5) or via face-to-face interviews with key informant(s) (sites 1, 3, 4 and 6). These helped to identify key individuals to speak to within each site, while snowballing from interviews helped to identify further potential participants. Further details can be found in the account of programme section.

## **4.3 Summary of site characteristics**

In this study we felt and agreed with the Ethics Committee that anonymity of both sites and individuals was important in allowing our respondents to be candid in their assessments of what went well and of what might have been problematic. In this description we are concerned to provide enough detail to allow readers to understand the nature of the sites we explored whilst at the same time preserving anonymity. We therefore only provide ranges for population sizes and have not identified the geographical locations of the sites.

**Site 1** was a MCP Vanguard that was formed to serve a total population of approximately 150-200,000. This was a provider led Vanguard, with Clinical Commissioning Group (CCG) involvement. It was considered important that GPs led the Vanguard as they were regarded as a powerful change agent. A previous initiative of collaborative networks of GPs provided the basis for the development of five operational centres all of very different character – urban, rural, small and large practices. Each one served a different geographical location and different local context to provide a range of community based services.

**Site 2** was a MCP Vanguard that was led by the CCG and driven by a partnership board of different stakeholders. It served a population of 300-350,000. Evolving from a system wide organisational development, it was supported by a very strong belief in the primary care led model and a deep

commitment to the local area. A portion of the Vanguard funding was invested in new services and the augmentation and/or alteration of existing ones while the remainder focussed on administrative changes.

**Site 3** was an EHCH Vanguard that developed from the existing inter-organisational work of a CCG and associated partners. Together, the partners served a population of 150-200,000. This included around more than 50 care homes, of which more than half were small learning disability homes. The rest were a mixture of residential and nursing homes, with nursing homes forming a slight majority. Initiatives centred around three work streams: quality assurance and safety (including interpretation of data and developing policies and procedures); care staff education and training; and integration. Some interventions were applied across all home types, while others were specific to a particular type of home (residential, nursing, learning disability etc.).

**Site 4** was an EHCH Vanguard that began as a loose provider alliance model, moving later into a new care model provider board. This served a population of 350-400,000 people. The Vanguard did not cover all care homes, with additional homes added to the programme over time. There were three to four different versions of the model across the Vanguard lifespan, testing out a range of initiatives.

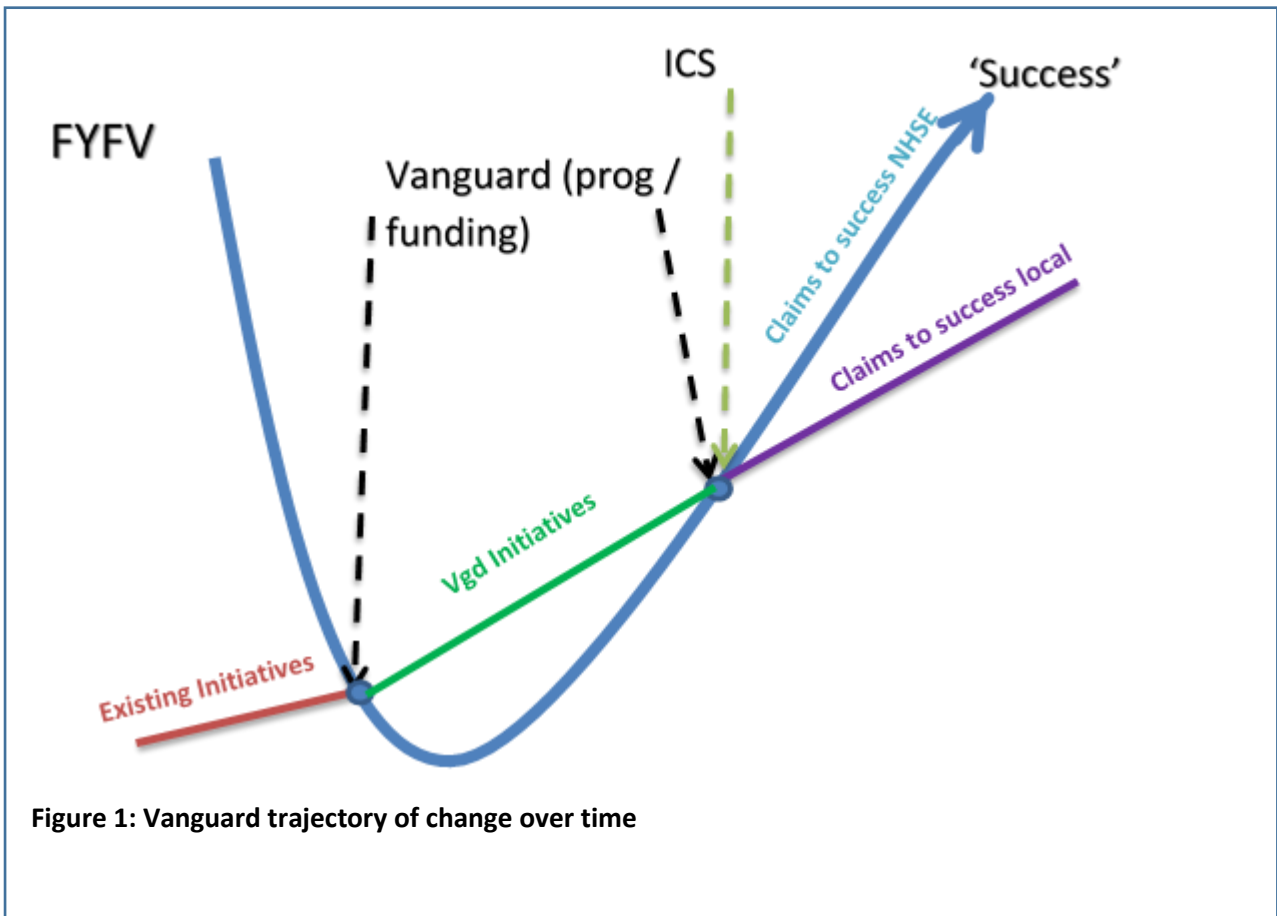
**Site 5** was a PACS Vanguard provided by an Alliance of partners including CCGs, Local Authority and acute and community providers. It served a population of 300-350,000 and was based on four elements: Care in the Home, Crisis notification, Care Navigator and Acute Care representation. Initiatives included both hospital based and community based services and new referral pathways.

**Site 6** was a PACS Vanguard. The Vanguard was an Alliance partnership of providers, which together served a population of over 300-350,000. The Programme Board included a range of local authority and NHS providers, with GP representation via federations. The focus was the development of locality-based GP-led collaborative groups that brought together local health and care organisations to ensure local people were supported to improve their own health and wellbeing and receive optimal joined up care when required.

Further details about specific initiatives are in **Table 5** in the findings section.

#### **4.4 Analysis**

Our primary analysis was thematic, looking across the cases to explore factors identified as important in the development and progress made in the Vanguards, guided by our research questions. Using NVivo software, our coding categories derived initially from our understanding of the policy context and from the findings of our initial work exploring the programme at national level. New thematic codes arising from the data were discussed by the team, and applied across the full data set. As we proceeded with this analysis across the cases it became clear that temporality was very important with respect to the Vanguards. In particular, we found a common trajectory over time. This trajectory varied in the detail of what happened, but we found common inflexion points across all of our different types of Vanguard, in keeping with our conceptualisation of the programme as a complex interplay between local social realities, meso-level developments and national policies and requirements. In order to better conceptualise this we developed a generic diagram that showed the different aspects of a Vanguard's working over its lifetime illustrated by colour coded trajectories (see below).



**Figure 1: Vanguard trajectory of change over time**

As an illustration, this trajectory diagram (figure 1) is necessarily complex and stylised. Rather than being a representation of what happened, it is a conceptual model used by the team to help us to understand what we were seeing and make comparisons across sites. It reflects our engagement and synthesis of the different factors present in each site – from before the Vanguard programme started, during its implementation and after the programme ended. It essentially maps the journey of the FYFV policy onto the real-world situation in the case study sites and illustrates how the policy *intersected* with the people and place, to bring about change. As a working document, we created a trajectory diagram for each site and populated the relevant details in a table.

In this diagram the thick blue arrow denotes the FYFV (NHSE 2014) Vanguard policy arriving in a local site, initiating change and providing an expected trajectory of ‘success’ as set out in the policy. This is depicted as an arrow which descends and then rises in order to try to capture the sense that an external policy arrived at the local level from national policy, and intersected with existing local initiatives. Across all of our sites there was a common finding that Vanguard initiatives were not new; in every case they built upon pre-existing initiatives (red line). The arrival of Vanguard funding invigorated and supported these pre-existing initiatives, so that their pace of development (and potentially scale) increased (denoted by the green line). The dotted (black) arrows indicate the initiation and termination of Vanguard funding. Once the funding for Vanguard initiatives ended and STP/ICS policy took over (dotted grey line), the trajectory of change for individual Vanguards varied. The purple line shows the local perceptions of success. Local respondents told us that, notwithstanding official (National) claims to significant success (the thick blue line), they perceived more limited local beneficial changes which were difficult to define and quantify, but which were

nevertheless perceived to be real and, in many cases, to be more important than the headline achievement of national metrics prioritised by the National level programme. These included things like better local relationships, better multidisciplinary team working and improved liaison between different providers. At the same time we looked for evidence of what had happened following the end of the Vanguard programme, including which (if any) initiatives had been retained in the absence of funding and which (if any) had been 'scaled' or 'spread' as intended by the programme.

The trajectory of each of these elements varied across our sites, but all showed evidence of these inflexion points, with the starting and ending of funding the most significant. The sites also varied in terms of whether any initiatives were retained and scaled up or spread out. Once diagrams were populated across each site they provided a useful shorthand way of comparing across sites, and highlighted significant common factors influencing what had happened locally.

We then considered these findings against the SAF framework (Mouton & Sandfort, 2017) to investigate how change at the different sites was conceived and driven, operationalised and implemented, using the concepts of social actors and skills, sources of authority, and exogenous shocks. This is discussed in the following chapter.



## 5 Chapter 5: Findings

In the following sections we will set out the findings from our case studies. Whilst we have treated each case study site as a distinct case, we will report our findings across cases, drawing out from the individual sites the broader lessons relevant to our over-arching areas of interest. This is partly in order to preserve the anonymity of our sites, but also in order to allow us to move beyond the specifics of what happened in individual areas to a more general exploration of how policy-driven change happens in complex settings.

We describe our findings according to the refined research questions which we identified in Chapter 3 section 3.3. In doing this we first address the substance of the *Vanguards*, seeking, as Moulton and Sandfort (2017) suggest, to clarify the nature of the public service intervention implemented and to consider what has changed, including local claims to success. We then consider the drivers of those changes using the Strategic Action Field framework as a guide. Finally, we consider across our cases whether and how far it is possible to link perceived beneficial outcomes to the contextual factors, local use of social skills and sources of authority that we have identified.

### 5.1 *Understanding the changes implemented in each case study site*

#### 5.1.1 Introduction: understanding the nature of *Vanguards*

Our first group of research questions focused upon the nature of the programme which was intended to be implemented in each case study site, before moving on to consider what modes of co-ordination were used to achieve this, the extent to which changes were embedded and the claims to success made by those we interviewed:

RQ1: What is the programme of change in this case study site?

- What has the local *Vanguard* programme involved, and what is the underlying causal logic assumed?
- What methods of co-ordination have been developed and used to support the change programme at both frontline and organisational level?
- What has changed so far in service operation and delivery, and what further changes are planned?
- To what extent do local actors believe that new ways of doing things have been normalised?
- What outcomes are claimed?

At the beginning of our study we attempted to draw up a typology of *Vanguards*, classifying them according to the types of initiative implemented. We believed initially that, whilst the three different types of community-based *Vanguards* were not centrally defined, in practice it was likely that there would be patterns amongst the initiatives introduced, particularly given the espoused intention to develop frameworks to allow rapid spreading of the models. However, in practice this proved to be mistaken. Whilst a number of common initiatives were implemented, including, for example, social prescribing, multidisciplinary case management etc., these were inconsistent in their focus and approach, and were combined with a wide range of other, locally-specific initiatives such as musculoskeletal services, the employment of case managers and the employment of community paramedics. Moreover, whilst each *vanguard* was required to publish a 'logic model' we found these to be high level and relatively non-specific, failing to provide a clear sense of what the causal logic underlying local initiatives was. Moreover, respondents struggled to identify clearly what had changed as a result of the *Vanguard*, with, for example, initiatives claimed by some respondents as *Vanguard* related, whilst other clearly identified them as pre-existing. Normalisation was also

difficult to establish, as initiatives were changing over time in response to funding changes and subsequent initiatives such as Sustainability and Transformation Partnerships and ICSs.

This in itself is an interesting and important finding: whilst the policy established three types of community-based Vanguard, in practice their components and operation were not clearly distinct from one another. Moreover, it was clear from the early phases of the research that, in part, this diversity arose out of the fact that most Vanguards did not start from scratch. Rather, they used the Vanguard opportunity to build upon and further develop local integration initiatives which were already in existence. Indeed, the selection process for Vanguard status explicitly sought areas which had had previous experience of developing local integration initiatives.

As a result of this, it was difficult in all of our case study sites to identify discrete initiatives and to attribute them specifically to the Vanguard, making our first set of research questions difficult to answer. In the sections which follow we identify as clearly as we can initiatives and approaches that case study sites themselves identified as Vanguard related, even if many of these started before the programme.

### 5.1.2 Initiatives implemented in each site and causal logics

Classifying initiatives was not always easy, as in many sites we found Vanguard-associated initiatives which were given different labels, but which in practice appeared to be similar. In Table 5 below we have attempted to bring together similar initiatives and show how they were distributed between the sites.

**Table 5 Vanguard initiatives in case study sites**

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

Multidisciplinary teams were ubiquitous across all Vanguard types. However, the details of exactly what was involved, who was invited and how the team functioned were very different. For example, in one site the focus was upon the development of integrated teams across neighbourhoods, with a focus on providing neighbourhood-level services such as wound clinics etc., whilst in another the focus was upon the proactive identification of frail and at risk individuals in order to target interventions to avoid hospital admissions. Both sites designated as PACS included a modified musculoskeletal pathway as part of their Vanguard. In both sites this reflected a local need to rationalise referrals for orthopaedic surgery, with a perceived need to deflect patients away from surgery, employing extended scope physiotherapists and more medical management of orthopaedic problems. In one of these sites the service was developed using a capitation-based payment system, with a risk and reward sharing scheme for commissioners and providers. In the other site the focus was upon neighbourhood working with an intention to provide better access to local physiotherapy services. Social prescribing was a common feature of four of the sites, but again this varied considerably between sites, from one site which largely focused upon the creation of a database of local voluntary organisations which could be used to signpost patients to alternative means of support, to another which integrated links to local voluntary organisations into the MDT in order to support the referral of patients. All sites introduced initiatives designed to support closer working between health and social care providers but, as is common in integration programmes (Erens et al., 2017; Warwick-Giles & Checkland, 2018), the mechanics of such integration proved challenging, including issues with information governance and differing philosophies of care. Four of the five sites introduced new clinical services. These included initiatives such as catheter clinics, community ophthalmology clinics, community geriatric clinics etc. Dementia care and end of life support were common focuses for some sites, often overlapping with the MDT process. Better integration of community pharmacists into community health services was also a popular approach. In some cases these were linked with MDTs, whilst in others the purpose was upon extending the role of community pharmacists in primary care. One site initiated a community paramedic visiting scheme.

Technology use was a common theme across most of our sites, with a wide diversity of schemes initiated including such things as apps to support patients in managing their own health and telemedicine clinics to allow remote access to expert support. Three sites introduced some sort of community café, with the aim of providing social support for vulnerable groups. Four of the six sites initiated some form of outreach clinic from hospital-based consultants, including some in care homes, and community-based therapies such as physio, occupational therapy etc. were also common. In keeping with a general intention that Vanguards would work to reduce hospital admissions, five of our six sites introduced some form of new pathway related to acute hospital admissions. This included things such as single point of access telephone lines to advise clinicians about available provision for patients in crisis, 'single front door' approaches allowing diversion of patients when they arrived in hospital and the employment of care co-ordinators to better manage communications between primary and secondary care about patients with acute problems.

A number of sites introduced services intended to extend access, such as longer hours in primary care, guaranteed same day appointments for particular categories of patients etc. Finally, sites introduced a number of non patient-facing changes, designed to support more integrated working. In some areas these included modified local policies and procedures, whilst in others the focus was upon backroom changes such as employment of administrative staff to support MDTs. Most sites included some form of specialist training for staff using the money provided by the Vanguard programme.

Each site had, under the auspices of the Vanguard programme, produced an initial 'logic model' setting out how their programme would generate desirable outcomes, and these were examined. However, these were variable in their level of detail, and few provided any clear indication of the

mechanisms by which these outcomes would be achieved, beyond a general intention that better care and support in the community would improve population health and reduce pressure on secondary care.

### **5.1.3 Methods of co-ordination**

The SAF framework specifically focuses upon 'methods of co-ordination'. Within our case study sites the methods of co-ordination used were similar across all of the initiatives implemented. In keeping with what is known about the factors which support integration between different service sectors (Elvey et al., 2018), our case study sites focused upon: co-location of services; the establishment of multi-professional team working and meetings of some kind; attempts to share information and data; and the establishment of co-ordination hubs based around single points of access to services, with the intention of streamlining entrance into services. These mechanisms cut across the initiative types identified above. Hence extended access and hospital discharge pathways often included some sort of 'single point of access', often a central 'hub', which would route calls to appropriate services, whilst co-location of staff from different services was a feature of many initiatives.

### **5.1.4 Summary**

Looking across these initiatives, a number of things stand out. The first is that no clear pattern of differences between the three types of Vanguard is discernible. Whilst EHCH Vanguards differed slightly in their scope (focusing upon care home populations rather than the population at large) the types of initiative implemented in EHCHs were very similar to those introduced in the other types of Vanguard. Secondly, whilst a number of sites had a compelling over-arching narrative about what they were trying to achieve and the way in which they intended to achieve it, it is hard to distil from these anything which might, in the longer term, develop into a 'new model' of care which could be straightforwardly codified and implemented elsewhere. Each of the approaches developed in our sites were local responses to local problems, built around existing relationships and previous initiatives. For example, in site 2 the MDT approach had been developed in a local area by a number of GP practices working together, and the Vanguard provided the impetus to develop this more widely, whilst in site 6 the particular local geography drove an approach which focused upon locality working and the development of locally-specific approaches to more integrated care.

As discussed above, the Vanguard programme was generally perceived as providing an opportunity to obtain additional funding to support and build upon local initiatives which were seen as having potential. Better integration of all kinds (between primary, community and secondary care, between statutory and voluntary services, and between health and social care services) was, in all of our areas, seen as an obvious and desirable objective and the Vanguard programme was an opportunity to pursue this. Two of our sites did have ambitions to use the Vanguard programme as a lever to support a wider change to the way in which services were commissioned and contracted for, but this has not been achieved to date. Finally, all of our sites followed a similar trajectory, with the short term nature of the programme perceived as problematic. In the initial stages, the substantial additional funding provided was welcome and used to support a wide variety of initiatives. However, as we documented in our interim report (Checkland et al 2019), funding was not secure, with some sites not receiving funding for year two or year three, based upon performance metrics which had not been stated at the start. Moreover, whilst many of the initiatives were locally perceived as having been successful, few (if any) were cash-releasing, meaning that many had to be scaled back or stopped when the additional funding ended. Staff were appointed or seconded to support Vanguard initiatives, but once the funding ended many of these roles disappeared. Some initiatives were absorbed into 'business as usual', but many were not. We will discuss perceptions of success and the trajectory of initiatives beyond the programme in more detail in section 5.2.

More generally, the wide variety of initiatives and the varied focus of the Vanguards perhaps illustrates a truism about integrated care which the initial policy did not acknowledge. Integration is a very broad term, with multiple meanings and definitions (Stokes et al., 2016). All of our sites were committed to the goal of providing more integrated care to patients, but the complexity of services, the wide variety of needs in the community and the inevitable difficulties associated with co-ordination between services with different foci and objectives meant that each site needed to focus on a small number of achievable changes. It is not surprising that these did not add up to a coherent 'model of care' which could be codified. This has been tacitly acknowledged with the shift in focus of policy from 'models of care' (initially intended to service populations of 200-300,000 and to be codified within contractual arrangements (NHSE 2014)) to non-contractual Integrated Care Systems (focusing broadly upon collaboration between providers) and Primary Care Networks (focusing upon more limited goals around integration between primary and community services) (NHS England, 2019).

## **5.2 Claims to success and Vanguard longevity: scaling and spreading?**

### **5.2.1 Introduction**

An element of our first group of research questions focuses upon the extent to which local actors felt that their particular Vanguard had made beneficial changes. The SAF framework emphasises the need to assess the extent to which changes implemented as part of a public service innovation programme had been normalised and embedded, and the outcomes claimed to be associated with these embedded changes. This is a difficult question to answer with regard to Vanguards, given the variety of initiatives and the issues experienced locally as a result of the ending of the Vanguard funding. Normalisation, in particular, was difficult to assess due to the ongoing fluidity in what was implemented locally and the ongoing changes associated with successive waves of integration policy. In this section we therefore explore, across our sites, the claims made as to the success of local Vanguard programmes and examine how far initiatives started under the programme were scaled up or spread out more widely. This will provide a background against which we can explore, in more depth, the factors which local sites felt had enabled their perceived successes.

### **5.2.2 National-level claims to success**

It is important to note that national policy documents tend to claim that the Vanguard programme has been successful. For example, the 2019 NHS Long Term Plan (NHS England, 2019) states that:

*Following three years of testing alternative models in the Five Year Forward View through integrated care 'Vanguards' and Integrated Care Systems, we now know enough to commit to a series of community service redesigns everywhere. (Para 1.6).*

And:

*Enhanced Health in Care Homes (EHCH) 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. We will upgrade NHS support to all care home residents who would benefit by 2023/24, with the EHCH model rolled out across the whole country over the coming decade as staffing and funding grows (paras 1.14,1.15).*

Some of our respondents were equally as positive and painted an optimistic picture of the Vanguard legacy locally, citing the Long Term Plan as evidence. A view from one local lead was that some aspects of it were already being implemented in their site:

*...one of the things that's really encouraging for me is, if you think about how successful has this been for us, when I read the new Long Term Plan, basically chapter one of the long term plan was our care model. There was practically nothing in there that we don't already have in place, you know. So there's one or two things that still need a bit of work, but it was fabulous to see that everything that we'd been doing over the course of the Vanguard programme is now actual national policy that everyone has to...is expected to implement (S2R01)*

However, some of those we interviewed at the local level were less positive about the successes of the Vanguard programme as a whole or the different model types (MCP, PACSs or EHCHs). They suggested that it was too soon to tell if the programme had been a success and the programme itself was too short in duration to make the differences that national level actors have claimed:

*I would guess that if it was really, really successful that the ten-year plan might have used the same terminology and not had to mandate [new] things really (S6R08)*

*I think it was providing encouragement and support to local leadership, and to local systems, to figure out, what their problems are, and how to address them. .... So, I don't think, necessarily, that it's about the codification of a model of care, and the telling other people about that codification. ...I suspect it's more a temporary greater degree of local dissemination, in what the right thing to do is, backed by a bit of resource, and a bit of enthusiasm, and a bit of spotlight. I think that's probably it (S2R011)*

### **5.2.3 Local claims to success**

Notwithstanding the formal goals of the programme and national level claims to success, all of our case study sites were able to point to what they regarded as concrete and valuable outcomes which had come about as a result of their engagement with the Vanguard programme. Not all of these were specifically associated with changes to services; many reflected positive benefits associated with new collaborations or opportunities to work together across traditional boundaries. Many of the Vanguards suggested the development of **Multi-disciplinary teams (MDTs)** was a significant local success, regardless of the model adopted:

*So the care home [named MDT] probably was the biggest success and the biggest service change and that is something that has continued so far (S3R02).*

*The multidisciplinary teams were definitely a success. You should see them, they're quite heart-warming to see. All those different individuals around the table, really concentrating on the person in the centre of the care and actually trying to find...between them, trying to work out what's best and what will meet that person's wishes and goals and needs, and everything else. (S1R03)*

MDTs were also cited as successful in catalysing wider change, recognised in the establishment of trusting relationships across boundaries:

*It's around the local integrated care teams, around how we wrap our services more within that space to target those high risk patients and potentially it's a single front door streaming model... More informally, the success of the Vanguard, what it's given us, cause that, I don't know whether I want to say true integration or collaboration, but the system operates as a system and it doesn't matter which organisation you work for,*

*those trusted relationships are there and because we've developed those trusting relationships. (S5R015)*

More broadly, some credited MDTs with re-establishing a local, place-based approach to care in which professionals from a wide range of agencies saw themselves as responsible for the same populations:

*I think the other thing it's done for us, from a purely social care perspective, because the MDTs are linked to GP surgeries, what starts happening over a period of time is that you get a deeper knowledge of place because your caseload is more localised and therefore your knowledge of community improves, and in a way, I think it's helped improve our social work offer, because we have people focused on patches again rather than generic working. (S2R012)*

Via MDTs, but also more broadly, many of our respondents felt that working in the Vanguard had supported the development of **more appropriate referrals and a better use of resources** more generally:

*MSK [Musculoskeletal] is a really good case study...because it has all the ingredients, the triage hub has opened up to self-referrals by patients, so they don't need to go through any, sort of, formal review, they can actually refer themselves to it and get an intervention. We've consciously set it up so that those lower level interventions are cranked up and the conversion rate through to getting review is much increased in relation to the right people getting to the right practitioner at the right time, getting the right interventions. (S5 FGD)*

This view was supported by a GP at the same site who explained that:

*we've got a small team within the CCG who look at the referrals from the team and they look at the high referring practices and, you know, go and sort of do audits with them and look at how they can reduce their variation, and actually was part of our overall scheme and target to reduce GP referrals by about nine per cent, which we've achieved [...]. That seems to have been successful, but we might have reached the limit of how much that sort of trio of things can do and it works well. (S5R014)*

Changing referral patterns was an important goal for a number of sites, and we saw a number of different approaches to this. Review by CCG staff was one option, as described above, but other areas had introduced other approaches, such as providing direct access to consultants for advice and guidance without a referral. It is important to note that neither of these initiatives could really be described as a 'new model' of care; rather they represent incremental improvements on the status quo, facilitated by the improved communication and trust arising out of Vanguard participation.

Many respondents told us that they felt that their Vanguard had led to **a better user experience and improving quality of care**. This was seen as more important locally than saving money or reducing referrals:

*Let's be honest about it, the work that was going on in care homes here and in the other Vanguards, the majority of the outcomes are improvement in quality of care and quality of life for the residents. If we can stop those residents needing to go to hospital, that's great. We're not going to save any money because the hospital has an A&E department chokka full of people, if you're not in the bed...someone else will be. To be talking in*

*terms of, oh, we've saved X million, it's nonsense, but such is the world that we live and work in. So we had quite a lot of outcomes that were quality of care related. (S4R02)*

In Site 3 enabling patient choice and providing care closer to home was seen as a success and part of that was achieved by supporting staff to enable patient choice:

*One element was a much higher proportion of people being enabled to die in their place of choice, which for most people actually was the care home. So ensuring that everything was put in place, the care home staff were supported and accepting, it's okay to die. It's going to happen. So that definitely made a difference and we have sustained that. The other thing for residents was for them to have more appropriate care closer to home. So one of the things that we were trying to do, and again it had started prior to Vanguard, was to try and reduce some of the hospital activity from care homes. (S3R02)*

Again, these changes represent incremental improvements rather than a radical new model of care. Some of the sites were able to point to data to show good patient outcomes:

*I'm pleased with the...we collect patient experience data. And we're up at 80%, 90% of patients who have had an improvement in their pain, or an improvement in their functionality following a treatment at the MSK hub. Which is just really good. (S5R011)*

However, as with many such local evaluation approaches, there was no comparison group, making it difficult to draw firm conclusions about service benefits.

One of the important objectives set out in the Five Year Forward View (NHSE 2014) and again in the NHS Long Term Plan (NHSE 2019) is the aspiration to move beyond an approach based upon the treatment of manifest disease to one which takes seriously **population health, prevention and local community resources** to support people outwith the formal health and care sector. Some of our sites felt that this was one of their successes:

*So what we're trying to do here is create a situation where primary care is the focus of people's health and wellbeing. And the wider provider sector is obviously involved in that, but that's a part of their care, rather than the other way around...So we're also trying to create something that actually through the contract looks after the whole population. Whereas our providers at the moment look after the people that are given to them, whether they walk through the door, or whether they're referred. We're trying to create a provider that integrates primary and community services that looks after the whole of this population. And for us that makes perfect sense. (S2 FGD)*

This approach does suggest something which goes beyond local incremental change, using contractual mechanisms to introduce a new type of care. However, in spite of significant enthusiasm, contractual change proved very difficult to achieve in practise.

Respondents across the sites suggested that **working differently, changing the culture and building strong relationships based on trust** were perceived as significant successes.

*You know, to have got the organisation to a stage that they're actually believing that it's the right thing to do, but we're working collectively on this so that we won't let one organisation fall over at the advantage of another, is a fantastic place to be. And I think that's a legacy of the Vanguard work definitely [...] Because it's a huge cultural change, you can't underestimate the change for people to get them into that space. (S1R03)*



*You're dealing with very complex organic systems where there's a lot of cultural change. So it's not just about, you know, implementing something new and seeing a result, there's a lot of cultural change that has to happen. (S5R014)*

*So having been a Vanguard and having had specific...I mean, this is quite a crude statement, but specific interventions to focus on, we have got a culture of people working together, you know, I mean, there are people from the CCG who spend a lot of time over here, some people from your organisation, like, [named person] who probably spend more time in the CCG, so people...that confluence of, you know, we have got that. (S5 FGD)*

This interviewee makes the important point that, in developing longer term trusting relationships, it helped to have spent some time working together across organisational boundaries on specific projects and initiatives. Many respondents told us they hoped that, whatever the longer term focus of health policy was, the experience of working together would inform what came next. However, such trusting relationships take time, and are often dependent upon specific individuals. Moreover, as this respondent points out, developing trusting relationships is more difficult in organisations working to capacity:

*Ultimately I think it's how you deliver sustainable change long-term and if you look at those parts of the country that are better at doing this, places like Greater Manchester, they've got a history of collaboration that goes back 25 years, and at some point in history, a group of people sat in a room and decided that the collective was more important than the sum of its individual parts, and I think it takes time and cultural change and mutual respect and trust to be able to sustain that, particularly at a time when all organisations are under-resourced and over-stretched, you know? (S2R012)*

We will explore the factors which enable and support the development of such trust in the next section.

Beyond the more general benefits associated with collaborative working, in many sites **specific collaborative vehicles** (e.g. partnership boards) had been set up and continued to work beyond the Vanguard:

*So, what [named person] is referring to as the [named] Board, that didn't exist when the Vanguard existed. That is a product of partnered chief execs coming together on the back of things like the Vanguard and what you can achieve by working together and deciding what their priorities are going to be, so they could all work together on them. (S4R07)*

An external commentator suggested that the work of an overarching partnership board had helped change culture, build partnerships and define a direction for the way forward in Site 2:

*And I think in large part, you know, through things through the work of the Partnership Board, through a lot of stuff, engagement, through a lot of public engagement, I do think that they have been successful in helping to change some of the local culture, build some local partnerships, and get a much clearer sense as to where they think the local health and care economy should head. (S2R011)*

Thus, specific structures were developed in order to manage the Vanguard process, and, in many sites, these persisted after the end of the formal programme, providing vehicles upon which ongoing collaboration can be built.

In many areas there was a specific ethos within the Vanguard of **enabling frontline staff to feel ownership of change** and empowered to do things differently. This was an explicit goal of the programme as a whole, with the Five Year Forward View arguing that: *'We can design innovative new care models, but they simply won't become a reality unless we have a workforce with the right numbers, skills, values and behaviours to deliver it.'* (NHSE 2014 p29). In many of our sites this was regarded as a valuable outcome of the programme:

*I think the staff experience was the biggest thing that came out of it [...] I think firstly it gave care home staff a voice. Up until recent years they have been a somewhat neglected part of the system, but actually they are caring for our most vulnerable population and quite a lot of people [...] Partly it was showing them that actually they are important in the work that they do and so by providing some training, different sort of training and resource packs for the homes and the staff it was actually about developing their confidence and recognising the skills that they have. (S3R02)*

*I would say definitely for staff, staff satisfaction has gone up. And you've just got to go in and sit in an MDT meeting, the atmosphere is fabulous. So you can just tell, there's joy back into their work. And we know from research that if you've got staff that are happy, patient outcomes are better. (S1R03)*

Others argued that providing the space for frontline staff from different organisations to work together was an important part of the mechanism by which change was accomplished:

*I think what we've learned through the process is when you get at an operational level the right people with the right knowledge and the right motivation to make something better, if you start with integration from a grass roots perspective and you give people a bit of space and say, look, we don't know what the answers are for this, everybody's facing the same issue which is demand up, resources down, on the basis of your knowledge and expertise, and also on the basis of the knowledge and expertise of the community, what could be better? And when we've done that, you can see the results, and you can see tangible benefit in different professionals with different expertise having a conversation about the same person. (S2R012)*

Again, this description appears to suggest that the valuable element of the Vanguard process was the impetus, funding and time generated for existing staff to work more effectively together. In other words, an approach which facilitates local incremental moves towards more functionally integrated services, rather than developing anything which could be called a 'model' of care. Providing time for staff to work together to solve problems was an important mechanism supported by the additional Vanguard funding by, for example, providing backfill for staff released to attend meetings.

Others highlighted the risk sharing inherent in a more collaborative and multidisciplinary approach:

*...with community work, you're working autonomously a lot of the time, you're taking a lot of personal risk. When there are situations where you think, oh, should I, shouldn't I, you tend to err on the side of caution and think, you know, this could be my registration, and you tend to go for the least risk averse option [...] Whereas I think when the team is*

*making the decision, you know that you've got a GP, a geriatrician, a nurse, a pharmacist, social prescribing, you've got adult social care around the table, you've collectively made a decision. So the decision to maybe keep someone in the community and manage them with the risk that might be associated is a joint one, and I think staff really appreciate that. Because, you know, it's a very difficult place to be when you're making decisions on your own. (S1R03)*

Again, this implies an incremental improvement, with the main beneficiaries being staff. More widely, collaborative working was also credited with supporting the **upskilling of staff**, alongside more traditional **training opportunities** supported by the programme:

*I think, if I look at the enthusiasm of people getting involved, it's really about the community nursing, particularly the nursing with physiotherapy background, and probably nutrition. Because it enabled them, it gave them a level, and opening, and able to get into care homes, and start speaking to care home staff, and upskilling them, and telling them about best practice. (S4R04)*

*We've also developed three other training packages [around dementia care]. Just to support care staff, really, locally, which a lot of the time, they do, they link, sort of what you're saying to a particular resident. And that's the message that we do want to get out, really, that supportive message. (S4R011)*

These claims to success are broad-based and wide-ranging. However, recurrent themes across our sites included: the concrete and longer-lasting benefits associated with collaborative working across boundaries, based upon the development of trust; the value of additional funding in creating time and opportunities for collaborative working; and the additional job satisfaction felt by staff who were given opportunities to shape the direction of the services within which they worked.

Moreover, the benefits claimed were generally incremental changes in which local ways of working or approaches had been changed in small but beneficial ways, making work easier for staff and thereby providing benefits for patients. One of our sites chose to develop a more far-reaching change to service configuration underpinned by a new contractual model but, in the time available, this proved impossible to achieve, in part due to existing NHS regulations.

There were, of course, more sceptical voices amongst our interviewees, with some lamenting the speed of the Vanguard programme, and the pressure to demonstrate success against measures which did not necessarily chime with their local objectives.

*So we've got this double risk on there now that is we were moving too fast, [name] is panicking that we're not going to be able to take people with us and make sure they can influence it and all the rest of it. To my goodness, we've promised this, people told us it's what they want. Now we're in a place where we can't pull it off quick enough and we're going to face some reputational and some relationship damage if we don't keep communicating about why this is taking so long. (S2 FGD)*

*I think the speed at which people were expecting to see results was frustrating, and sort of that results were being misinterpreted...not misinterpreted exactly, but seized upon as extremely positive when all the people involved in stats and evaluation just kept saying, you can't really take this as a true picture. These are really early days, and actually some of the data is not robust. (S4R05)*

Even if it did not achieve the overall goals of developing new models of care or reducing hospital admissions, all were agreed that working together across traditional boundaries was both possible and valuable.

#### 5.2.4 Spreading and scaling Vanguard initiatives

We have specifically focused in our analysis on the scale and spread of Vanguard initiatives because it was one of the initial goals of the programme, set out in the FYFV to: *'identify the most promising models that can be spread elsewhere'* (NHS England, 2014 p20). This section critically describes the extent to which our case study sites claimed they were successful in scaling and spreading their Vanguard initiatives. We first address the respondents' accounts of these successes and challenges with local and national scale and spread; and then briefly comment upon the future plans of including the Enhanced Health in Care Homes model within the Primary Care Network Programme.

There are many different definitions of scale and spread within the literature. For the purposes of this report, we have adopted the following definition to underpin our understanding of the meaning and context of scale and spread within the case study analysis:

*Scale-up or large-scale improvement are often used in the context of international, national and regional health programmes. These terms refer to deliberate, systematic approaches to increasing the coverage, range, and sustainability of services (Eaton et al., 2011).*

*Scale-up may be seen as the equivalent of vertical diffusion as it is planned strategically, in a top-down way. In contrast, spread is associated with horizontal diffusion, for example, with an innovation spreading along a care pathway (Institute for Healthcare Improvement, 2008).*

##### 5.2.4.1 The extent of local and regional scale and spread

We asked our respondents to talk to us about how far they felt that their initiatives had either been spread locally and/or nationally, or scaled up to cover larger populations. Claims to 'success' varied in this regard, with some claims more tangible than others. Those claiming success stories did report significant challenges, with many unable to point to anything significant. The extent of national coverage appeared limited, poorly defined, and more aspirational.

There were reports of expansion of MDTs developed within the Vanguards. In site 1 for example, local Vanguard members worked alongside other GP practices to set up MDTs across a wider geographical area. This was facilitated by information exchange and visits by practice staff, including health and social care co-ordinators (a feature of the Vanguard model) who were implemented in the neighbouring region

*I've had some really good feedback from clinicians in my role across different localities, because they said, you know, this is what we need [...] how does it work for you? And sharing – you know, so sharing ideas, and sharing data, and sharing information, and just saying, you know, these are my contact details if you do ever have anything established and want some support...". (S1R07)*

Some of the claims to wider spread and change were optimistic. Thus, for example, this interviewee suggests that a whole range of new initiatives had their origins in the Vanguard:

*It's absolutely essential to recognise that whatever has happened to the Vanguard since, it's set the blueprint for general practice at scale, multidisciplinary working and identifying the frail elderly. (S1R05)*

Overall, as the success of the MDT model was dependent upon GP practices working together, the initiative was difficult to spread to smaller practices where the necessary infrastructure to support the multi-agency model was not in evidence. In addition, in other practices (including those with a single GP) there was limited appetite and enthusiasm for the initiative. For example, we were told by one GP that it would have been difficult to justify sending a GP to another site for a two hour meeting especially when only a portion of their time would have been spent discussing their own patients. Other issues may have been due to local politics and poor interpersonal relationships between different GP practices and their willingness or otherwise to embrace the cultural change needed to adopt the model:

*...if I had to go to a smaller practice with another set of GPs for the same two-hour meeting, without [name of colleague], crouched into a tiny room, without access to the information, having to write on paper, to go back to my practice to input it all onto a computer...no, wouldn't be doing it. (S2R014)*

Interviewees were able to articulate a number of reasons why a particular model might not work in a different context:

*Look at [regional locality], I mean, you've got lots of single handers, and tiny practices, and a lot of them are failing. A lot of whom can't get staff. You know, to try and get them to club together into general practice at scale, for 32,000 patients, is a bigger challenge than it was around here. I mean, general practice is challenging in this area, but already, the practice size is bigger than it is over there. And, you know, I've given talks in other places [...] I go and talk in [regional locality], and you know, you see them thinking, well they say, that's all very well, I think it's a lovely model, how on earth do you think we're gonna get there? (S1R01)*

*I think for too many practices they're struggling, they're struggling financially, they're struggling operationally, they don't [care] about the local health economy either in terms of overall population health or performance of the bigger providers, so why would they want to play? (S1R09)*

This illustrates some of the issues associated with spreading Vanguard initiatives. As documented in section 5.2.3 (p38), part of the impetus underlying perceived successes within Vanguards came from a combination of their sense of exceptionality (Bailey et al., 2019), which brought with it additional motivation and ownership, and the additional funding available. This allowed financial support to backfill staff attending meetings and which provided pump priming for new services. Without these things the spread of MDTs depended upon the extent to which local champions could enthuse their colleagues and argue for the projected benefits. Moreover, the nature of the programme, emphasising the bottom up development of locally-developed changes, itself mitigated against wider scale and spread, with other areas arguing that their local context required a different approach. Overall this suggests that some of the factors identified earlier as underpinning success – locally developed and focused solutions, and the opportunity to devise incremental improvements to local services - themselves mitigated against scale and spread.

A slightly different approach occurred in site 6, where local geographical localities were encouraged to trial new services or ways of working, which were tested in single areas and subsequently rolled out across the whole Vanguard area if deemed successful. Thus, for example, a musculoskeletal (MSK) service and a community respiratory service have both been rolled out. However, the ending of Vanguard funding resulted in a cutting back of support for the geographical localities. In site 5 a MSK service was deemed successful in reducing wasted outpatient appointments, with a dramatic increase in the number of referred patients who subsequently went on to have surgery. Respondents were delighted to tell us that this approach had spread to other areas:

*...already [area a] has picked it up. I think [name] CCG has picked it up. I think if I'm right, [area b] have something similar to it or [area c] have something similar to it. (S5R09)*

This site has aspirations to roll out the model used for the MSK service to a wider range of service areas, and this is ongoing. Within the care home setting, an initiative in site 3 was seen as a great success and was spread to other locations, including site (4), and more widely across the region. Local scale and spread was reported to have taken place extensively during the lifetime of the Vanguard. However, this was a relatively limited initiative, focused around the handover of care between care homes and hospitals. Even so, they described others having difficulties implementing the initiative, due to a lack of understanding of local context and prior engagement:

*There were a couple of the Vanguard areas that implemented it, and literally implemented it as was, without doing the engagement, and lo and behold it didn't work. [...]So actually there was quite a bit of damage done nationally around the [specific initiative] because the messaging was wrong. And of course we've...and that still rumbles on now. I know there are parts of the country that are trying to implement it but some of them are still missing the point or not approaching it in quite the right way. (S3R02)*

This highlights one of the important issues associate with importing initiatives from elsewhere – without a clear understanding of the purpose and careful work to fit the initiative to local context, successful implementation of the transferred initiative is unlikely to occur.

Site 3 also developed a number of training initiatives and shared learning fora that were spread locally from nursing homes to residential, nursing and learning disability home workers during the Vanguard period, and became available for domiciliary care workers in the community. In addition, community pharmacist post has continued with secured funding and has spread to the local region.

In general, expansion and even continuation of initiatives at the case study sites did reduce or end after the National Vanguard programme concluded due to the termination of funding. To counter this, one site secured funding from NHSE to continue scaling work with mental health and learning disability care homes, but other sites were dependent upon bidding for additional funding or persuading their local CCG to invest in a particular service. Given the difficulty in demonstrating concrete financial savings, this was generally difficult to achieve.

For some respondents, especially those delivering the services, there was a frustration that even when a service was making savings, commissioners were not always prepared to fund it once the Vanguard programme had ended:

*We are saving at least £2,000,000 per year, £2,500,000 per year, currently, because of the work we are doing. It's actually the funding of the MSK service that's proving to be*

*the sticking point. Nobody wants to pay for us. Everybody wants the savings, but nobody wants to, nobody wants to pay for it. (S5R011)*

This was explained more fully by a finance officer:

*The problem is we need to more than self-fund, we need to be able to create savings, because there's not enough funds in the system to be able to meet the activity increases, so we'd invest two million pounds, but you need to see three, four million pounds of savings rather than two million pounds of savings, so there's a bit of an issue here in terms of how do we in the NHS start to recurrently fund these new interventions rather than being underpinned by non-recurring transformation money all the time, and that's where [this site] has been for a long time. It's tried to put in place innovative interventions, but has struggled to fund those recurrently. (S5R010)*

Overall, therefore, sites were able to point to specific examples of Vanguard initiatives which had either spread beyond the original Vanguard area or been maintained following the end of the programme. However, these were relatively limited in scope, and mostly represented spreading of specific service initiatives (e.g. an MSK service, an MDT) rather than a redesign of services more broadly. Moreover, a significant number of Vanguard-associated initiatives faltered after the end of the programme due to the termination of their funding.

#### 5.2.4.2 The potential for national scale and spread

Despite the examples of local scale and spread in some sites, in general there was limited evidence of national scale and spread of these initiatives, although some sites were keen to highlight that there was 'national interest' in some of their schemes. Site 3, for example, held the firm belief that a national roll out of their most successful initiative was possible, and the initiative also spread to other EHCH Vanguards as well as being taken up by non-Vanguard sites. It was reported by NHSE that just over 40% of Health and Wellbeing Boards had reported that they had implemented the scheme in their area and a quick guide was published to help increase this number.

Two sites used their experiences to develop 'how to' guides for others to learn from, which they shared with NHSE and other areas, and distributed to people who enquired from other Vanguards and non-Vanguard sites. However there was limited evidence that this had had an impact on scale and spread, or that they were used anywhere else. One of these sites reported there to be particular national interest in subjects related to empowering communities, patient initiated follow up, and telehealth initiatives. This however does not seem to have been developed further.

#### 5.2.4.3 Influence and impact of Vanguard activity on Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs)

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

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

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

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

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

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

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

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

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

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

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



#### 5.2.4.4 Inclusion of Enhanced Health in Care Homes Models in Primary Care Networks

From 2020, Primary Care Network members are expected to support the implementation of what is called 'Enhanced Health in Care Homes'. Whilst our case study data is not representative of all EHCH Vanguard sites, it does suggest that more successful scale and spread in relation to care homes is centred around distinct circumscribed initiatives rather than wholesale models, which are not easy to define nor transport into other areas. Moreover, in general care in care homes has historically been poor, making any improvement potentially of high impact. The model being implemented via Primary Care Networks includes some of the elements which were part of the EHCH Vanguards, including a local MDT for care homes and regular medical oversight via ward rounds. However, as a contractually defined model it may not allow the local adaptation which many found useful. Additional funding will be provided for GP practices implementing these services, and it is possible that this will facilitate useful change. However, the difficulties with scale and spread are well documented in the English healthcare context (Horton et al., 2018), suggesting that spreading the EHCH model via PCNs may not be easy.

#### 5.2.5 Summary

Respondents from all of our case study sites were able to point to valuable effects perceived to be associated with their Vanguard. These largely centred on the benefits of working together across boundaries, with frequent references to increased trust. Moreover, the processes associated with the Vanguard, particularly in the early stages, engendered a feeling of exceptionalism, in turn generating enthusiasm and engagement. The additional funding associated with Vanguards was very important, and this is particularly evidenced by the post-Vanguard trajectory in which many initiatives were abandoned and downgraded as the additional funding ended. Many initiatives represented incremental improvements in local procedures and approaches to care rather than anything which might be identified as a 'model' of care. We found very limited evidence of scaling or spreading of Vanguard initiatives. Where this did happen it was usually either limited individual schemes (such as the care home initiative designed to facilitate communication between hospitals and care homes) or regional spread of a service or service model (e.g. MSK services, MDTs). This type of spread was supported by the transfer of relevant staff to posts within STPs/ICSs, and it was hampered by the lack of additional funding. This limited evidence of spread of Vanguard initiatives contrasts sharply with the programme goals and with the ambitions set out in each areas' initial 'value propositions'. The exception to this rather limited picture of impact is the EHCH model, elements of which are to be rolled out via Primary Care networks<sup>2</sup>. This largely reflects the much more limited scope of the EHCH model, and the fact that care homes were relatively neglected in terms of health care initiatives prior to the Vanguard programme. However, it is important to note that even in our care home sites some of their initiatives were downgraded or ceased following the end of the Vanguard programme due to lack of funding. Additional funding is likely to be an important determinant of whether or not this initiative endures.

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<sup>2</sup> [https://www.engage.england.nhs.uk/survey/primary-care-networks-service-specifications/supporting\\_documents/Draft%20PCN%20Service%20Specifications%20December%202019.pdf](https://www.engage.england.nhs.uk/survey/primary-care-networks-service-specifications/supporting_documents/Draft%20PCN%20Service%20Specifications%20December%202019.pdf)

### **5.3 Understanding Vanguard implementation and the nature of outcomes**

#### **5.3.1 Introduction**

After spending some time exploring across the cases to try to understand what happened as a result of the Vanguard programme, our analysis turned to the SAF framework in order to explore the factors which may have supported implementation and the beneficial outcomes claimed by our respondents. In this section we will address our expanded research questions:

RQ2: What have been the drivers of change in this case study site?

- What sources of authority (including national, regional and local levels) have been successfully mobilised, by whom and under what conditions?
- What social skills have been used to support change, by whom, at which levels and under what conditions?
- What has been the impact of exogenous factors originating at local, regional and national level?

RQ3: Looking across the case study sites, what are the common factors at local, regional and national levels (including sources of authority, social skills and exogenous factors) underpinning (perceived) successful implementation of Vanguard change programmes, and what factors have prevented or hindered progress?

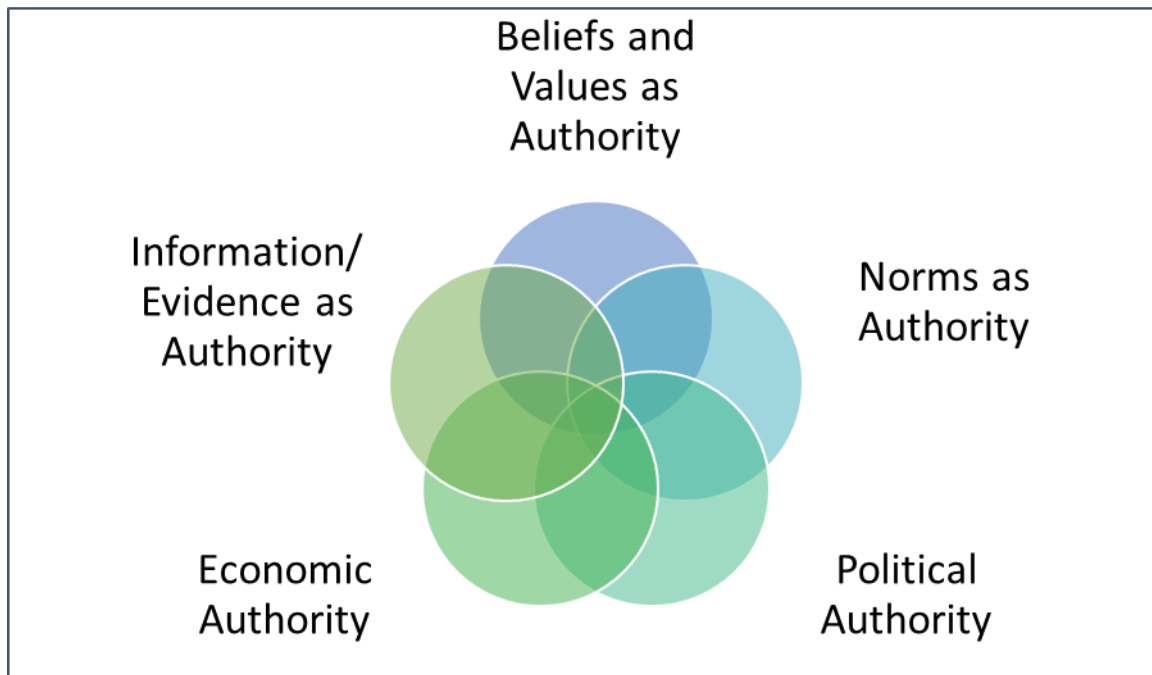
Our analysis process explored each of these issues in each case study site. We then analysed across the cases to look for commonalities, and it is these which we present here. Our aim in this analysis is to look beyond the conventionally identified facilitators of 'success' in integrated care programmes) such as data sharing, leadership, trusting relationships etc. (Elvey et al., 2018) to understand in more depth the concrete behaviours and skills used by those involved in generating enthusiasm, engagement and action. In this section we will explore in turn: sources of authority; social skills; and the impact of exogenous shocks.

#### **5.3.2 Sources of authority**

The SAF framework (Moulton & Sandfort, 2017) proposes that skilled social actors leverage diverse sources of authority to enable change and support the implementation of a new policy initiative. Crucially, sources of authority are not objectively present and do not independently exert authority – they are selectively mobilised by social actors to achieve desired implementation. Selective mobilisation is crucial, because sources of authority can be competing and require skilled reconciliation or prioritising and prevent tensions and ambiguities from becoming acutely apparent (Moller, 2019).

The reason for mobilising different sources of authority, is to engage other social actors at all implementation levels (i.e. from frontline workers to national policy makers) in order to encourage and guide implementation work and keep up momentum (International Institute of Administrative Sciences, 2017). In line with Moulton and Sandfort (2017), this section focuses on political authority, economic authority, beliefs and values, and norms. Aside from these, information and evidence are discussed as a form of authority which emerged as a distinct source of authority in the interview analysis of Vanguard case studies (see Figure 2).

Figure 2: Intersecting Sources of Authority



It should also be stressed that, within particular social settings (both between and within case study Vanguards), people vest different sources of authority with more or less legitimacy. For example, a particular source of authority may have legitimacy in one Vanguard site, but not another. Similarly, one source of authority may be well-utilised with senior management, but lack success if mobilised among frontline workers. A significant variation in implementation conditions and outcomes among settings is therefore understandable and expected.

#### 5.3.2.1 Political sources of authority

According to Moulton and Sandfort (2017), “political authority defines what is legally permissible, establishes mandated processes, stipulates which public institutions are vested with legal responsibilities, and delineates hierarchical governance relationships between fields” (p. 154).

In our study, being a Vanguard was in itself a political license – and obligation - to ‘do things differently’. As discussed in our earlier report (Checkland et al., 2019), it was seen as an important ‘badge’ which legitimised the efforts of those in charge to make change happen, even if those changes were uncomfortable. As conceptualised by the respondent below, Vanguard status both drove change and disallowed actors subjected to this change from refusing to take part in the implementation of change:

*It forces change. You can't be a Vanguard and say, right, great, we've got the cash, now we're going to sit on our arse. It doesn't work like that [...] it did exactly what [Chief Accountable Officer] wanted it to do, it set a metronome, it set pace, it set an expectation of change, and it didn't give anybody the right to turn their back and say, no, I'm not interested, and I don't want to be part of that. (S2R12)*

*I think there'd be a lot of egg on face, politically, if people withdrew from this (S2R16)*

Local actors actively used this national policy licence as a source of authority. For example, Site 3 described that the Enhanced Health in Care Homes framework helped to encourage public body involvement in supporting the hitherto overlooked private care sector in the area.

*Enhanced Health in Care Homes framework was published that obviously all CCGs to a greater or lesser extent sort of sat up and took notice and thought, oh gosh, we need to see how we are addressing this. (S3R02)*

Importantly, local leaders looked out for new policies which could similarly be co-opted to support developing initiatives, with the *naming* of initiatives important as a symbolic expression of that authority:

*[W]hen the [integrated] care systems came in we were like, oh, we're already doing this. This is what we're doing. And so we kind of added, I don't know how it worked politically, but we kind of added that to our Vanguard. So then we became a kind of [Vanguard name] Alliance as opposed to just a [Vanguard name]. (S5R017)*

Notably, this was not always a passive process of hoping that local processes would fit national decisions. The setup of the Vanguard programme, with explicit mechanisms and official encouragement for feedback and sharing learning provided local actors with a sense of power and agency. They had licence to publish their experiences, and being seen to be contributing nationally fed back to provide authority locally:

*So there were a number of case studies that were written for NHS England. So [colleague] wrote one, [another colleague] wrote one and I wrote one. I wrote the one on social prescribing, [colleague] wrote one on MDTs and set them up. I can't remember the one that [other colleague] did. And also as well as people visiting and talking to them about what we were doing and us going to people and us having phone calls or sending things, we used to get quite a lot of email queries asking us for information, and because after a while we built up these packs, we would just send those out and refer people to those". (S1R04)*

At the same time, case study sites used their processes of consultation with local people as a political source of authority. Whilst such processes were valued and seen as 'good' in and of themselves, they also provided useful authority in generating momentum for change locally and in providing authority to, on occasion, deviate from national policy:

*I mean, when we actually explain it to [NHSE], there's a lot of understanding, you know. Yeah, they're on this journey with us. And I think one of the things that's been...I guess one of the things that's been really positive for us about this process is that we have been engaging the public on this journey constantly and actually, a lot of the design principles about how this works came from them. (S2R01)*

*I think the culture between the NHS and local government, we are directly accountable to local people through our councillors, we are not at the command and control and the government doesn't tell us what to do [...] So my message would be what was good about the Vanguard and what's good about our continuation of it is that we're able to do what we think needs to be done in [our area] and co-produce that with our local citizens. (S2R15)*

Being awarded the political authority associated with Vanguard status, therefore, drove implementation of the new initiatives. However, it was not just a source of authority that social actors – from leaders to frontline workers - within the Vanguard could utilise to ensure compliance. It was also authority imposed by the national team (i.e. NHSE) as pressure to succeed; a pressure that largely replaced license to innovate towards the end of the Vanguard funding period.

*[It was] driven by the need almost politically for the programme to be seen to be succeeding, because there was definitely also a weird, kind of, controlling [...] with central bits of a system [...] end up with people being drafted, recruited in to relatively middle leadership levels who then don't see the bigger picture and they revert to that thing about 'I'm here from the government to hold you to account' (S5R01)*

This respondent clearly described the change that they perceived in the programme from an initially permissive approach to one where central control was reasserted:

*NHS England mode of operation, it seemed to me at the outset of the Vanguard programme, was to provide licence and support. And I find that surprising. But then it lapsed into its usual mode of operation, of assurance and performance management, about midway through, or maybe in the latter third of the programme. So maybe that was sort of slightly surprising that NHS England showed a vague understanding of programming at the outset, and some sense as to what local innovation might look like, before all of a sudden quickly just grabbing hold of its usual machinery and stomping about the place [...] But, I think if you're aiming at a mature system that's got the ability to spot its own problems and to address them, you can't do that by national dictate. (S2R011)*

The centrally mandated targets themselves could also be mobilised as sources of authority, with publication of league tables providing the potential for additional authority if targets were met:

*Health Service Journal put us number two, in terms of financial return on investment, so that says something. That end of term report was good. [The national lead] said 'well done'. With a sense of relief, as much as anything else, I think. (S1R01)*

The corollary, of course, was that those who failed to meet targets lost some of this political authority. This respondent describes the complex juggling required of local leaders as they managed the negative effects of missing national targets, whilst at the same time mobilising the authority vested in the Vanguard designations:

*NHS would never call anything a failure regime, so they called it the success regime and they were pissed off because we were a Vanguard and one of my jobs was constantly to stop that language causing disruption between the GPs in [area] at the time, I remember that. I remember we had hell on in executive meetings, but there was a certain kudos with [being a Vanguard] and it raised morale I think. (S6R02)*

In addition to this, while – as described above – national body pressures were often unwelcome, lack of national approval for specific Vanguard initiatives was also seen as unhelpful. The existence of such a mandate, according to interviewees from several sites, would have functioned as a significant source of political authority:

*[A]nd at the moment the framework is not mandated, it's something that everyone's being asked to work towards, but they haven't mandated it. [...] Whereas this doesn't*

*have the same level of must do, I guess, it's everyone's seeing it as a good thing, and what the benefits are, yeah, so while we have a framework, it is a national framework, it's not a compulsory piece, it's a, you should be doing this, but if you don't do it, you don't get into trouble per se. (S3R01)*

One area was keen to engage social care more formally in their Vanguard, but this required specific political agreement, which was not forthcoming:

*[S]o what the procurement says is that social care could be rolled into the scope of the Vanguard, subject to five key tests that the council's set, but until such time as those conditions are met and approved by the cabinet, it won't happen, so it's entirely possible that the Vanguard goes ahead with social care outside the scope of it. (S2R012)*

Respondents also identified a mismatch between the political authority provided by the Vanguard programme to try things out and do things differently, and the current legislation governing the activities of commissioners and providers. Current legislation was seen as encouraging competition instead of joined-up, integrating working between local organisations:

*I feel that organisational form, who controls governance and resources, has taken precedent over outcome and design. So there are your pros and cons. I think locally, the bit you've always got to be honest about is this whole thing is fraught with perverse incentives. [...] So of course, the acute wants to win that contract, irrespective of whether it will deliver fundamental change or not, because if it doesn't, it'll affect viability, it'll affect jobs, it'll affect the hospital as a going concern. Similarly, the CCG needs to commission something different in order for its decreasing budget to be able to stack up in the future, and the CCG has therefore got a vested incentive to shift a lot of commissioning risk onto the provider, and say, well, whatever the problem is, it's not our issue because we've effectively commissioned that service out. (S2R012)*

Nonetheless, these perverse incentives could, at times, be overcome by the authority arising out of a sense of agreement and engagement amongst senior leaders across a local area. The existence of joint fora and concrete collaborative mechanisms provided a source of authority which could, in the right circumstances, overcome or work around other perverse incentives. Alignment with national policy documents was very helpful as a political source of authority:

*So there was a lot of convergence of views actually about what needed to change and the model of care was actually very much what was in the five year forward view, so the things that people said needed to happen, they predated the forward view, but they were very much aligned to it. (S5R01)*

Consensus per se, however, was insufficient. To become a source of authority it had to be made visible to both the national and local actors. Visibility of the Vanguards was, in fact, identified as crucial source of authority in several case study sites. For example, high-profile visits from NHSE and other national-level bodies was used by social actors as a source of authority; in fact in some cases Vanguards invited high-profile visitors:

*So if we talk about CQC, then [CQC chief inspector] was interested, and [local leader] would particularly meet with [CQC Chief inspector] and he'd come down and he'd use it as a test case for, how would you develop CQC for multi-organisation developments. (S1R06)*

*And they're just starting the meeting, so they were given my name. So I invited them to our meeting, so they've been to a couple of our meetings now just to see how it is and how they work and I have offered to go over there if they need me to. [...] I think let people come to see how one is actually running would be fantastic. I think let us go out there and advertise it, roadshow it, sell it. Tell you that it works. Let people get an understanding of what it is. Present it. (S1R010).*

Along with allowing visitors (including those from overseas in some cases) to learn about the Vanguard, local social actors also made the Vanguards visible by giving presentations to various audiences and by building contacts with NHSE officials.

Being visible to the public and frontline staff was also important, although interviewees disclosed that it required an amended format depending on audience.

*Yeah, we knew...like I say, at one point we realised that we were getting a lot of staff to the public events, so we put on some specific sessions for staff to target them. We knew when we went out to certain events that the format of them needed to be more engaging. So we did address and tinker with things around the edge. But we very much took the approach of let's go big, let's push it out through all the channels that we can and it's get groups to come to us to invite us. And then we will do everything we can to get out to every group that wants us to go. (S2R010)*

It is important to note that areas varied in their appetite for this type of exposure. For some, it was embraced as a crucial source of authority which allowed them to demonstrate locally that their Vanguard was seen nationally as a leader. For others, however, a lower profile was preferred as it potentially allowed them to get on with things in their own way with less national scrutiny. For example:

*When we were talking to some other areas, one of them, they were miles ahead in what they were doing with care homes and they had evidence to show it. And one of the people in the team said, well why didn't you apply to be a Vanguard. And they said, because it would be more hassle than it was worth. We will just carry on doing it under the radar in our local area for our local population. And that was very interesting and looking back on it I can absolutely understand why they made that decision. So being different I think needs to be some element of recognition of what is required for all these changes. (S3R02)*

This illustrates clearly how sources of authority are selectively mobilised, with the local complex social situation crucial in determining which sources of authority are valuable or necessary.

In summary, political sources of authority varied from those clearly falling into the categories enunciated by Moulton and Sandfort (such as formal rules, mandated targets) to other more diffuse political sources of authority based around the legitimacy associated with belonging to a high profile pilot programme, which, to some extent, licenced local behaviour at odds with existing rules. Public engagement also provided a powerful political source of authority, again providing legitimacy to deviate from usual ways of working. To some extent the actual content of the public consultation mattered less than the fact that it had taken place, with its very existence used to legitimise action (Harrison and Mort, 1998).

### 5.3.2.2 Economic Sources of Authority

Moulton and Sandfort (2017) argue that: *“Within implementation systems, economic authority is often quite visible, creating incentives tied to specific processes or outcomes. Yet, signals often conflict, and consequences are not inevitable but shaped by actors within a particular context.”*(p154)

In all of our sites, the perceived parlous state of national NHS finances was wielded as a source of authority to generate buy in and an appetite for change. In keeping with the rhetoric in the FYFV (NHSE 2014), sites mobilised the idea of a ‘burning platform’ to generate urgency and a sense that something had to change:

*I have said this, I don't mean it flippantly, but I almost think hallelujah for a crisis. Because if you don't get to the stage where there is no other way out, it drives you to change. So we'd got to that burning platform with, you know, lack of workforce, GPs, some of the practices falling over, closing, to do something. So sometimes you need that. And it actually has been for the good, so, you know. (S1R03)*

*But the trigger was really – it's the burning platform idea – the health economy within [name of site] was functioning reasonably well, we weren't in financial crisis at that point, but we knew that within a few years the demand problem, plus the amount of funding, was going to cause us actually quite a major issue. (S2R016)*

Beyond providing a sense of urgency, the concept of a burning platform also gave sites additional authority to realise long held ambitions. Allied to this, Vanguard status provided additional funding, which was itself both practically useful and more broadly motivating to support change:

*I think there were benefits on two or three levels, firstly there is no doubt there was a financial one. The financial one particularly allowed us to have money to pay for clinicians, another step forward and lead our work outside the core clinical duties. That was tremendously powerful particularly for general practice and people that otherwise wouldn't have had the space and capacity to lead on this work (S6R03)*

*The apportionment of funding to facilitate the rollout of a very defined project, in a defined number of organisations, the six care homes, I would say, had a positive impact. It harnessed hearts and minds of those involved (S3R02).*

*So what we found in the beginning we had the very senior people come along, I think everybody thought, oh, there's lots of money, so we even had the chief exec of the local hospital come to the first meetings and to be fair, he has still played a part. S3R01*

Additional resources were rarely enough on their own, but these acted synergistically with other sources of authority to generate space, time and a sense of purpose:

*We got some additional funding from [named organisation] to try and help with...like come and work in [area] and it's an exciting place to be [...] it got people hooked to look at that. (S6R07)*

*The other enabler was having national prominence, and with that the funding which gave the headroom and also the support. (S1R06)*



However, as discussed above in section 5.3.2.1, additional funding could be a double edged sword, in that the removal of funding was both practically difficult and demotivating, with some areas finding that the decision to award (or not award) funding annually was particularly problematic, leading to short(er) term planning.

Moreover, funding came with performance requirements, which did not always fit with local aspirations:

*It was great to get the funding to be the Vanguard, but, as we went through there were these six elements, and there was a real push to say, we have to put all these six in place. And we knew the primary care challenge, we knew the digital challenges. But I think because we were the Vanguard, there's a lot of pressure from the New Care Model Team to say, you have to sort these out. (S3R01)*

Moulton and Sandfort (2017 p154) refer to this as 'conflicting signals', highlighting the fact that economic sources of authority are rarely simple and may be interpreted differently in different areas. For Vanguards, money was generally overwhelmingly helpful, but the *mechanisms* used by NHSE to allocate and distribute funds were sometimes less helpful.

In summary, the legacy of years of NHS funding below inflation and social care funding under severe pressure gave all Vanguards a powerful economic source of authority, with all sites arguing that 'doing nothing' was not a viable strategy. Against this background, the additional funding associated with the Vanguard programme was clearly a motivating factor, although the rules surrounding its distribution were problematic at times.

### 5.3.2.3 Beliefs and values as sources of authority

Moulton and Sandfort (2017) highlight the importance of beliefs and values as a source of authority in enabling and supporting change. They argue that:

*A final source of authority is the beliefs and values shared by individuals and groups. Scholars document how shared beliefs and values reduce uncertainty, operating as a cognitive framework that provides a means of sensemaking, often in light of what is understood about the past (Khademian, 2002; Weick, 1995; Yanow, 1996). For example, moral categorizations of both workers and the target population may shape how an intervention is implemented (Mettler, 2007; Schneider & Ingram, 1997; Soss, 2005). Shared beliefs about the efficacy of an intervention may shape whether or not actors integrate new activities into daily practices (Damschroder et al., 2009; May & Finch, 2009). (Moulton and Sandfort p155)*

From the outset of our study it was clear that the Vanguard programme was deeply infused with a sense of moral purpose. Respondents often spoke to us about integration being 'the right thing to do', and this was often articulated as being in conflict with the existing norms and values embodied in existing NHS structures, processes and rules. It could be argued that this stems from the moral terminology within the FYFV (NHSE 2014), which projects forward to a bright future and uses language which emphasises that what is proposed is *a consensus view* and identifies it with positive concepts such as *empowerment*:

*That's because there is broad consensus on what that future needs to be. It is a future that empowers patients to take much more control over their own care and treatment. It is a future that dissolves the classic divide, set almost in stone since 1948, between*

*family doctors and hospitals, between physical and mental health, between health and social care, between prevention and treatment. (NHSE 2014 p7)*

For many of our case study sites, the so-called 'triple aim' articulated in the FYFV of "better health, better care, and better value" provided a clear starting point and presented sites with both a goal and guiding principle, as they developed their new care models. It was a powerful concept, that every change or initiative introduced or dropped in the course of the Vanguard could be measured against, and it provided moral authority for those trying to bring about change:

*The triple aim, you know, beloved of the Five Year Forward View, and every other civilised health care system, which is increased clinical and financial efficiency, an increase, an enhanced patient experience, and better health outcomes. I mean, that's it, that is the triple aim of the Five Year Forward View. (S1R01)*

Locally, sites invoked this in a number of different ways. For some it became a background concept that simply served to underpin their new plans; for others it was used to confirm if developments already underway (prior to Vanguard status) were on the right track; while for one site it became the means by which other partners were persuaded to sign up to the idea of primary care delivered at scale, as a way forward:

*There was a triple aim around not letting people go into hospital that don't need to be, who are maybe lonely and isolated, but we had measures in place around life improvement scores and things. We used a leaf tool that Age UK... So, it's how they feel supported. And evaluation was key. I suppose we take the principles that you need to evaluate something. (S4R07)*

Far from being cynical, as might be expected from a managerial and clinical workforce well-used to national policy change and fleeting initiatives, the FYFV appeared to enthuse and engage across our sites, at least in their early stages. The rationale set out chimed with existing beliefs and values, and, importantly, was consonant with changes already underway in many areas. Sites varied in the exact motivations for engaging with the programme, and these reasons influenced the nature of changes implemented. In particular, local systems pressures (lack of workforce, GPs, some of the practices closing, poorly performing A&E and cancer targets) and/or financial deficit were reported as primary motivations for a number of sites. Other reasons given included meeting local population needs and identified goals:

*I mean, for us the work that we were doing in [name of site] started before the Vanguard programme, so we were looking, we developed a strategy or vision of the CCG for the [name of site] system. And a large...and that was really focused around how do we...you know, thinking about what the model of care needed to be, based upon the needs...the population needs that we'd identified and the way we saw demographic shifts and changes in patterns of service happening...So we had kind of worked on the design of a care model and were in the process of starting to implement it when the five-year forward view came about. (S2R01)*

The freedom awarded to Vanguard sites to develop a programme of change to suit their own needs was a further benefit that was welcomed widely and gave Vanguards a tool to motivate the staff within them to participate and implement the different plans proposed. This generated a lot of excitement among various stakeholders who regarded this as a genuine opportunity to do what was needed locally. After many years of working in a top down bureaucracy, respondents told us that they felt 'liberated' by the opportunity to do what they knew was needed in their local area. It

appeared that this aspect of the programme chimed with a deeply held value common in the NHS of commitment to local services and populations:

*I mean, it was exciting to be on a, you know, cutting edge development thing that was going on, you know. It was challenging, in that, as I say, you know, certainly in the area I worked in, you were kind of, you know, sort of working, obviously, on your own in developing stuff. So, you know, which in some ways, is a little bit scary, but you know. But it's good, you know, you felt challenged, and you felt empowered by that. And, you know, it was exciting, and obviously, you know, you felt liberated as well, being able to go in and do things without, you know, the constraints of the system ..., so it was liberating coming into an environment, it was good. (S1R02)*

Many sites found the opportunity for staff to engage in a 'bottom up' initiative provided a novel approach that was highly motivational, especially when presented as a unique chance to be part of something really important to their community. This enthusiasm, culture of self-belief and teamwork provided by this approach was a potent combination that could be observed, at some sites, to last throughout the entire duration of the Vanguard programme:

*Oh, it's brilliant and it's really exciting. I'm really proud of everybody. I feel a real pride in terms of what we're trying to do in [name of site] and it feels dead exciting, and it feels we've pushed the boundaries. It's a really positive thing, I think. I think giving us the local flexibility has been incredibly important. (S2R015)*

*So I think you need to believe in it yourself, but you also need to have those good relationships, so when it is difficult people stick with it. And I think you also need to be in a team where people support each other, so when it's difficult, when you all believe in it together and it's doing that up and down that keeps you going as well when you believe it's the right thing. (S1R04)*

However, there were some cases where 'buy in' was more difficult to achieve, and partners were not so committed to changing their existing approach. Here, Vanguards had to employ, additional strategies, including using 'champions' and having a 'show and tell' of the value of proposed changes and initiatives. Respondents also described a virtuous cycle in which positive changes could feedback to generate more enthusiasm. The value being appealed to here is the sense of a universal public service ethos, in which benefit to the population is the ultimate good to be pursued:

*I think there are champions in the organisation, and that's not just doctors, you know, there are other champions in the organisation as well, from all sorts of disciplines. Who got it, and really wanted it to happen. And, you know, enthusiasm is infectious, as is cynicism. So you have to try and get the enthusiasm to outweigh the cynicism. And then, when you start to get results, then it becomes easier to promote it. (S1R01)*

There was an element of fatalism in some sites that their visions would be difficult to implement, due to system or other contextual conditions. However, the fact that visions were generated locally, rather than imposed from outside was seen as an important supporting factor. Having a shared and locally generated vision provided a moral compass which could guide progress:

*If you've got a vision, you can always come back to it, if you're having a bit of a wobble, or if you're testing an initiative, you know, is this initiative appropriate, is it within scope? Well, if you come back to that vision, if it satisfied those three criteria, then it probably is in scope. (S1R01)*

Pre-existing good local relationships could help this process:

*I definitely think a big bit that was important, was some of the personalities and relationships, and building on existing relationships, so ... while there was some funding, there was also a lot of goodwill, and that people drawn in, who became part of it, everyone had this shared vision and focus and wanting to make a difference and make a change. (S3R01)*

Many of the sites created new 'partnership boards' or charged existing ones to oversee the creation of the shared local vision. Formed by parties from different stakeholder organisations, these could include third sector or public representatives, and their role was to ensure that plans stayed on track as much as possible. However, this was not always straightforward and could take considerable time:

*And so we sat down, and this was actually, yeah, shortly before the five-year forward view programme started, sat down with all the provider chief execs and said, you know, we'd like to get you to restructure things. And they all said no to start with. Because...the reason why they said what they said, they said no, unless you give us some money because it's going to be difficult and we'll need some funding. And in the end, we managed to get them to agree to test it out in a couple of places. (S2R01)*

The exact nature of local visions varied, and one of the strengths of the Vanguard programme was the space it provided via the initial permissive approach for local visions to be developed/pursued which met local needs. For some the driving vision was around delivering increased life expectancy for patients, whilst for others it was reducing work challenges for staff. Some sites focused on a rather grander vision of the development of a whole healthcare economy, whilst others took a more pragmatic approach focusing upon ensuring their immediate financial survival. Experience of former integration initiatives had taught stakeholders that creating change is often a slow process. Some sites explicitly built this into their vision, aiming to allow time for values and beliefs to become embedded:

*Basically, it works out that if you make incremental improvements on all those measures year on year, we could actually positively impact on healthy life expectancy. At the moment, in [name of site], healthy life expectancy is getting worse and the average person in [name of site] lives about the last 19 years of their life in ill-health, which is a staggering thing really. We think that after five years of creating [the Vanguard], we could actually turn that around and have a positive impact of improving the average healthy life expectancy by about one and a quarter years. Which would add an extra 440,000 years of health lives to the whole population, you know, which actually is not insignificant. (S2R01)*

However, this in itself generated issues, as the perceived acceleration of the Vanguard programme, alongside the narrowing of the assessed performance objectives left sites feeling let down towards the end of the programme. National policy focused away from the Vanguards towards STPs and ICSs, leaving Vanguards unsure of their place in local health economies. The vision generated locally continued in some areas, but in others much of it was lost. Moreover, the narrowing of focus of the Vanguard programme to concentration of the twin metrics of reducing attendance at Emergency Departments and reducing emergency hospital admissions conflicted with the locally developed visions of some Vanguards, where the focus was more upon community benefit and improvements in quality of life:

*I mean, let's be honest about it, the work that was going on in care homes here and in the other Vanguards, the majority of the outcomes are improvement in quality of care and quality of life for the residents. (S4R02)*

The use of public consultation as a political source of authority is discussed above (Section 5.3.2.1). It also was used as a moral source of authority in some sites. Demonstrating effective engagement and communication with the public became a critical mechanism in justifying the changes they wanted to make as being required and desired, not only by providers and organisations, but also by the local population, infusing them with a wider sense of moral purpose.

*I think we started from asking people what the problem was, and that's what gave us the things that we needed to fix through the MCP. We'd also got on top of that...we can see some of the problems for ourselves, the consequences of it, rise in emergency admissions, growing elderly population. But they're the things you can feel. What's wrong for people was...emergency admissions might be because we can't blinking get through on the phone to anybody. We're not confident in accessing these services. So we need that fixing. So there's always a logic step before the consequence that we see as health professionals that we're trying to fix. And it's understanding that first that's the key. (S2R010)*

*We basically went out and said what's wrong with the way services are working at the moment. What do you want to see in the future? What needs to improve? People said they'd access continuity, coordination and communication. And we then created the outcomes framework ...which hung off those threads. (S2R08)*

*I felt that the Vanguard was particularly strong at the engagement side over the communications. Because generally in the NHS I felt if someone said right, we need to make a change, let's go and do some consultation, we've got this plan, let's find out what people think. Whereas we were very tell us what you think and then we'll make the plan. (S6R06)*

Within many of our case study Vanguards we found a strong commitment to equity as an important shared value. This was particularly invoked with regard to patients who may previously have been 'somewhat ignored' or overlooked, and also improvements in quality of communication and services, ensuring that improving the patient experience came first.

*Well, it's already here to a degree because I'm already seeing patients, you know, levels of social isolation reducing, patients utilisation of primary care going down because they're getting better support in the community. I'm already seeing more and more patients co-producing their care and producing joint care plans about what objectives they want to achieve. So we're already seeing a lot. (S2R01)*

However, the history of sites that became Vanguards, and the organisations within them, meant that balancing the patient perspective and the organisational perspective was often fraught, in spite of a clear commitment to a shared vision. This was especially noted where previous efforts at local NHS organisational change had proved difficult and slow. In such cases, Vanguard leads had to negotiate the challenges of these past experiences in order to develop new, effective partnerships and joint working.

*Normally the emphasis is very much on communicating the good news. But this was a lot more about the patient and public involvement and engagement. (S6R06)*

In summary, Vanguard sites were infused by a powerful sense of moral purpose, which was, to some extent, given voice initially in the FYFV and which chimed clearly with local actors' existing strong public service ethos, built around a moral commitment to their local population and, to some extent, to local services. Creating a strong shared vision was important, and was buttressed by moral claims related to public engagement and the pursuit of equity.

#### 5.3.2.4 Norms as a Source of Authority

While significantly interlinked with Values and Beliefs as a source of authority within case study Vanguard sites, professional norms and standards of behaviour often operated as a separate source of authority. Moulton and Sandfort (2017 p155) describe them thus:

*'Norms associated with professional expertise may be a particularly potent form of authority in particular fields. Expressed through professional codes, evidence-based practices, or industry standards, norms can create binding expectations of what needs to be considered during implementation activities. They are demonstrated when powerful field actors issue white papers or offer training programmes.'*

It should, however, be stressed that developed by associations and affiliations with other social actors within the same organisation often align with deep ethical principles, and so beliefs and values and norms are closely tied together.

The strongest theme, emerging across most of the case study sites, related to subverting the 'old' norm of competition between organisations and establishing the 'new' norm of working collaboratively. The difficulties resulting from inter-organisational competitiveness were defined as creating barriers and disadvantaging patients:

*And a lot of that comes down to the way we've been commissioned in the past, because there's lots of brick walls been put up between organisations. They don't want to share their intellectual property with one another because of the tendering process and probably being destabilised as an organisation because they'll lose tenders. But that hasn't helped the patient journey and it hasn't done very much. (S1R03)*

*So, it isn't surprising that all the chief execs run scared and do what they're told and protect their organisation before the population. It's not unusual, is it? [...] Yes, because for Foundation Trusts, their first obligation is to their board and to their organisation, not the NHS. (S2R013)*

Collaboration was stressed as something that newly emerged in many of the sites, although in one site interviewees (e.g. S4R04) described collaboration as an existing feature of the Vanguard site:

*[E]verybody wanted to work together but I think there were almost split groups. And there was that period of time of learning to trust each other and were there going to be winners and losers. It took a period of time to almost say, and some people are better at it than others, let's be organisationally agnostic. (S6R08)*

Some interviewees stressed specific benefits of the new norm of collaborative working, especially at the frontline level, where greater collaboration also meant an increased ability to access advice from different teams/organisations:

*So, the physios that come from the two organisations work really well together, really, really well together. And it's lovely to see. I mean, there are some tensions, there's always some tensions aren't there, but you know, generally, they do work really well together. And I'm pleased with how the surgeons have embraced the new way of working. I'm really pleased with how some of our admin staff in our secondary care organisation have warmed to us. They were a bit hostile to begin with, but now they, kind of, fall over themselves to help us out with nerve conduction studies, for example. Just, yes, really, really pleased with what we've achieved. (S5R011)*

Beyond a direct benefit of accessing knowledge and expertise from other teams and professions, some interviewees identified that normalising collaboration led to moving away from a medical model and towards a more holistic approach:

*I think the whole point about an MCP, as opposed to what we're trained, as doctors, we're trained in the medical model. You know, here are the blinkers, I'm looking at the medical model. And MCP is much broader than that, you're looking at the voluntary, and the community sector, you're looking at social care. Which, as a doctor, whether you're a hospital doctor, or a GP, that's not what you're actually trained in. So you're actually retraining yourself to think holistically about a person, a family, a society. Where's, you were trained, actually, in looking at diseases. (S1R01)*

Collaboration was also seen as producing trust and openness among professionals and greater willingness to share or transfer patients and spaces:

*GPs [were] initially thinking they had to be there, that rather than having a GP colleague in the multidisciplinary team representing a GP voice, they felt that every GP had to come along. And I'm seeing that in other places. So that's a journey for them to let go of their patients and trust the team to look after them. (S1R03)*

Outside of the frontline, at organisational and regional levels, the new norm of collaboration was also emphasised as crucial – so much so its importance was conceptualised as transcending the Vanguard interventions and a 'right thing to do' overall (S5R10) and, crucially, as a way to garner power and exert influence (S2R18). Working collectively, therefore became both a source of authority in itself and as a lever to access political authority and autonomy:

*When we finally get to giving out 250 million to somebody that's kind of the beginning of the journey. That's where I want to see these outcomes delivered and where I want to see us move away from the being paid for seeing people and more into making a difference to people's lives. I want to see us have far more influence over...not just me, as a collective, far more influence over how these things are happening locally. (S2R18)*

As a source of authority, the new norm of collaboration had effects that did not solely depend on the economic and political push to collaborate, and transcended the formal Vanguard period in its influence. Normalising inter-organisation collaboration meant that initiatives continued to be funded:

*When we didn't get all the money we wanted, we built such a rapport and such a vision that [named charity] funded our [local initiative] out of their money. (S1R06)*

It also ensured that new initiatives in the area were driven by a collaboration of senior executives across organisations, and many sites told us that they wanted this new collaborative norm to continue to operate beyond the formal life of the Vanguard:

*[W]e want the Partnership Board to continue, because it seems to have actually kind of galvanised lots of interests from the various partners, so hopefully that will continue into the near future, as a means by which we can discuss the wider issues. (S2R016).*

Collaboration, while the most dominant and pervasive, was not the only 'new' norm mobilised as a source of authority to ensure Vanguard implementation. This was also achieved by normalising the upskilling of the workforce. Whereas historically ongoing professional education was seen as an individual obligation, linked for both nurses and doctors to their professional regulation, many Vanguards saw their approach to professional education as an important motivator and source of authority:

*I think what they would say is, they love the fact that we've given them more skills, so we've trained them all to do injections and all the diagnostics. We've given them much more autonomy. We give them 45 minutes to see a patient, which is unheard of almost, nationally. But we recognise that if they have that 45 minutes with the patient, the patient is more likely to become empowered, engaged and also, more likely to be put on the right pathway. So, they have more time with the patient, we've given them the time to work on shared decision making, and we're giving them more skills on that in the New Year. (S5R011).*

Respondents also spoke reflexively about differences in norms between front line clinicians and managers, and argued that working together through the Vanguard was helpful in allowing different types of professionals to understand each other's perspectives:

*So, I think if you're senior management, they would be much more reticent about how things were going. Whereas, as a clinician, you would say, we know that things sometimes go a bit off the rails, and we'll work hard to put it right. But as a clinician, I don't feel under pressure for it [as senior managers do]. (S2R013)*

One new norm which was evident as a result of the Vanguard programme was that of supporting and allowing innovation. However, the ending of the programme proved problematic in this regard, as the new norm was no longer evident:

*Sometimes you feel like you're putting your own head on the block, in, you know, taking those positive risks. Because you know that you need to take them to develop the care home, and for them to move forward. And if you don't take positive risks, nothing is ever going to change, nothing is ever going to progress. (S4R010)*

*We've embedded everything that was done with the Vanguard, so those things are carried on but, I think, with the Vanguard it's just that opportunity to be a bit more innovative, you know, and that, probably, is not so prominent now. (S3R04)*

Beyond specific norms that were utilised as sources of authority, the process of normalisation (i.e. establishing new norms required for the Vanguard to succeed) was also discussed as a challenge that either required a mobilisation of other forms of authority or was seen as unachievable/very difficult to achieve:



*[I]t didn't start with all the services together, they had to develop that over time because they realised actually to make it work properly, you needed both of those forms of integration. But can you get there on day one, you know, overnight? No, you can't. It's the same argument that I make with the GPs, you know, you can't expect all GPs to sign up to the way of working immediately on day one. What you need to do is create the framework that enables them to participate and develop that and evolve that over time. (S2R02).*

Thus, in summary, whilst norms are closely allied to values, we found that Vanguard sites had clearly mobilised new norms in order to achieve their desired changes. The most prominent of these was a new norm of collaboration. This was clearly consonant with the wider changes taking place in the NHS, as other initiatives have also downgraded competition within the NHS as a mechanism for service improvement (Osipovic et al., 2019). However, our sites also told us that existing NHS structures and legislation were problematic in this regard.

### 5.3.2.5 Data as a source of authority

In addition to the four categories of sources of authority elucidated by Moulton and Sandfort (2017) we also observed our case study sites mobilising a further source of authority: data. This was manifest in two main ways. Firstly, several sites highlighted the importance of providing concrete figures to illustrate the problems they were having in their local area and generate enthusiasm for change:

*I wouldn't suggest for a minute that it was sophisticated population health analytics, but we said, this is our population, these are the diseases they're suffering from and if we apply the current model of care to that population taking account of the demographics, then the gap...it was a bit of a straight line, which I'm sure it never is in real life, but we said we will have a gap of £150,000,000. (S5R02)*

In some cases, local demographic data was used to generate a sense of urgency and/or injustice. Excess use of hospitals was argued to be not safe as well as undesirable, while existing economic and demographic data provided evidence to underpin the 'burning platform' narrative that many sites utilised to generate their logic models and innovations introduced under the Vanguards.

Secondly, many of our sites highlighted the value of data analysis in proving the value of particular initiatives to generate buy-in for them:

*Yeah, absolutely, so the evaluation I did on my service, I demonstrated that we had saved the system £1.6 million in 12 months in avoided hospital admission, so ambulance conveyance and dispatch et cetera. And the service cost a million to deliver, so return on investment, demonstrated big tick. We got commission...mainstream commissioning because it was proof of concept initially, so we did prove that it is effective, which is good. (S5R016)*

Importantly, the quality of such analyses was not necessarily questioned, with few sites able to provide robust evidence against a strong counterfactual that their services had saved money or improved quality of care. This did not always matter; what mattered was to be able to point to figures which demonstrated progress. This tension was reflected nationally, with NHS England pressing Vanguard sites for what they called 'case studies' of positive effects. These were published on the NHS England website, often illustrated by somewhat speculative figures of the benefits gained. This was important in supporting the national momentum behind the Vanguard programme

as well as subsequent policy; the Long Term Plan (NHSE 2019) contains similar anecdotal reports. Some were aware of the tension surrounding such reports:

*So, one of the pieces of work that I was involved in was to look at the impact of the multidisciplinary teams and the evaluation that was done around that, which was very interesting, actually. It was quite thorough, quite detailed, quite person-centred. I think the business case that came out of the back-end of it was a little bit questionable but it claimed a certain investment per person that I think was speculative at best, and the cynic in me could almost imagine the audience in which those numbers were designed. I think there was a bit of sales going on there, you know? If you go to the GP on the basis that you're feeling socially isolated, the voluntary sector work with you, find a support package for you, your mental health improves, it does not necessarily mean that you've saved the lifetime cost of residential care for the council. That's a bit of a jump. (S2R012)*

Moreover, data analyses which did not show expected benefits were potentially problematic:

*That's the anecdotal feedback, the care homes don't call...didn't call as often or when they did call they knew it was something important rather than three or four calls every day for this and that and whatever because they knew the GP was coming but we didn't really evaluate that. The other thing is that even if we had of said, okay, it frees up 40 minutes in primary care time every day, that doesn't release any money back into the system. So I think that was hard because I think all of the subjective feedback was really positive and like you say, qualitative impact and it just makes sense, doesn't it, logically, was positive but that wasn't going to get our chief financial officer to put a couple of hundred thousand pounds into a lease to sustain it. (S3R01)*

Evaluation was an important element of the Vanguard programme, with sites required to procure a local evaluation as well as contribute to a variety of national evaluations. This in itself was seen as an important source of authority, as it provided evidence that the programme was robust and well-organised:

*And, to be honest, it's probably a good thing isn't it, 'cause it's a national pilot, you want to be able to look at the impact in as broad a way as possible, and I think some of the things might be slower burning changes, than even two and a half years. And, like I said, the GP pilot was nine months, and maybe it wasn't long enough...So, we have kind of got a whole load of evidence there, to be able to pick up and look at, and say, well let's learn from this, and what can we take going forward? (S3R01)*

As discussed earlier, funding for Vanguards in their final year was dependent upon their performance against a small number of metrics, and this was regarded as a problem by many:

*Why are we judging the performance of primary care against what happens in a hospital? We don't judge the performance of a hospital by what happens in primary care, do we? (S2R01)*

The end of the programme was something of a disappointment to some of our sites. They were all required to produce a final report alongside their local evaluation, and some were hoping for some kind of national assessment or summing up of the programme:

*...we expected there to be some kind of conference where all the Vanguard teams would come together, and everybody would say what they'd done, you know, specific to their*

*own team, and you know, what their own statistics were. There was nothing, nothing like that at all. I think we had a half an hour evaluation, didn't we, where one of our CCG IT analysts came, and just recorded, and asked us as a group, and asked us as two different groups, about, you know, with some set questions...And that was it, there was no kind of national evaluation that involved the Vanguard teams coming together, which is what we'd assumed we would have. (S4R011)*

In summary, data analysis was used in many sites to justify and legitimise action, although data which did not demonstrate progress could be problematic. However, the sheer breadth and scale of initiatives associated with Vanguards meant that most could show progress of some kind. This was reinforced by the constant requests from NHS England for 'good news' stories to be showcased on the website.

#### 5.3.2.6 Summary

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

In the next section we will explore in more depth the specific social skills used in order to effectively mobilise these sources of authority to generate change.

#### 5.3.3 **Social skills**

The idea of social skill, according to Fligstein (2001), originates in symbolic interactionism and is defined as the ability to induce cooperation in others. According to Moulton and Sandfort (2017), socially skilled actors use knowledge about field dynamics to influence others to either reproduce the current order or make change. It is recognised that most field members are committed to prevailing conditions. However, if a particular actor understands or frames change in relation to what already "makes sense" within the setting, social skill can enable the adoption of incremental changes, in this case the adoption of new ways of working under the NCM (Vanguard) programme. The field in which they operate will have some common characteristics, which we will unpick in the following section.

### 5.3.3.1 Common contextual conditions

In exploring social skills across our case study sites we initially identified a number of common contextual conditions which, when present, appeared to have a facilitative effect on the system and if absent could potentially hinder developments. These include: the position of key actors in a system (hierarchical and individual); fixed personal attributes (earned credibility, longevity and experience); collaborative working structures (within a healthcare economy) and the presence of boundary spanners. These will be discussed in turn below.

#### *Position of key actors in a system*

One of the key concepts within the literature on change management is that of leadership. The SAF framework does not specifically address this concept, focusing instead on the concrete behaviours used by those driving change. However, in exploring social skills we found that it was necessary to consider the position of those using the skills, and across our case study sites we identified two categories of individual leading change: those in formal leadership positions within local organisations; and those with earned personal position. Those with formal positions within a hierarchy included, for example, chief officer, senior manager within an NHS organisation, or high level local authority (LA) or voluntary sector position. Those with earned personal position were generally from the operational level of organisations, often with a degree of longevity in the same role, or experience across a range of roles. We will address each of these categories in turn.

In many of the sites the various social actors driving the Vanguard developments held traditionally identified high status roles within organisations involved and used this status to exert top down power. Examples included Chief Officers of CCGs, very senior managers and senior clinicians from provider organisations, the voluntary sector and on occasions associated LAs. They often worked in small leadership groups within the lead organisation for the Vanguard or across a number of organisations and often had a history of joint working in the past. For many this had begun well in advance of the Five Year Forward View (NHSE 2014) and the associated Vanguard programme, with the development and trial of more integrated ways of working. As stated in our previous report (Checkland et al 2019) this enabled them to gain the initial funding for the Vanguard from NHSE by showing evidence of joint work across a health economy.

In MCPs and EHCHs these individuals with formal status most commonly came from CCGs, and in PACS they were most commonly located in provider organisations, but this could vary. These individuals used status driven power initially to be heard and gain the buy-in of others, in their own and other organisations involved with the Vanguard from the initial proposals, through gaining funding and onwards to implement and drive developments.

For example, in one Vanguard, the CCG Chief Officer was described as having a very clear vision for the whole health economy and its future development. S(he) utilised status driven power and prior reputation for getting things done. They were described by others as:

*(S)he combines an incredible strategic brain, and a vision, and exercises a particular mode of leadership that they need, or you would need in order to do what they've done. And is also able to operate nationally, to understand what procurement might require, at the same time as being able to build relationships within the system. (S2R011)*

The same respondent went on to say:

*None of this is to say that everything that [they've] done has turned to gold, that's just completely untrue, but minus [them] and [their] abilities, they would be nowhere near*

*where they are now. It's not to dismiss the rest of the team or the institutions because there's some very talented people in the area, but (s)he really has been pivotal to the whole thing. (S2R011).*

External organisations involved in this Vanguard also recognised the importance of having someone in a senior position to drive difficult conversations in terms of motivating developments across organisations:

*It definitely needs some leadership, it definitely needs some grit. Needs people to say things that probably haven't been said before [...] its only when you get to a certain point that you think it's really important that we work together in true collaboration rather than just paying lip service to it. (S2R018)*

In other sites those driving the process did not have the same level of formal status but had been given lead roles for the Vanguard due to their appropriate skill set alongside their individual standing (see next section). However, all were seen to have the confidence and support of higher status strategic managers within the local Vanguard system.

For example, in Site 1 the Vanguard lead had limited hierarchical status but instead had a history of driving innovation and success locally and nationally which was important at the beginning in terms of establishing the Vanguard and its early development. This individual was not in a position to command authority based on role alone, therefore needed to lever their personal standing alongside social skills to get buy-in to the proposals. They were however seen by the CCG as a 'powerful change agent' who was allowed freedom to lead the developing Vanguard. In addition, the project managers in Site 1, brought into the system at 18 months, appeared to also have a significant impact in engaging staff (especially GPs) and driving the process of change forward. Importantly both had clinical backgrounds and established relationships locally.

In another site (3), four individuals from various organisations were identified as crucial to the success of the Vanguard, since they shared a vision and made links between the organisations involved. They did not have hierarchical job related-status (none being at the top of the hierarchy of their organisations) but used their established personal status to gain traction and had support from those with hierarchical status. One individual from the CCG was described as a very charismatic facilitator "(s)he added the sparkle". This was enhanced by consulting with and giving power to Care Home managers, holding monthly meetings at which they arranged speakers, pushing individual initiatives and providing positive feedback to care home staff 'engendering enthusiasm'.

*in [site] there had been a history prior to the Vanguard of some focused work on care homes and that was really the kind of initiative of some local kind of personally driven individuals, not for any personal gain, they just all thought things aren't working very well in the care homes so we want things to be better. There was a particular person here at the CCG, [named] [...] who had led some of those changes and raising the awareness of the issues of working with care homes [...] There was [named] from the CCG, [named] from the ambulance service, [named] from the community services and then [named] who was at the hospital. So the four of those kind of had connected and through their, kind of, as I said personal focus saying, right, this is important, change had started to happen. (S3R01)*

There were also examples in Site 3 of 'dynamic new individuals' (e.g. support workers, local authority workers involved with implementation), supported by management in their organisations

but who were able to move past historical challenges as they weren't identified with previous difficult relationships:

*Historically there have been certain issues arising in the work with local authority. However, we had really dynamic people who were engaged and on board, and completely behind it at local authority. (S3R01)*

Utilising the core skills and ways of working of individuals at the operational level was encouraged by higher level management in order to make change happen. Here a service provider (hospice) describes how a core MDT team member could make everyone feel included and valued:

*She had an enthusiasm and a drive and an energy and an ability to form relationships with people across sectors, that was just fantastic and she was somebody that made everybody feel involved and integrated in what was happening. Because she was somebody who would also go back to care homes, and say to them, you are doing a fantastic job, and she had a way of engaging enthusiasm. (S3R05)*

#### *Fixed personal attributes*

Alongside what might be thought of as individual personality traits, which facilitated earned personal position, there were a number of common fixed personal attributes which were seen as facilitative by those involved. One of the most important of these was personal credibility based around past operational experience. Examples included a team leader who had previously delivered front line services as a nurse and a public health consultant who had worked in the health service before moving to the Local Authority. In both cases this prior experience enabled them to communicate with colleagues using shared language and helped in interpretation and understanding of situations. They were seen to empathise with those carrying out similar roles, understanding the challenges, but also pointing to facilitators and opportunities. Being a manager who had actually done the relevant job on the front line provided credibility which at least gained a hearing for the individual concerned, allowing them then to use their relevant social skills.

Where this kind of credibility was lacking, it could cause difficulties in communicating ideas and the rationale for change. An example of this was seen in an interaction between high level managers in Site 2 at a focus group, where they acknowledged that a lack of background in primary care hampered them at times when trying to justify significant changes within this sector. In this case they believed the CCG looked at things from a patient perspective while others were focussed on their organisations:

*And my learning from this, I'm glad [S2R01] brought the thing up, no one in senior management has ever come from primary care. It's probably true. There's the odd one who says they were a practice manager once, isn't there...But apart from that... Is that a lot of the organisations we have to deal with come from an organisational perspective, not a patient perspective. I'd like to think from around this table we come from a patient perspective, and that's a really important thing. (S2R07)*

Some respondents tried to overcome such issues by enlisting others to help communicate messages for them. For example, this respondent asked a project manager with a clinical background, to help communicate messages to GPs on their behalf, where they were struggling:

*when I was having difficulty with some of the GPs, (s)he'd pick up the phone to them and say, come on, and use them by their first name, because (s)he was used to that relationship. What are you playing at, (s)he'd say.....So actually, I think the combination*

*of us both was very good because (s)he just knew them of old and having worked with them, (s)he had a different relationship. (S1R02)*

Credibility of individuals was not only important at the local level but between other levels of the Vanguard system – regional and national. This was seen in particular with the account manager role. In our previous research (Checkland et al 2019 p45) we stated that “Account managers were deliberately chosen to have a variety of different backgrounds for example, nurses, managers. They were also supported by a clinical adviser (with variety of backgrounds e.g. nurses, GPs, Occupational therapists)”. Interviewees confirmed that these backgrounds provided additional credibility.

Credibility also came from knowledge of the history of a local area, its established working practices and people working within the system. There were many occasions where respondents described knowledge of a geographical area, the history, and established working relationships etc. as helpful foundations to joint decision making. Respondents also found it helpful to know who in the system was a potential ally and who they could potentially call on for favours. For example:

*I think the fact that, certainly in GP land, we all knew each other already, because we all belonged to the same CCG. Part of being in a CCG is having, you know, protected learning time afternoons, where you bump into each other. Some of us are both commissioners, and providers, I am, I'm on the CCG governing body, and several other people in [named Vanguard] are also on the CCG governing body. (S1R01)*

*So I had previously when they were PCTs I'd worked for [named] PCT so I had some knowledge of the local area. I'd worked for them for about five years and had worked with [named individual] in the, you know, not side by side but we were in the same organisation and obviously had some knowledge of some of the local people here as well because people came from here. (S3R01)*

Building up relationships and trust over time enabled people, especially those with sufficient longevity, to call in favours and expect that they would be called upon by others too as this service manager and voluntary sector respondent explain:

*we've had people like NHSE come and say, you know, people talk about speaking with one voice, but you really do speak with one voice in [local area], across the Trust and the CCG. And that is not by accident, that's all the relationship building we've been doing in the last few years. (S6R04)*

A Service manager explained the importance of longevity linked to organisational / system memory:

*It's having that longevity of staff and people who are around for a long time who can remember why we started out on this journey in the first place and we're not saying that we don't want new eyes and new blood, but actually sometimes too much staff turnover means that you forget why it is that we're here in this place that we are now, and the lessons that we've learned to get here. (S5R016)*

Another respondent pointed to continuity in relationships built with the public especially within a given project (such as the Vanguard developments) as important:

*So I'd say the other big thing is continuity. I think that's really important. So when you're in a project that lasts... for us it was a four year project, because we were doing it for a*

*year before we got our funding [...] When people say oh, I saw you last time, that when you know you are gaining [...] they are used to people being brought in... (S6R06)*

However, some respondents contrasted these examples of positive continuity to the difficulties of working across wider areas and keeping relationships useful. It was intended from the outset (see Checkland et al 2019) that Vanguard initiatives would be pilots which could be scaled and spread more widely. This was framed as a potential problem, because the important local relationships could not easily be replicated:

*The wider you get, the less easy it is to have those relationships, and people – but, sorry, but, people and guidance or whatever you want to call it, assumes it can just happen together, and it doesn't. So we want to hold on to that, we want to hold on to that relationship, we want to be part of trying to build the others, but my view is you'll never get those relationships on a larger scale because it's harder to trust across lots of people and areas you don't know. (S6R04)*

Having discussed the importance of hierarchical and personal position of individuals, the following section looks at the contextual condition where individuals come together within and across organisations to work jointly, forming some sort of collective in both views and resulting practices.

#### *Collaborative working structures*

Another important contextual condition that many sites identified as being important was the prior existence of collaborative working structures, such as inter-organisational boards, which could include NHS organisations (commissioners, providers) but also in some cases local authorities (Social care, public health, health and wellbeing boards etc.) and voluntary organisations. These proved useful as co-ordinating bodies and their existing working systems supported understanding across organisational and professional boundaries. In most cases these pre-existing inter-organisational arrangements included relevant governance mechanisms, which were helpful in supporting new developments. Moreover, the existence of such bodies was helpful in drawing in new collaborators. These 'boards' or 'alliances', in most cases started prior to the FYFV, continued to operate to oversee Vanguard initiatives and continued after the NCM programme had ended in 2018.

In Site 5 high level managers from each of the local commissioning and providing bodies met regularly and had developed strong working relationship over many years prior to the Vanguard initiative. There was therefore already a high level of trust between them and confidence that each would be listened to at the fora and would make good on promises to deliver on their agreed commitments. They claimed that they had worked together to create a shared belief to get engagement from all organisations involved in the Vanguard:

*I think we had a mini advantage, because the four of us [strategic level managers] all knew each other, we've known each other for more than a decade, we got some rapport certainly a lot better through [a named] steering group. So when the five year forward view came out, when the Vanguard started, we'd already got trust, relationships built up across the health care department [...] and I think it stood us in massive stead and got us through this... And you can't capture that as a model, so you can say, those trust relationships are crucial and you can have a view whether it's friendly or whatever, about how you do that, but we were lucky because we had an element of that in place, which has allowed us, I think, to go even further than if you were starting from scratch. (S5 FGD)*



This manager explained the circumstances in their site and how ongoing joint work acted as an enabling context for their Vanguard developments:

*We couldn't have achieved anything that we had without our engagement from our local providers; so the hospital, the [named] ambulance service; the community services provider, the CCG and the local authority. So we needed those, the relationships and so at the high strategic level to give permission to do. And then at the sort of next level down, which was the operational level, so the key people within those organisations that actually make things happen. (S3R01)*

#### *The Presence of Boundary Spanners*

As well as working collectively in a local area to help build trust, gain shared perspectives and facilitate change, the presence of boundary spanners proved an important contextual factor. According to Williams (2019 p646): “*this world is shaped and defined by a scaffolding of a myriad number of boundaries, including organizational, professional, social, cultural, and psychological. Some of these boundaries are real and others socially constructed. They are dynamic and shifting; they can form barriers of variable permeability or conversely help to facilitate interactions; and, they interweave together to form complex policy spaces*”. It is across these that boundary spanners (as social actors) can operate.

*The working across the Vanguards as well with the other members, so [named 3<sup>rd</sup> sector organisations x3] that as well. I think its credit to individuals involved that we were all passionate about what we wanted to achieve and that we were all willing to work together on that. (S4R09)*

This respondent found working across boundaries in such ways interesting:

*Q : I mean, what is it like for you, kind of, working across those, sort of, two organisations?  
R: I quite like it actually. I find it interesting. You do see different perspectives on the job, don't you, so it just makes my job a bit more interesting really. (S2R019)*

Boundary spanning has become a core activity of contemporary public management and boundary spanners are actors equipped and experienced with the skills and competencies to manage, weave, and bridge the myriad of boundaries that exist. Importantly, whilst the skills used by boundary spanners are essential (and will be addressed below), it is also helpful if such positions exist. Thus, whilst it is possible for individuals to act beyond their role and span boundaries out of personal conviction or skills, the formal recognition of the importance of boundary spanning, and the creation of space/time/positions by those in authority could be valuable.

For example, this individual was tasked with implementing the changes under the Vanguard EHCH developments. They were given permission by their manager to take time to develop relationships with other local organisations that would have an impact on the implementation of the Vanguard. As a consequence they identified people within the Local Authority with whom they could broker relationships to help with the local evaluation and voluntary sector organisations who could provide information and potential funding, as well as carry out surveys with care home residents. Links with the voluntary sector also enabled wider asset-based initiatives to be trialled and helped to join up with the community sector provider to enable the new MDT team to be developed:

*(S)he had a lot of capacity to be able to manage and develop and do the networking, go to meetings. So I think to have that, well, it's almost like having a project manager as well isn't it? (S4R08)*

This individual also established strong linkages with the account manager responsible for their Vanguard and up towards the developing STP/ICS (meso level relationships). The individual was given time to attend national knowledge sharing events to share good practice and established strong working relationships with other Vanguards, enabling cross-fertilisation of initiatives. Thus, individuals with perceived licence and opportunities to operate across boundaries were an important facilitator of implementation. In keeping with the more general Vanguard programme ethos of supporting innovation and giving 'permission' to deviate from existing norms, such individuals were able to try to ensure that local organisational rules and conventions did not limit innovation and change.

### *Summary*

Thus, across our sites we found supportive contextual conditions which interacted with the personal social skills of those involved to support (or potentially hinder, if lacking) the development and implementation of Vanguard initiatives. These contextual conditions were neither always necessary nor sufficient in themselves, but when present they formed a background which acted as a catalyst or enabler for service change. Local longevity and credibility due to personal background seemed to be particularly important. The underlying condition here would seem to be trust. Trust could arise out of previous personal interactions, demonstrable local knowledge or trusted status associated with clinical skills and knowledge. Trust was also an important outcome of pre-existing formal inter-organisational collaborations. These not only provided a 'safe' environment for those involved to think creatively beyond the confines of their home organisation norms, but also supported problem-solving and provided a governance mechanism to oversee local developments. Hierarchical status appeared to operate somewhat differently – in this case the status associated with a senior position appeared to support and enable difficult conversations or unpopular moves, with perceived permission to operate the important attribute. The existence of boundary-spanners similarly supported decision-making which went beyond local norms. Whilst in some cases boundary spanning was an individually-driven process, the establishment of formal boundary spanning positions or the alteration of individuals' working conditions to free up time to work across boundaries were particularly helpful, when they occurred.

#### 5.3.3.2 Use of social skills

Interacting with these personal attributes and contextual conditions, we identified a number of social skills which individuals were able to use to catalyse or support change. Just as contextual conditions were neither always necessary nor sufficient alone, social skills similarly operated to reinforce positive contextual conditions or to overcome unhelpful ones. These included the vision and ability to communicate; framing (the art of persuasion); leveraging position; seizing opportunities; role flexibility, imagination and risk taking; brokering and translating; and harnessing external support.

#### *Vision and ability to communicate*

Individuals with a clear vision of how things should be developed and changed needed to be able to communicate this effectively to others. This could be facilitated by the above prevailing contextual conditions but required use of communication skills to make things happen.

In two of the sites (both PACSs) there was some anxiety around the type of Vanguard being proposed. Some individuals felt constrained by having to choose a Vanguard model type at the outset. However, those leading the Vanguard developments were able to use brokering skills (see below), predominantly with clinicians, to help them understand that the type of Vanguard wasn't

the issue. In both cases, boundary spanners were key in working and communicating across the organisations involved and selling the idea effectively to get some, especially GPs, on board with the proposed changes.

*R3 I have a recollection and I may be wrong, but there was a bit of agonising around titles, so was it an MCP or was it a PACS and what's the difference?*

*R2 Yeah, there was a lot, yeah, there was.*

*R3 And I think the fact that [named hospital], sort of, when [S5R04] took over, the medical leadership came out of special measures, because I think initially the GPs were a bit, well, if it's PACS it's just about propping up this failing acute trust and we were, like, well it really didn't matter if it's a PACS or an MCP, it's about working together [...]*

*R2 I think it was only really an issue for the ones that were in corporate, you know, sort of, CCG roles. Because I think they thought it was the difference between the GPs being in charge or the hospital being in charge. (S5 FGD)*

The ability of being able to communicate a clear vision to others was vital to avoid being distracted at the outset. In Site 6 the PPIE lead could be described as a boundary spanner, using both interpretation and mobilising skills. They described their role:

*It was engagement in communication. I think that was different to other roles that I've done was there was a much heavier emphasis on engagement and involvement... normally the emphasis is very much on communicating the good news. But this was a lot more about the patient and public involvement and engagement (S6R06).*

They claimed that engaging clinicians and managers was fairly straightforward, as long as those being consulted felt that their involvement was real, rather than symbolic, as had often been the case in the past:

*It didn't take me any time to get them on board, the clinical people. I think, dare I say it, some more non-clinical people who are writing plans, they're like oh, is that how it's done? [...] I think a lot of people over the years have seen engagement and involvement and consultation as we'll present a set of facts, we'll present a set of plans and we'll get feedback. So you have to explain to people if you tip it the other way you get far more valuable information [...] So it's really getting people to sit around a table and have a conversation. Not sign things off. (S6R06)*

### *Framing*

The ability of an influential individual or group of actors to frame an argument to be persuasive is vital. Thus, the framing of an issue is often more important than the argument being made, with appropriate framing situating the proposed course of action as obvious and difficult to argue against (Jones & Exworthy, 2015).

We were told that conversations and winning 'hearts and minds' were important to making change a reality. Good project management (project plans, excel spreadsheets) was necessary but getting the workforce on board and feeling part of the developments made a big difference. In Site 5, GPs advocating to their peers by framing changes proposed as 'beneficial to patients' was crucial to developments:

*so for the staff or the clinical workforce, it's truly that trusted relationship and collaboration that we're in it together and how are we collectively going to solve or*

*create solutions to better manage or case manage patients for their benefit and what outcomes they want to achieve as well.(S5R015)*

This framing supported the mobilisation of beliefs and values as a source of authority. In a focus group in Site 2 a senior officer of the CCG (S2R01) described the importance of individuals using social skills to drive changes in the wider culture across organisations in healthcare systems:

*So you build up this mentality and this culture and that fits quite well with the team. Here it's been reflected to us and I genuinely believe this. If it wasn't the individuals around this table and others this would've failed before now. Because you need such an amount of determination to keep fighting for something. (S2R01)*

In the 2 EHCH sites there was a perception that, especially for initiatives previous to the Vanguard, care home staff and community care staff had been neglected in terms of consultation about changes. They described, often feeling that things were imposed on them, with the logic behind the changes not explained adequately in the past. In both of the EHCH sites, there was evidence of this previously neglected group now being brought into conversations, receiving training and being supported by both the NHS (CCGs) and local authorities to understand the rationale of developments. Thus a change in framing and inclusivity helped staff to have their say at an appropriate time and understand their roles in the change process.

More generally, across all of our sites senior leaders and others driving the Vanguard change programmes repeatedly used framing to mobilise their involvement in the programme as a source of political authority. A narrative of exceptionalism and claims that acceptance on the programme was recognition of an area's strength was used to frame Vanguard involvement as a badge of success and superiority.

#### *Leveraging position*

As discussed above, positionality was important, with clear evidence that either formal position or earned personal position were important if individuals were to gain a hearing. However, position alone was not enough, and we found evidence across our sites of individuals acting to leverage the position in which they found themselves. For example, in several sites (e.g. sites 1, 4 and 5) lead GPs or other 'clinical champions' acted within the developing Vanguards to bring on board other clinicians. Traditionally clinicians (especially GPs as independent contractors) have been focussed on their own practices and registered populations rather than the wider population and as such have proved harder to engage in some initiatives. While this has changed somewhat since the 2012 Health and Social Care Act with the development of CCGs, challenges and resistance still exists, especially where clinicians at the primary care level see more responsibility coming to them with few extra resources. The ability of these lead clinicians to gain the trust and sell the merits of changes to fellow clinicians was therefore seen as an important factor. It was described as an 'easier sell' from clinician to clinician, than from a manager to clinician, and those with strategic oversight encouraged this form of operation as well as the lead clinicians choosing to ask in these ways.

For example, in Site 5, despite initial reluctance and trust issues between the CCG and many GPs, they eventually came together to deliver services in a different way under the Vanguard programme. One manager described it as:

*we had many conversations about the fact that we'd got good GP engagement at a clinical lead level, but we found it really difficult to know how to get the GPs at the GP shop floor, for want of a better term, we knew how to reach into acute clinicians, we knew how to reach into the community nursing workforce, and that sort of thing, but as*

*providers, we really struggled, I think, in terms of getting that relationship and engagement with GPs who were jobbing GPs, for want of a better term. (S5 FGD)*

The lead GP in this site also explained the importance of engagement to gain trust, especially locally with other GPs. Many had been suspicious of motives of the Vanguard at the outset:

*A lot of practices don't trust each other or the CCG or other units that you might have in the mix, including our GP provider vehicles because they feel like they'll take work away from them or funding, or take over their contracts. Not true [...] So there wasn't really any buy-in from GPs to being a PACS and quite a lot of fear that, you know, it was a means for their trust to take over their contract. Although where we are now, probably a lot of people would be quite keen to give up their contract. So I think that could have been...so I think if we'd have had more time to engage on that at the beginning, we would have been able to move forward more quickly. (S5R014)*

Champions with strong persuasive powers and the ability to speak to large audiences were also described as important in selling a positive change in other sites, for example:

*We're a team with a strong leadership, and you know, persuasive people who were happy to stand up in a room full of people and, you know, sing the message. So I think that, you know [...] I think there are champions in the organisation, and that's not just doctors, you know, there are other champions in the organisation as well, from all sorts of disciplines. Who got it, and really wanted it to happen. And, you know, enthusiasm is infectious, as is cynicism. So you have to try and get the enthusiasm to outweigh the cynicism. And then, when you start to get results, then it becomes easier to promote it. (S1R03)*

In site 2, engaging clinical champions was not promoted in the same way. Instead it was hoped the positive experiences of those initially brought on board would provide incentive for others to join in the later stages.

### *Seizing opportunities*

As the Vanguard programme was established to trial new ways of working and test new ideas in local contexts, it is unsurprising that unplanned fortuitous discoveries and opportunities have arisen. In order to capitalise on these circumstances, it requires individuals or groups with the appropriate social skills to take the necessary action at the appropriate time. The result is a sequence of events that result in a positive outcome, as the examples below demonstrate. This requires organisations to be alert to potential opportunities, recognise them when they occur and act quickly and appropriately to take advantage of them. Flexibility, and alertness to the wider context are both important.

For example, in Site 4 there were several examples of prior relationships leading to the transfer of ideas (from one Vanguard to another) or established relationships leading to the generation of new ideas which were trialled and subsequently implemented. For example, the existing relationship between a mental health nurse and a psychiatrist enabled the nurse to informally ask for advice for the developing MDT (of which she was now part) and resulted in the consultant suggesting interventions which were later adopted in the care home setting. Without this prior work relationship this initiative would probably never have happened. This was identified by several of the interviewees in the site:

*that was something that [named nurse] had agreed with Doctor X, in particular. We have linked into one of the psychiatrists as well, who is happy to provide that information. Because they obviously cover care homes within a certain catchment area, so that's how we link into them. But it's just, I think it was just based on conversations, some close working within the Trust, that we both come from anyway, because we are both seconded from [named] Mental Health Trust. (S4R011)*

A presentation by someone from the community trust who was engaged with the Vanguard at an external meeting led to the provision of extra funding from a local voluntary organisation whose lead officer was in the room. The key factors coming together were the right individuals being at same meeting, talking same language, similar background of individuals, and of the telling of persuasive stories.

*We only, we got the funding from [named voluntary organisation], because I was asked to present at an NHS England meeting, a quarterly assurance review meeting. And the Chief Executive, [named], from [named organisation] was actually there. And she's a physio by background, which was so lucky for me. She was quite touched by the pictures, again, on the presentation. And she offered to pledge over £2,000, so we could buy this kit. And this kit, we now loan out to care homes. So, each resident will have, you know, a proper assessment, and then if they need one of these postural supports, to go with the Botox injections, then they have that support for as long as they need it, until we run out of postural supports, really. It was just amazing, yeah, it was, it was really, really good. And I think the power of pictures has been key in this project, definitely. (S4R010)*

#### *Role flexibility, imagination and risk taking*

Respondents across the six sites spoke about the importance of supporting flexibility and imagination and the creation of a permissive environment where sensible risks were tolerated in order to allow innovation and new ways of working and enhancing trust at the various levels of and across organisations.

In site 6 a frontline manager described taking calculated risks to enable a better process:

*So, the Vanguard comes in, and for me that was about moving deckchairs again. And obviously we have a lot more data and population health information and everything that helps inform; whereas historically we've done it on gut reaction. So, I think that's the difference is that we didn't seek permission and we carried on doing that. (S6R08)*

*I think there was that ability to be creative. My messaging to my staff was if it doesn't cost more, if it doesn't throw the organisation into disrepute, if it doesn't have any issues with your professional registration or compromise any of that then give it a try. If it doesn't work we can go back to trying it and doing what we were doing, but there's no harm in trying new things. (S6R08)*

A frontline member of staff in site 4 explained about taking positive risks. Here there was a dilemma between knowing taking the risk was the right thing to do for development but being concerned about support in the system for doing this:

*Sometimes you feel like you're putting your own head on the block, in, you know, taking those positive risks. Because you know that you need to take them to develop the care*

*home, and for them to move forward. And if you don't take positive risks, nothing is ever going to change, nothing is ever going to progress. But I think sometimes, there's been times when you've thought, should I do this. But I know that I need to do this. (S4R010)*

In Site 5 the creation of risk sharing was seen as important to facilitate innovation and change:

*Well, I guess the fact that they have all signed up to work for the Vanguard. I think the fact that they've all taken a step into the unknown by saying, yes, we'll all work together to make this MSK service work, has been helpful. If they hadn't done that, if someone said, do you know what, we're not going to do it, then we wouldn't have been able to start with it. But the fact that they've all been willing to take that risk, or whatever you want to call it, is good. (S5R011)*

Participants at the initial focus group in Site 2 explained the conflict between taking acceptable risk to help facilitate innovation and being part of a bureaucratic system such as the NHS:

*R1 I do think that the underlying challenge in all of this is that you have a new care models programme that was encouraging flexibility, innovation, and yet it's part of a bureaucracy... the NHS is a bureaucracy, isn't it? And how do you facilitate more innovation, more flexibility in a...*

*R2 In that type of system.*

*R1 When the bureaucracy is equally seen...*

*R3 When they're meant to be safe and at right angles to each other.*

*R1 Yeah, when the bureaucracy is increasing all the time rather than decreasing.*

*R3 But bureaucracy with politics overwritten on top, and risk adverse on top of that, isn't it? Or whichever way you want to put it... (S2 FGD)*

Thus, pre-existing trusting relationships and high-level buy in from individuals of senior status, were helpful contextual conditions in supporting risk-taking.

The whole premise of the Vanguard programme was to allow creativity and test out different ways of working. It could be seen that there were different levels of risk involved for individuals, organisations and the healthcare economy as a whole across the 6 sites in doing this. In most of the sites, support was given to taking sensible risks supported by others in the system and acknowledging that some risks would pay off and others not. Moreover, we found evidence of sites acting to try to manage or reduce risks. For example, in some of the sites they had introduced 'work passports' to enable workers in one part of the system to move to another easily. This detailed skills and attributes and any checks the member of staff had undergone, so that movement was facilitated. This could be in care homes within chains or between homes.

In addition to risk taking, respondents in all of the sites provided examples of particular individuals going above and beyond their general everyday role. While this facilitated good working and things happening locally, this would not necessarily be able to be replicated elsewhere, thus having implications for spread and scale of initiatives developed under the Vanguard:

*...Named nurse [...] (s)he did a lot of the groundwork for me in terms of engagement with the homes and asking them what was going in and what services they'd got and what education they felt they needed and things like that. (S)he did a lot of that. (S)he had a really close connection with one of the consultant psychiatrists. (S4R09)*

*Named person has just been such a star... and he was a really dynamic individual. I think the problem with his organisation, is it's quite hierarchical, so I think some of the higher powers that be in the LAs, didn't necessarily support his work, and at times he would come in on his day off, to be a part of meetings and so on, 'cause they didn't necessarily recognise the importance of it. So, that potentially could have been a big problem, but he was just so committed, that he basically made himself available. (S3R01)*

The nature of the Vanguard programme as requiring working across organisational boundaries provided opportunities for this kind of individual flexibility. For example, in some sites individuals reached out across organisational boundaries to support others who were seen to be isolated and unsupported.

However, there are risks associated with the reliance on the skills of particular individuals, especially those acting above and beyond their formal role. This was important in one site where a particular individual was brought in to manage the Vanguard. When they left, momentum was not maintained and they were later re-employed. In another site, stability of a team or particular individuals was described as being very important:

*R2: So we've not really had any movement of individuals out of that team, which has helped. So given that this is four, five years actually, that's quite unusual I think, with the movement of people. And that skillset which is different it seems. When we talk about the skills that we've put into this and we talk to other areas, they haven't put the level of skills that we've put into it as well.*

*I1: And trust is a big one.*

*R2: Trust is huge.*

*R1: Yes, trust. Well also you kind of feel a moral obligation to see it through as well.*

*R2: [...] I think that's quite unique about us. [Named] from the new business model team comments on that such a lot, because there is, it's like we're all literally morally bought into this now. So for any one of us to not to do it just seems like we just...you feel like you couldn't, couldn't you?*

*R7: It's almost like, as you say, it becomes the more difficult it becomes, the more stubborn we become*

*R1: But if a couple of members of the team left, I don't think we'd make it to be honest. Because [R2] is right, we're very fortunate with the skillset of the people that we've got, that it just works. But it could very easily fall apart really if we didn't...*

*(Site 2 FGD)*

This has significant implications for general sustainability and spread of initiatives.

### *Brokering and translating*

We found across our sites that it was necessary to have individuals or groups of people who could effectively translate from abstract strategic ideas into practical messages for others. This could be straightforward or may have required some brokering or negotiation in getting the message through to those on the ground working with patients, residents or co-workers, especially if they were in different organisations often with different working practices and cultures.

For example in this PACSs Vanguard the appointed PPIE lead (for the Vanguard) championed new ways of working with patients and the public, and had strong support from those driving the Vanguard locally and NHSE, both regionally and nationally. This individual had convinced people in



the Vanguard that asking patient and the public before things were put in place, rather than consulting on an idea already being implemented, was the right course of action. To do this they instigated a consultation bus to reach outlying communities, and in other places provided refreshments to entice those in disadvantaged areas to attend (an idea from a clinical colleague). Food was appropriate to those participating and acted as a reward for people giving up their time:

*So I work with a GP who works in an area of deprivation and I really am talking deprivation. I know in the NHS everyone goes oh, our area is more deprived than yours. And she had this thing about actually, people need nourishment. People need food. If they're going to give us their thoughts and their time, we need to give them a good square meal [...] So I believe if you have the traditional engagement where you've got cups of tea, little triangular sandwiches, it's completely different to actually getting people around a table and eating pie, peas and gravy. And it's also a way of recognising that people are giving their time, which is valuable. (S6R06)*

With the encouragement of the GP this individual had reached a wider selection of informants, gained the trust of local communities and got valuable input to initiatives at the outset and feedback on them once implemented. The same respondent explained the importance of being truthful with those involved, not raising unrealistic expectations but asking for their help and ideas:

*We had GPs that would sit in a church hall and go right, we need to make this a healthy community. There's no money in the pot, so let's be creative. This is not about money in the pot, this is not about extra GP services at the beginning, end of the day and the weekend. There isn't the money and the staff for that. But what else can we all do as a community to make it a healthy place to live. (S6R06)*

Account Managers were seen as having a particularly important role in relationship brokering at all levels. Their role was described to us as including: 'critical friend'; bridging between local and national teams; brokering relationships; and 'filling gaps'. Account managers roles were intended to be supportive and developmental in focus. However, in some cases the account managers were perceived as taking on a more performance management role over time with the Vanguards (Checkland et al 2019). This potentially led to tensions around their roles within the overall programme and to distrust between types of actors in the system.

*[Named account manager] was here numerous occasions [...] he was always available on hand and would sometimes come and work from the CCG as well. I think that the unique thing about the care home Vanguard was that every two weeks, we used to have a teleconference just for an hour, Friday afternoon, and it was where all the project managers could dial in and we'd give an update on where we were, and we would share our learning. That was one of the things that was invaluable, I think, and every other project manager that I've spoken to felt that that was really important. (S4R01)*

#### *Harnessing external support*

Many of the sites looked for support from individuals and groups from outside the Vanguard structure, where skills within were lacking. This included one site that outsourced all its financial arrangements (3), another looked for help with organisational development (2), several looked for help with understanding data (1 and 4), one employed an external consultant for leading the Vanguard process for a period of time (6) and all of the sites outsourced at least part of their local evaluation (to other local organisations, to the commissioning support unit, to external consultancies or universities) with differing levels of success, depending on which social actors were steering these relationships and for what purpose. Some external collaborations resulted in better

functioning of the Vanguard programme locally. For example, Site 6 appointed an external Vanguard lead who described their role at the outset as being to train an internal manager to take over the role. However, this proved unsuccessful and they were asked back to continue the role until the Vanguard funding ended:

*Part of my role was to try and translate this sort of role I had into one of the executive director's sub-portfolios across one of the existing organisations. So that happened in August 2016, but a year later I was invited back because that particular person didn't actually, unfortunately, come up to the sort of capability that they were looking for. So I came back in July 2017, which was the back-end of the Vanguard process, at the final, and I stayed until obviously it finished in the March 2018. (S6R05)*

In Site 4, collaborations with external organisations for data analysis and specific technical parts of the local evaluation also worked well – the Public health team at the local authority took on data analysis. This helped to build relationships between the CCG and LA, provided an independent oversight on the success of initiatives and the arrangement put in place continued after the Vanguard programme had ended.

### *Summary*

We have identified a number of key social skills which actors used to support the development and implementation of Vanguard initiatives. Perhaps the most important of these was the ability to frame issues and initiatives in ways which chimed with individuals' internal beliefs and values. Understanding the worldviews of those involved and framing proposed actions as the obvious solution to local problems was a key skill. The mobilisation of many sources of authority rested upon this ability to frame things in appropriate ways. This has echoes of Lukes' (1974) characterisation of a third dimension of power, in which power is exercised by shaping the context (Hay, 1997) such that particular courses of action appear inevitable. Individuals and organisations were also seen to leverage particular positions by, for example, ensuring that clinicians led meetings with other clinicians, or fronted public meetings where a clinical voice was seen as particularly persuasive. The ability to recognise and act upon opportunities was also important. Serendipity – the right person, with the right connections, in the right room, at the right time – was repeatedly described to us as an important element in what had occurred. This ability to seize opportunities was linked to the willingness to tolerate risk, act in ways which might be risky or act beyond the formal confines of a particular role. Creating conditions in which others were confident enough to take those risks was an important social skill, requiring flexibility and imagination. As described by Moulton and Sandfort (2017), brokering and translating were important skills, underpinned by knowledge of relevant local conditions. In some cases, Vanguards felt the need to bring in those with such skills from outside. Social skills were rarely sufficient alone to bring about change, but gained power when they interacted with relevant contextual conditions. Strongly charismatic individuals could, for example, overcome their lack of hierarchical status; but without a supportive environment, which encourages and enables risk-taking, change may not be possible. Similarly, the establishment of flexible decision-making processes and the existence of trust has the potential to allow unexpected opportunities to be seized, whilst boundary spanners in situ will be able to translate and broker relationships across those boundaries. However, there are significant risks associated relying on the unique skills of certain individuals, and the narrative illustrated a number of examples of people acting above and beyond their formal role, with implications for the sustainability and spread of initiatives.

### 5.3.3.3 Supporting functions

We found that these social skills, set against a background of important contextual factors, were facilitated by functions established in the Vanguards. These included, for example, mechanisms for engagement and communication. This helps to gain and build relationships and trust between individuals and organisations. These include bi-directionality and modes of communication; and regional/national level support.

#### *Bi-directionality and modes of communication*

Overall, we found that whoever was leading the changes within local Vanguards, listening or making sure that others perceived they had been heard was seen to be important. Moreover, being seen to do what you said you would do was fundamental in developing and reinforcing trust between individuals, professions, organisations and sectors, whatever an individual's status or position in the system. However, top down communication alone was not enough. To successfully initiate and sustain change, communication needed at least the appearance of bi-directionality. In other words, local actors needed to feel that they were involved and listened to. In most sites, individuals were appointed formally to communications and engagement roles and sites claimed to have established formal engagement groups (e.g. site 6) or utilised established groups which were then asked about Vanguard developments (e.g. sites 2 and 5). Many sites undertook some form of consultation with the public which often involved staff associated with Vanguard developments going out to consult with the public at convenient venues in the community. Some used various transport mechanisms for example a 'consultation bus' and/or held organised public meetings, produced newsletters that were widely circulated or communicated via social media (e.g. Facebook, twitter etc.). This was aided by the decisions of budget holders to ring-fence some funds for consultation/communication activities, alongside the development of specific Vanguard initiatives.

In one of the sites, consultation and engagement events with the community were seen to be particularly important. This included many different mechanisms including stands in supermarkets, videos, a website, citizen's panel and public meetings. However, this was generally as part of the wider integration agenda, rather than being solely focused on the Vanguard initiatives. Members of the panel were keen to stress the transparency of the organisations involved in the integrated working agenda but were also disappointed at the lack of consultation at the beginning of new initiatives:

*I've always said this about the CCG, that they've always been transparent with us, they've always come to the table and been fully inclusive of us as patient, or patient representatives, and if we have asked questions we've always had answers back [...] And perhaps if I had one quibble, it's always we're not always involved right at the beginning, as patients we want to be there when the piece of paper is blank; but that's just I think that's just something that happens. (S5 PPIE FGD)*

In Site 2, despite describing wide ranging consultation mechanisms (Vanguard group, PPGs, surveys etc.) which the higher level management fully supported and believed was impacting on their decision making, those being consulted had a different view and having given up time were disappointed in how their contribution had been treated:

*R1 But at the end of the day I think that we were never given a role, we were never asked what we would like to contribute. We were never asked how we felt we could contribute [...] It was a tick box exercise every time. (S2 PPIE FGD)*

This is important as it demonstrates how raising expectations which are not met can be significantly demotivating.

Consultation with staff who were going to be integral to changes being made under the Vanguard was also seen as important and again achieving bi-directionality and being seen to engage and listen was fundamental as described by this provider manager:

*It's fascinating for me, because certainly I inherited a group of medics, senior medics who were very down beat and down trodden. So, we had a big piece on engagement to do, which we did in a very structured way, and we had to listen to that sort of thing you're describing, GPs to understand what the frustrations there were and then we made a pact that we'd do our level best to manage and get some of those in a better place, but in return, we need you to be behaving in a different way and I think we forget that medics...because we're all trained through the same, roughly, sausage machine and we're selected on very similar criteria, you can put medics largely 75 per cent of them into a predictable personality, it's true, but we forgot that and when we try and interact with them, we don't use that information in a way of using that to help get them involved. None of this is going to work without the provider GPs, jobbing consultants, mental health consultants, community staff being on board and understanding. ....This is engagement going to shift and that takes time, so you want the dials to change, it's tempting to try and push them and actually that's never sustainable, you have to do the groundwork. (S5 FGD)*

In the two care home sites it was recognised as crucial to engage effectively with care home managers, so that they understood that initiatives being developed were not to check up on them but instead to make their jobs more effective and rewarding, as well as making improvements for the care home residents. Relationships were established with the home managers but were often more difficult with the wider caring staff due to the high turnover within the care home sector. Therefore, building trust and relationships was an ongoing task for those driving change.

In Site 3, relationships between the CCG and care homes were difficult to facilitate as forums had previously been run via the LA. However, this was recognised by the CCG lead who started to run some sessions led by the CCG and encouraged two-way communication to listen and understand:

*So the forums so they had been run by the council, the local authority and [named CCG lead] wanted to try to get involved with that and initially it was difficult getting in. So she kind of said, well, let's run some CCG forums and they were really warmly received; a big change, you know, very, very positively received. She tried to change it from being a sort of talking at them to trying to make it a warm vibrant place where there would be some sharing of information, but you would have the care home support team sitting in the audience alongside the care home managers. They tried to generate that kind of interworking and giving them the opportunity to feed back. She always described it as trying to be a safe space where people [...], there weren't people judging you. (S3R01)*

As trust was built up, relationships became easier and with that better communication:

*So, there was, over the time, the relationship between the [care home teams and community nurses], I would say, became a relationship of trust. And there was a two-way communication, because the community nurses could ring the care home team, and say, we've been in to see this patient, actually they're not specialist, they're generalist, we're handing over to you, so that was a positive, and you call us if there's an issue.*

*Equally, the care home team, if they were doing their rounds, and doing oversight of the patients in the care homes that were allocated to them, would always come back if there was an issue about a patient, and discuss it with a member of the community nurse team. (S3R05)*

However, in other sites lack of investment in communication was perceived as problematic, and without the additional funding associated with the Vanguard programme it is hard to see how the depth of engagement required could have been achieved.

#### *Regional/national level support*

One of our key aims in this study was to explore how the broader infrastructure of the Vanguard programme had supported and enabled implementation. The element of the programme which we found had had most resonance at local level was the role of the regional account managers. Effective communication up to and down from the account managers and to/from the national programme was identified as important (Checkland et al 2019). Account managers were deliberately chosen to have a variety of different backgrounds for example, nurses and managers. The account managers were also supported by a clinical adviser (with variety of backgrounds e.g. nurses, GPs, Occupational therapists) which helped engage with others within the local system. The regional level was described as a 'dating service' (ID 017) in our macro level research (Checkland et al 2019), which can facilitate links throughout the regional health economy (including developing STPs) and enable sharing of learning while also reporting upwards to the NHSE team:

*[Named account manager] was fantastic. Any issue that we had he would immediately escalate it for us or find out an example of what someone else was doing elsewhere to try and address it. So the account management function I think it worked incredibly well actually. I mean I think it was as much down to the individuals working with us. (S2 FGD)*

However, the sheer number and variety of other supporting functions within the Vanguard programme could be difficult:

*So separate people that we had to deal with. So [named individual] primarily dealt with [named individual] and [named individual] from the project team, I primarily dealt with the evaluation team, and quite often...And [named individual] was finance, yeah. (S4R02).*

*Quite often, they had different messages or different understandings of what the expectation was on various things. (S4R01)*

This could lead to overall frustration, despite individual relationships being described as good.

#### 5.3.3.4 Summary

The SAF framework focuses upon the social skills used in order to initiate and maintain policy-driven change programmes in public sector settings. In our data collection we explored with individuals and groups the factors which they felt had supported their programme, and the things which had made their task more difficult. Our analysis then looked across the cases for common examples of particular social skills. What we found was somewhat more complicated than this. In particular, we found a complex interplay between particular contextual conditions, individual use of social skills and surrounding support functions. It appeared that beneficial or other outcomes were driven by the particular configuration of these elements at any given point in time. None were sufficient alone,

but together they combined to facilitate and enable change. Not all were necessary in all cases, and the exact combination depended upon the complex social situation involved.

Thus, at all levels throughout the system – Vanguard, STP/ICS, regional and national - in a given context, actors utilised social skills (vision, framing, leveraging position, seizing opportunities, positive risk taking, using flexibility of roles and brokering) facilitated by functions such as communication and engagement in order to ‘sell’ to others the theory behind the changes proposed, work through how to best make changes locally and implement them to benefit of those delivering and receiving the health and care services. Which skills were available at any time was dependant on individuals and groups of people working across the local system who had hierarchical or individual standing. Particular characteristics such as occupational credibility, length of service and ability to work across traditional organisational boundaries were important in establishing this standing.

#### 5.3.4 Exogenous shocks

According to the SAF framework (Moulton & Sandfort, 2017), external events can trigger more large-scale changes. These exogenous shocks can be a driver of change and influence the degree of stability or instability. Examples cited include a new actor to the field or a large-scale event that may affect an entire system such as a new piece of legislation or an economic crisis. The implications of these exogenous forces are not predictable and social actors will influence how these factors are received, interpreted and utilised.

Within the Vanguards, exogenous shocks were interpreted and responded to in specific ways. Exogenous shocks were identified which were localised and specific to individual Vanguards e.g. key staff changes, or more generalised, such as funding decisions. A number of shocks were identified across all case sites, namely: the allocation of money which had implications for the scale of initiatives and the ability to plan long-term; loss of freedom to experiment over time which was related to a narrowing of national metrics; and changes in leadership and other staff changes.

##### 5.3.4.1 Funding

Issues around the allocation of money was the most commonly cited external influence on the Vanguards. Although the sites acknowledged that NHSE funding was essential to establish the Vanguard, money was also seen as a ‘double-edged sword’ in that, for some, less money was allocated than was asked for both in year one and in subsequent years. For one site, the loss of money was seen as damaging to their reputation. Most sites did not get the full funding as requested in their application:

*You’re talking about a million pound say and we got £300,000. So we built our business case and our model on the proviso that this money would come in and it was slashed right down so we had to completely rethink about how we could deliver those services. (S4R01)*

*[Trust] hadn’t agreed its control total<sup>3</sup>, there was one on the naughty step and we were well and truly the national focus. They [NHSE] determined that those kinds of patches couldn’t benefit from certain things. [So] we weren’t allowed the Vanguard funding for the final year. (S6R04)*

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<sup>3</sup> Control totals are the NHS finance mechanism by which local areas are allocated an overall budget for their population. Historically control totals have been applied to individual organisations, making collaboration across organisational boundaries difficult.

This financial uncertainty impacted on the Vanguard's ability to deliver initiatives they had set out to implement or resulted in a scaling back of initiatives. Whilst this was mostly seen as detrimental, for one site, this scaling back resulted in a more realistic programme of work which was believed to be more sustainable in the longer term:

*There was a bit of light at the end of the tunnel because what we found is that the majority of things we did as a care home Vanguard, we've managed to continue because we had to scale it back and speaking to some of the other project managers out there who did get millions and it's gone, they've struggled. (S4R01)*

That the funding allocation was determined annually, led to difficulties in recruiting and retaining staff, many of whom were employed on short term contracts:

*We had a workforce plan of people that we wanted to recruit, but we couldn't do that until we had assurance that we'd get the money. And as the clock ticked the amount of time that people would be doing that job for reduced, and then it's harder to recruit. But who's going to come to do a job for six months that may not carry on? It makes it very difficult. (S1R04)*

The Vanguard's referred to 'threats' by NHSE to reduce or withdraw funding if nationally imposed targets were not met. The provision of ongoing funding being tied to meeting these targets was unexpected and a source of frustration and injustice for the Vanguard's, and created some tension with NHSE. For some, these threats were seen as empty, but for others they were very real:

*I didn't enjoy the low point when they threatened to withdraw funding. I didn't appreciate that. (S1R01)*

The abrupt way in which funding was terminated at the end of the programme in April 2018 was also seen as an injustice even though, arguably, this had been identified at the start of the programme.

In addition to financial shocks associated with the design of the programme, more general issues associated with NHS funding flows could also be problematic. For example, for one PACS Vanguard, the implementation of a new pricing regime known as 'local price modification (LMP) policy' ((NHS England/NHS Improvement, 2019) led to an increase in the price for some services which was unanticipated. This restricted the amount of money available and impacted on what could be delivered by the Vanguard:

*[There was] that extra tariff we had to pay [local price modification] that sort of blew a hole in our [budget]. (S6R01)*

#### 5.3.4.2 Constraints associated with performance metrics

We have already alluded to the positive impact of the initial, permissive approach to Vanguard development, and its attenuation over time as horizons were narrowed and performance more closely monitored. At the start of the programme, in keeping with this sense of freedom, Vanguard's set their own objectives, and commissioned local evaluations focused upon these indicators. However, over time this experimental freedom was lost as national metrics e.g. bed days, hospital admissions, became the key indicators against which the Vanguard's were judged and became the basis for ongoing funding. This was felt to be unjust as many of the Vanguard's were not designed to impact on these nationally determined metrics, especially within the lifetime of the programme, and resulted in the locally determined metrics, which sites felt were more relevant, being less important:

*The programme intention seemed to me to go from 'let see what works, let's attempt to see what a decent new model of care might look like, so let's learn as we go' to 'let's prevent emergency admissions' [...]. I think the nature of the programme nationally changed to an admissions prevention programme [...]. If you set out with that intention, you wouldn't do a Vanguard programme would you? You'd do an admission avoidance programme. (S2R011)*

*My biggest frustration with the Vanguard programme was about halfway through, the sort of drive came from NHS England [...] that instead of it being a 'let's trail new ways of working, let's see what works' it became 'unless you evidence you're saving admissions you're not getting your funding. (S4R01)*

#### 5.3.4.3 Staff changes

As discussed above in section 5.3.3.1 individuals were very important in the establishment and running of the Vanguards. As a result, the loss of key staff was experienced as destabilising. This was particularly true when changes affected those in leadership positions:

*The issue we've had locally in terms of taking this forward is changing leadership. (S5R010)*

*We were all new [...] so that's 18 months in and we had all changed, virtually 90% of the team and it wasn't until the first quarterly review that at the end of it, they [NHSE] said they were just about to pull the plug on the money because they were really concerned that a new team had come in and wouldn't run with it as quickly. (S1R03)*

More generally, many Vanguards were dependent upon the particular skills, experiences and knowledge of individuals at all levels, and they were vulnerable when these individuals decided to leave.

#### 5.3.4.4 Summary

As predicted, exogenous shocks had potentially significant impacts. Whilst some exogenous shocks affected all Vanguards, others were locally specific, and each Vanguard reacted somewhat differently to each shock depending on their local contextual conditions and social actors. Important shocks included: an unpredictable annual finding round; the increasing reliance by NHS England upon specific performance metrics, which were not necessarily the focus of individual Vanguards' initiatives; and the loss of key staff. Whilst the final end of the programme was clear from the outset, the cessation of the programme and cessation of funding were experienced as shocks by our case study sites, in part, perhaps, because they anticipated that there would be some sort of follow on initiative. However, after the end of the programme the focus shifted to Integrated Care Systems, and there was no systematic attempt by NHS England to link ex-Vanguards into the ICS programme.

#### 5.3.5 **Conclusions**

The SAF framework provided us with a lens through which to view the complex interplay of policy and individuals in particular social settings. In this analysis we took as a given that, notwithstanding formal assessments of success, all of our sites had successfully implemented changes; all of which went beyond what might have been expected locally without this particular policy push. We therefore focused on the factors which had been facilitative and which appeared to have influenced the trajectory of change in each case study site. This approach took us beyond the usual 'barriers



and facilitators' to unpick in more depth the factors which may be important in facilitating initiatives which require working across boundaries and out with traditional structures. Whilst we have focused on supportive factors, clearly the absence of many of these things was experienced as a problem at different times, and all sites followed a complex trajectory over time as the policy waned in its latter stages.

The concept of 'sources of authority' was a particularly fruitful one, with this lens allowing us to explore both the expected, policy-driven sources – with the impetus provided by a national 'badge' of esteem and authority the most obvious – and those which were not expected, such as the creative use of data. The double-edged nature of this latter source of authority has been explored. We have also highlighted the combination of these sources of authority into a narrative or story which helped to engage individuals and sustain the programme. These narratives wove a tale which incorporated a sense of being singled out and special, a burning need for change and a compelling vision as to how that change could be accomplished. Under the heading of social skills we found that it was impossible to separate the behaviours of skilled actors from both contextual conditions – their individual and organisational positionality and characteristics – and the surrounding supportive structures. In any given site, individuals worked alone and as part of a group to frame, broker and translate what was happening in locally specific and meaningful ways. Successful action arose out of shifting combinations of factors brought together at specific times and in specific places by individuals with relevant positionality, either formal or informal. We will reflect further upon this complexity in our discussion. Finally we demonstrated that, as expected, exogenous shocks can have a significant impact on local trajectories of change, but the impact of these is, again, context dependent and mediated by the social skills and attributes of those involved.

#### **5.4 RQ 4: Linking local factors to outcomes**

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

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

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

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

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

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

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

Underlying all of these factors is the issue of trust. Time and again individuals told us that their achievements rested upon knowing and trusting one another, and that taking time and opportunities to build trust was the most important element in their success. We will return to this in our discussion of the Vanguard programme as a whole in the next chapter.

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

*I think the positives are it's allowed the flexibility and the resourcing to work up an alternative model. I think it helped us pre-anticipate changes that are likely to take place right the way across the country perhaps ahead of time. I think it's really tested commonality of purpose across the local health and social care economy and public health as well and got us to think very clearly about the challenges that lie ahead and how we're going to address those issues collectively. I think as a bit of an offshoot to the Vanguard there's been a number of examples of really positive integration across health and social care. (S2R012)*

## 6 Discussion

### 6.1 Introduction: summary of findings

Our case studies were undertaken towards the end, and after the conclusion, of the Vanguard programme. This has the advantage of enabling those involved to look back with a degree of distance to consider and evaluate the local programme as a whole, reflecting upon its trajectory over time as well as its final achievements, and allowed us to consider the sustainability, scale and spread of Vanguard initiatives. However, the downside of this retrospective look at the programme is that we necessarily have not captured in depth the changes as they occurred; rather we have been dependent upon the retrospective reconstruction of what happened by those involved. This may have led to a loss of nuance. Nevertheless we gathered rich data, which painted a picture of enthusiastic individuals and organisations engaging with and implementing a change programme in which they felt significant personal and organisational investment. Looking across our cases we have been able to tease out a number of common contextual conditions, sources of authority and use of social skills, providing valuable insights to inform future large-scale policy pilot programmes.

The services, processes and new ways of working implemented as part of the Vanguard programme were eclectic, local and firmly rooted in existing programmes of integration. Local areas had engaged with the programme, not by seeking to design new local organisations to deliver care using contractual models (as envisaged in the Five Year Forward View, NHSE 2014), but by looking for incremental and locally specific ways in which the particular organisations delivering care across a particular geography could work more effectively together. The solutions chosen had many elements in common, including multidisciplinary team working, care co-ordination and attempts to streamline processes. We found limited evidence of scaling or spreading initiatives beyond their origins, in large part because of their local and incremental nature.

Notwithstanding the acknowledged failure to achieve the programme goal of designing and spreading frameworks setting our standardised new 'models of care', and leaving aside questions of whether or not the programme achieved against a narrow range of performance metrics (to be addressed in our final report), all of our sites told us that they felt that there had been significant and tangible benefits associated with being part of the Vanguard programme. All were able to point to the local development of improved trust, enthusiasm and new ways of collaborating together that, it was claimed, seemed likely to endure. Whilst some individual services were dropped once funding ceased, all of those we spoke to agreed that their local relationships had been enhanced by their experiences as a Vanguard in ways which would support future collaborative working within and across organisations, even if ongoing initiatives were no longer badged in the same way.

In seeking to elucidate the factors which had enabled and supported these claimed beneficial outcomes, we turned to the Strategic Action Field framework (SAF, Moulton and Sandfort, 2017), seeking examples of sources of authority, social skills and exogenous shocks which had affected what happened in our sites. We found that one of the most important factors was the fact that the Vanguard programme, in its initial manifestation, spoke to strongly held local values and beliefs. In particular the emphasis on improving care for patients across organisational boundaries spoke to deep-seated public service values in our sites. The establishment of an accompanying new norm of collaboration was also a frequently mobilised source of authority. This is in keeping with the finding from previous research that the emphasis in NHS policy over many years on competition between providers as a means of improving quality may be at odds with the overall ethos of the institution of the NHS (Checkland et al., 2012). The initial permissive nature of the programme was also valuable, as it supported the idea that local areas know best what changes are needed. This in turn was

perceived as empowering. However, alongside local empowerment, the association with a well-branded and high profile national programme provided political authority to address local issues and problems preventing collaboration. This political authority was lent power by the associated funding, although interestingly previous programmes without such generous funding also found the 'badge' of belonging to an elite club to be helpful (Erens et al., 2015). Funding acted as an economic source of authority, alongside an appeal to a sense of economic crisis often articulated as a 'burning platform'. Ironically this metaphor was often mobilised to justify a need for radical change; although changes associated with Vanguard were most often incremental. This raises questions as to whether such dramatic metaphors are always necessary to shift away from entrenched behaviour patterns, even when the changes being implemented are not in themselves very dramatic. Alongside these metaphors, local actors wove narratives using data to illustrate the need for change, often tapping into shared perceptions of fairness and equity. For example, pointing out socio-demographic inequities in life expectancy was often used to justify changes.

In supporting local change, we identified a number of social skills used by those in positions of power to influence and enable this, including framing, brokering, tolerating and managing risk, seizing opportunities, translating and boundary spanning. We also found that the use of such social skills was underpinned by a range of contextual conditions, including positionality and structures which supported local collaboration and boundary spanning. Successful social actors could have personal authority arising from their formal position, or earned credibility based upon their previous actions. In addition, personal credibility also arose out of fixed personal attributes such as relevant clinical training or longevity in a local area. Being known and knowing others was a particularly powerful position for those driving change. The use of social skills was also supported by some functional processes such as good communications, and both regional and national support, with regional Account Managers themselves using a wide range of social skills to support their allocated local Vanguard. It was clear across all of our sites that, in order to exercise social skills, individuals needed a sense of personal agency, and the time and space to act outside of their formal role. Additional funding helped with this, by allowing backfill. Personal agency – the sense of being able to achieve something – was supported by senior managers who were prepared to tolerate risk and provide unqualified support, and this in turn was enabled by the overall tenor of the programme, including its initial permissive approach.

Exogenous shocks had a significant impact in all of our sites with the vagaries of the annual funding round particularly problematic, often due to short planning cycles. In addition, the shift later in the programme from a permissive approach to one focused mainly on performance against a small range of metrics was perceived as problematic, reducing local enthusiasm and undermining the sense of local agency. This was echoed in the findings from the local Vanguard evaluation in the North East (Maniatopoulos et al, online ahead of print) where they found "there was a sense in which the pressure coming from the centre (i.e. NHS England) and being felt was forcing the pilot sites to deliver without the appropriate substantive change being in place or sufficiently embedded and without there being adequate reliable evidence to support change".

Underlying all of these factors was the importance of trust. Individuals who were trusted were most effective in facilitating change, and working together was said to engender trust within and between organisations which it was felt would support future collaborations. It was clear that a previous history of working together was very helpful. This raises a significant issue, in that trust depends upon individuals, with the associated danger that personnel changes may disrupt and derail initiatives, although our findings suggest that this risk may, in part, be mitigated by the establishment of formal collaborative structures which will endure in spite of personnel changes.

## 6.2 Theoretical issues: The Strategic Action Field framework

The SAF framework was a fruitful approach, allowing us to look beyond the specifics of individual case study sites to identify more general conditions and behaviours supporting change. It is instructive to return to the original exposition of the framework in order to consider which aspects were most useful and whether any adaptations might be required.

The first element of applying the framework, according to Moulton and Sandfort (2017), is to explore in depth the particularities of the local policy being implemented. We found this challenging to do, as the Vanguards were in fact a diffuse and variable collection of individual service and other changes. It was difficult to determine in any one site exactly what had been implemented, when, and how it differed from what went before. In part this reflects our methods; if we had been able to observe implementation of particular initiatives (e.g. MDTs) in real time we might have been able to use implementation frameworks such as normalisation process theory (May & Finch, 2009). We do however draw on our work synthesising the commissioned local evaluations for MCPs, PACS and EHCHs Vanguard models, which helped us to explain some findings and understand if these were more widely applicable. More detail can be found in our separate report (Wilson et al 2019). These difficulties did not detract from the overall value of the framework in our work. Indeed, we found it to be particularly useful in the context of diffuse collections of service changes, as it moved the analysis beyond the local specifics of changing this referral process or that set of working practices, facilitators or inhibiting factors. Such issues have been extensively studied in implementation science, and it is unlikely that the changes necessary in our local areas were significantly different from those seen in, for example, the implementation of case management for dementia or discharge planning processes (Bamford et al., 2014; Nordmark et al., 2016). What the SAF framework adds to these local level accounts of implementation is an appreciation of the wider system factors that lead to the initiation or sustaining of change programmes over time, and the macro-level policy drivers which support or inhibit the progress of policy pilots. These were an important feature of the Vanguard programme, and the SAF provided a framework within which they could be incorporated into the analysis.

We found the concept of ‘sources of authority’ to be particularly useful, as it provided a theoretical lens through which to consider the programme as a whole, including the high degree of enthusiasm we found amongst local actors. The ‘badge’ of being singled out to be part of the programme provided a powerful political source of authority to enthuse local actors, and the consonance between the programme and the local beliefs and values of front-line public service workers has been highlighted. However, our study also offers some clarifications with regard in particular to political sources of authority as applied within the Vanguard programme. Moulton and Sandfort (2017) describe ‘political’ authority as that which: *‘defines what is legally permissible, establishes mandated processes, stipulates which public institutions are vested with legal responsibilities, and delineates hierarchical governance relationships between fields’* (p. 154). In our study – and perhaps in policy pilots more generally – we suggest that the notion of *political* authority also incorporates the concept of legitimacy and sanction to act outside the rules. Vanguards were not legal entities, nor were they clearly situated within hierarchical governance relationships; nevertheless, the sense of legitimacy associated with the Vanguard label was an important one which we would identify as ‘political’. We are using ‘political’ here as in the sense that politics is concerned with the acquisition and exercise of power (King and Marian, 2008), and in our case studies we found that being labelled as a Vanguard gave local actors the power to over-ride rules and to act in ways which would not normally be sanctioned, including disregarding the national rule enshrined in the Health and Social Care Act 2012 that commissioners should put services out to competitive tender in most circumstances (Osipovic et al, 2019). Political authority, therefore, in the context of policy pilots, can mean legitimacy to act outside current rules, in addition to authority arising out of those rules. This

is in keeping with recent literature exploring policy pilots as 'states of exception' (Bailey et al., 2019) – in this case, being a Vanguard gave local areas authority to act as exceptions, outside the rules. In addition, the fact that public consultation had taken place (irrespective of the content of that consultation) also provided powerful political authority, providing legitimacy for the desired course of action (Harrison and Mort, 1998). Economic authority was a powerful motivator, with a common narrative built around the need for radical change in the face of long term funding deficits. However, as predicted by Moulton and Sandfort (2017, p154), incentives and payments could be a double edged sword, with particular targets and the vagaries of the annual funding rounds proving problematic.

Similarly, the category of 'norms' as a source of authority provided a useful analytical category, highlighting the importance of collaboration, a cornerstone of integrated care that was perceived as a 'new norm' within the case study sites. The enthusiasm with which this new norm of collaboration was embraced in all of our sites perhaps expresses the fact that, whilst the norm of competition between providers remains firmly enshrined in the formal rules and structures of the NHS, individual public sector managers have perhaps embraced it less than fully (Checkland et al, 2012). Given the multi-agency and multi-professional structures needed to achieve this collaborative state, our findings add different dimensions to Moulton and Sandfort's (2017) description of this category of the SAF framework. The authors suggest that norms can be expressed through professional codes, evidence-based practices, or industry standards, and can lead to 'binding expectations' of what needs to be considered during implementation activities. This infers a body of united professional opinion driven by requisite criteria. Within integrated care, however, norms in this description do not take into account multi-disciplinary working, where singular professional norms must become merged, or challenged in the name of collaboration. It is worth noting that, while this was viewed positively by our respondents, change or compromise may not be palatable or enduring. In addition, the Vanguards created new norms related to innovation, but these were at the same time risky and transient, with implications for long-term sustainability. Thus, through the lens of the Vanguards, our analysis sheds a different perspective on norms, providing some additional aspects to consider within the SAF framework.

The SAF framework is notable in not utilising the concept of leadership, preferring instead to focus upon 'socially skilled actors' and their actions. Indeed, Moulton and Sandfort's (2017) original exposition of the framework does not use the word 'leadership' at all. This is in marked contrast to many other frameworks for understanding change in organisations (By, 2005; Fitzgerald et al 2013; Best et al, 2012; Storey et al 2018). In our study we found the focus on social action rather than leadership useful, in that it ensured that actions by those in roles not conventionally associated with leadership would be captured. For example, some of those whose actions were identified as important saw themselves as 'facilitators' rather than leaders. Their own or their socially ascribed identity was less important than what they did. However, in operationalising the concept of 'skilled social action' we found that skills alone was not a rich enough concept to explain what we were seeing, as it leaves open the question of who gets to use the relevant skills. In order to understand this we found that we needed to add two concepts: contextual conditions; and enabling processes. Contextual conditions related to who acted in any given situation. Whilst in some sites leadership was relevant to the extent that much action was taken by those with formal authority by virtue of their position in an organisations, we also found that those without formal authority or leadership roles had established or were able to earn the positional authority to act as a result of their particular personal skills, experience and abilities. These had often been demonstrated in previous change programmes, and this provided licence to act in the here and now. Others had positional authority by virtue of fixed personal characteristics over which they had little control – these included longevity in a local area, and particular qualifications. Having a relevant clinical qualification could be a powerful enabler of position. Over and above position (which determined who got to act),

we found that other important contextual conditions included the pre-existence or rapid establishment of collaborative structures such as oversight boards or joint committees was important in providing a forum within which social skills could be used. The presence of individuals who acted naturally as boundary spanners and/or the appointment of staff to boundary spanning positions was also important. Whilst individuals can and do act as boundary spanners by virtue of personal agency or preferences, the establishment of formal positions which required such activity was helpful. Finally, we found that supportive processes could generate conditions which enabled and supported social actors utilising their skills. Mechanisms for communication were important, as was the availability of support from NHS England. Account managers, the national support team and programme leaders (Checkland et al 2019) created conditions which allowed local actors to effectively use their skills.

These findings are compatible with the work of Fitzgerald et al (2013), who sought to determine 'patterns of distributed leadership' present in successful health care change management programmes. They conclude that 'leadership' is necessary at three levels: senior management; middle management change agents; and local collaborators who engage enthusiastically with a change programme. As in our study, they highlight the important role of clinicians and the value of good local relationships. Our study extends these findings by highlighting the importance of longevity in a local area and 'earned personal position' as an important element in those local relationships. It is, perhaps, interesting to consider how two studies can reach such similar conclusions whilst using quite different language and concepts. This could suggest that the concept of 'leadership' adds little in understanding change beyond a post hoc label to give to the skilled social actors whose actions in practice influenced change. Indeed, current definitions of leadership perhaps acknowledge this, with, for example, Edmonstone (2019 p1) defining leadership thus: *"In this book leadership is seen as 'a social influence process through which emergent co-ordination (making social order) and change (new values, attitudes and behaviours) are constructed and produced (Bolden 2004)'. It is essentially therefore about the making and mending of working relationships between people and organisations in order to get things done"*. This could be a definition of skilled social action to support change, with the label of 'leadership' adding little.

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

### **6.3 Understanding major system change**

In our introductory chapters we highlighted the insights into major system change provided by Best et al (2012) and Turner et al (2016b). In this section we explore these normative claims, and consider how our insights might modify or expand them. Turner et al express their insights thus:

**Table 6: Rules for major system change in health services (adapted from Turner et al 2016)**

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

These 'rules' offer useful insights for those seeking to establish and support change programmes in health systems. They suggest an inherently rational process of change management, in which those in senior positions can and should assess the context in which they wish to make changes happen, designing a change programme to accommodate and manage these local contextual conditions. Our study offers some support for this approach, particularly acknowledging the value of political authority and the importance of system-wide governance structures.

We also found that each of our sites offered a complex and fluctuating picture of interwoven factors, including: individuals with particular positionality and agency; historical accretion and sedimentation of previous initiatives (Coleman et al., 2010) and locally specific structures and processes. Importantly, our study suggests that exactly what constitutes an important or relevant local contextual condition to be 'managed' may not be obvious until initial action has been taken. This is in keeping with the work of Weick (1995), who highlights the importance of action in allowing retrospective sensemaking about any given situation. The Vanguard programme interacted with this local complexity, supported by its associated political and economic authority, and its consonance with public service beliefs and values.

Our study therefore offers a further elucidation of the theories offered by Best et al (2012) and Turner et al. (2016) in two ways. Firstly, our study suggests certain aspects of local context which made the environment a receptive context for change (Hunter et al., 2015; Pettigrew et al., 1992). In this previous work eight factors are mentioned as potentially constituting a receptive context. Arguably most of these could apply to Vanguards: quality and coherence of policy, simplicity and clarity of goals and priorities (these two being further discussed in Coleman et al 2020), change agenda and its locale, environmental pressure (sustainability), management – clinical relations, co-operative inter-organisational networks (related to knowledge spread and learning) key people leading change and a supportive organisational culture. In particular, we found that having individuals championing change who had a significant history within a local area was helpful. Such individuals had garnered trust through previous roles and responsibilities, and were able to leverage that trust to support the Vanguard programme. Inevitably in any health and care system individuals will move between roles and across geographical areas, and it is often considered that mobility and



experience of multiple roles is useful in advancing in a chosen career. However, our study also suggests that investing in staff in situ, valuing their longevity and their deep knowledge of a particular context may bring dividends, as such people can, if engaged and involved, be powerful agents of change. Similarly our study suggests that the ability and willingness to seize opportunities was very important. This implies a system architecture which encourages local managers to be alert to potential opportunities and to feel empowered to act when such opportunities arise. This in turn suggests that a supportive approach to risk taking, in which performance management processes reward and encourage activity beyond narrow role specifications, may be valuable. Whilst in some ways the Vanguard programme was an unusual one (in particular it was unusually well-funded and supported), in others it was quite typical of health system policy programmes, in that it was announced with a very short timeframe for application and it grew out of previous similar initiatives. Our study suggests factors which may make systems more able to respond to such initiatives, including nurturing a stable cadre of engaged and knowledgeable staff, and setting up performance management and other systems which reward initiative and willingness to take calculated risks.

Secondly, our study suggests features of change programmes which may facilitate engagement. Turner et al (2016) highlight the need for 'system wide authority'; our study has shown the different types of authority that can be mobilised. Political and economic authority were very important, but so too was the authority arising out of the consonance between the beliefs and values embedded in the programme, and those common in public organisations and espoused by local actors. This consonance was a vital element in the Vanguard programme. Similarly, the strong supportive structures put in place – including the role of the account managers – were important in initiating and maintaining the programme, with meso-level encouragement and recognition from someone outside the local area seen as a very important element promoting engagement.

In summary, our study confirmed some of the findings of Turner et al (2016) but also elucidated some additional contextual factors which were important in supporting local change initiatives. We have also highlighted some features of the Vanguard programme which facilitated engagement.

#### **6.4 The Vanguard programme overall**

As we discussed in our interim report (Checkland et al., 2019, Coleman et al 2020), it was the overarching goal of the Vanguard programme to generate transferrable 'models of care' underpinned by standard products and frameworks which could be quickly scaled and spread. This goal was manifestly not achieved but, nonetheless, our case study areas all felt that engagement with the programme had been valuable for them in a wide variety of ways. At its core, it would appear that the initial framing of the programme as permissive and grounded in local realities was vital in generating engagement and also played an important role in the valued outcomes that our sites described, including the development of trust and sense of shared purpose across organisational boundaries. The consonance of the programme with the common public sector values of co-operation and collaboration was important in this. Looking back over the programme as a whole it would seem that the notion of a codified 'model of care' was probably misconceived because of the sheer complexity embodied in the notion of 'integrated care', alongside the complexity of local contexts. Even where the initiatives implemented were superficially similar – MDTs, for example – we found a wide variety in operationalisation of the concepts in ways which were usually locally appropriate. This suggests that seeking 'the best way' to provide care or achieve any given outcome is likely to prove problematic. What the Vanguard programme offered for local sites was funding and support to work together on a variety of projects, which in turn generated deeper trust and led to some reduction in unhelpful barriers between services. Such a programme may lack high profile rapid impact but in fact support useful and sustainable incremental change.

However, the programme also contained some inherent problems. In particular, the annual funding round was significantly destabilising, with those whose funding was withdrawn in the second or third years struggling to maintain any progress made and even those whose funding was maintained struggling with the inability to plan beyond the year end. Moreover, the shift in policy focus away from Vanguard's halfway through the programme to focus on larger geographies under the label of 'Integrated Care Systems (ICSs)' was also problematic, as it failed to capture lessons learnt in any systematic way. Respondents told us that they felt that the programme had 'petered out' without any clear attempt to learn lessons or to consider what elements of the Vanguard experience might be relevant in the quest to integrate care across wider geographies. Any scaling up or spreading of lessons from the Vanguard's into ICSs was dependent upon the individual actions of social actors who obtained roles in ICSs and who took their experiences with them or spread via the work of boundary spanners across the system levels.

### **6.5 Lessons for developing policy and for future policy programmes**

Most Vanguard's operated at a population scale of around 200-300,000. The NHS Long Term Plan (NHS England, 2019) designates this level as 'place' in the developing system, but provides no details as to what is envisaged as occurring at this level. Focus is now upon ICSs (covering 1-3 million population) and local 'neighbourhood' Primary Care Networks (PCN), covering populations of 30-50,000. Considering our case study findings, a number of lessons may be transferrable to these different levels, including: the value of a compelling narrative in establishing the nature of the problem and a case for change; the value of local knowledge and experience; the need for trust; the need for support for risk taking and flexibility in roles; and the importance of finding a narrative that chimes with existing beliefs and values. All of these factors may be equally as important at 'system' and 'neighbourhood' level as we found them to be at 'place'. However, there may also be some issues in this transfer, arising out of the nature of the different levels. Firstly, we found that trust was developed in the close working together on concrete programmes of work across organisational boundaries. ICSs cover very large populations and it is unlikely that such concrete programmes will exist. In Greater Manchester, for example, whilst strategic plans are made at the ICS level (known as the Greater Manchester Health and Social Care Partnership), it is at locality (place) level that concrete programmes of integrative work are taking place (Walshe, Lorne et al 2018). Developing trust between partners at ICS level will therefore require a different approach. Secondly, PCNs cover much smaller populations and are likely to be supported by many of the factors that we have identified. However, PCNs are being developed using a contractual model containing tight specifications, which focuses upon general practice (British Medical Association & NHS England and NHS Improvement, 2020), with all incentives so far directed at GP surgeries. Our study suggests that such strong economic authority directed at one sector may militate against the necessary shared beliefs and values which supported the Vanguard sites. Finally, the general enthusiasm and positive experiences of those involved in the Vanguard's that we have documented suggests that 'place' is a scale which can be comprehended and engaged with by those working locally. Our respondents repeatedly told us that their particular community of local organisations was well-placed to address issues relating to care co-ordination and planning. The absence of policy directed at this level of the system within the long term plan is, perhaps, concerning. At the very least, our study suggests that 'place' might be an appropriate scale at which the activities of a number of primary care networks ('neighbourhoods') should be co-ordinated and overseen.

More generally, our study suggests a need for a more considered transition from one policy to another. Lessons from the Vanguard programme may have been incorporated into the programme for ICSs, and elements of the EHCH Vanguard's are being explicitly rolled out via PCNs, but there does not appear to have been a systematic approach to such learning, at least in public. The Vanguard

programme was well-funded, supported and evaluated, and it would be a missed opportunity if the rich experience gained in the programme was not used to support ongoing policy development.

## **6.6 Strengths and weaknesses**

As a retrospective examination of the impact of the Vanguard programme our study inevitably will have failed to capture all of the nuances of implementation. However, our qualitative approach, underpinned by a strong theoretical framework has allowed us to generate some rich data and draw lessons which go beyond the immediate context of this particular policy programme. We have elucidated some issues which will be relevant to other policy programmes and contributed to an elaboration of previous work on major system change. We only collected data in six case study sites, and so may have missed important issues from other sites. However, we were reassured to find how closely the sources of authority and social skills mobilised in each of our sites resembled one another, and are confident that the issues we have highlighted apply more widely to change programmes.

## **6.7 Future work**

The most obvious legacy from the Vanguard programme is the roll out of improvements to enhanced health in care homes via the PCN programme (NHSE 2019, NHSE 2020). In the final phase of this research we will explore that roll out, examining whether and how the learning from the Vanguard programme has informed PCN service development. In addition, we will undertake a further quantitative analysis in order to explore whether the small improvements in emergency admissions seen in the latter stages of the Vanguard programme have been sustained over time. A final report will bring together the findings of the entire evaluation programme that we have carried out.

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## **Appendix A**

### **National evaluation of the Vanguard new care models programme Interim report: understanding the national support programme: Executive Summary**

**October 2018**

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## **Introduction and background**

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

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

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

## **Study aims, objectives and research questions**

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

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

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

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

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

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

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

## **Theoretical framework**

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

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

We have used Matland's (1995) classification of policy programmes to help aid the identification of appropriate approaches to implementation. He summarises both top down and bottom up models of policy implementation and suggests a number of possible definitions of 'implementation success'. He suggests that adjudicating between these different definitions depends upon an understanding of the goals of those developing policy, and that therefore approaches to implementation should be different depending upon the characteristics of the policies concerned. His resulting model classifies

policies along two axes: the degree of conflict, and the degree of ambiguity. Conflict, as envisaged by Matland, refers to policy goals or means to achieving policy goals which are, in some way, incommensurate or incompatible. 'Conflict' does not necessarily mean conflict in its colloquial sense of overt opposition or political wrangles. Ambiguity refers to how far goals are clear.

In addition, we characterise Vanguards as forms of policy pilot<sup>1</sup> and use Ettelt et al's (2014) definition of the purposes underlying policy piloting to explore the programme. These include:

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

## Methods

In this report we address the following research questions:

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

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

## Work package 1 methods

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

**WP1b:** understanding the national context (macro level) Between October 2017 and March 2018 we carried out 29 national level interviews with a variety of respondents at the national level, leads, consisting of current and past NHSE employees (n=19), advisors (n=7) and Arm's Length Bodies (n=3.) In addition, in spring 2018 we collaborated with the National Audit Office (2018) in carrying out a survey of Vanguard leads.

## Findings

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

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

## **Programme goals**

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

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

In Matland's (1995) terms the programme was high in ambiguity – the proposed 'models of care' were not specified in detail – and low in conflict, in that the programme is presented as being the settled view of all of the relevant NHS organisations, with a clear road towards the development of defined models of care. Careful reading of the policy documents suggests that the Vanguard programme was conceived of as a pilot supporting early implementation (as evidenced by the intention to establish Vanguards in areas which have 'already made good progress') and for learning, with an explicit intention that the Vanguard sites would test out approaches to change, which would then be spread more widely.

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

## **The support programme**

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

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

It is difficult to establish clearly the exact costs of the NCM programme. Direct funding to the 50 Vanguards, the NHSE NCM team, evaluations (national and local) and funding from the Vanguards themselves, set against savings being generated would ideally be included. The recent NAO report (2018) suggests approximately £329m direct investment between 2015 and 2018 with an additional £60m on the Vanguard NCM programme, support and monitoring (including national and local evaluation and staff costs). However, support costs are approximate, as there is no clear accounting for the time of staff seconded from other roles in NHSE to support the programme.

### **The evaluation programme**

The programme was underpinned by an extensive evaluation programme, consisting of the following elements: Individual Vanguard evaluations, including locally commissioned evaluations and a quarterly 'dashboard' setting out performance against a number of headline metrics compared with baseline and with non-Vanguard sites. Outcomes from the whole cohort of MCP and PACs Vanguards were compared with counterfactuals, using statistical techniques to establish whether or not any changes seen were statistically significant. Some individual interventions were subject to evaluation; Interventions common across a number of Vanguards were subject to thematic studies in order to understand how different contexts affected these Independent national evaluation (our study). In addition, an Improvement Analytics Unit was set up in partnership with the Health Foundation in order to provide advanced analytics support to NHSE. The Unit has so far produced 2 detailed analyses of individual Vanguard performance, with a third completed but not yet published.

### **Enabling and inhibiting factors**

We found some common features, mechanisms and ways of working which helped in achieving the programme's goals and supporting its operation. These included: The development of relationships and alliances, incorporating learning and feedback, with local Account managers particularly valued; Robust and multi-modal means of communication; Strong local and national leadership; Availability of expert knowledge and skills (within and outside the programme); Flexibility within the programme, with the support team endeavouring to react to the needs of local sites; Good level of funding (across the programme elements).

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

### **Assessment of programme success**

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

The impartial nature of the national elements of the evaluation (including the data dashboards and the IAU) were felt to be helpful, as was the rigorous approach to assessing outcomes. This impartial and rigorous approach to evaluation was somewhat in contrast to the active approach taken by the national support team to generating case studies and 'good news' about the Vanguards for dissemination. The purpose of this activity was to generate and maintain local enthusiasm, in keeping with the 'bottom up' approach to development, as well as to provide evidence of progress to ensure continuing national support for the programme and wider dissemination of the approach.

### **Cross-cutting themes**

In addition to the specific issues relevant to the different aspects of the support programme, we also found a number of issues arising across the interviews: Being a pilot: licence to do things differently?

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

These tensions are inherent in the programme which was seen as both long and short, bottom up whilst meeting narrowly defined top down goals, and capable of both scaling up and spreading out. In addition, many of the elements of the programme were found to have multiple purposes. For example, local evaluations were intended to support local learning and feedback, and provide formative evidence for sites, but also provide context for the findings coming out of the broader analysis of data. The programme itself also appeared to have had multiple purposes. Piloting for demonstration, implementation and learning are all visible in the initial design and set up of the programme, whilst the evaluation team took an approach which constructed Vanguard teams as experiments which may or may not deliver better outcomes. This highlights the inherent contradiction in the programme between an underlying assumption that the new care models would be beneficial (evidenced by the initial intention to have waves of Vanguard teams and by the requirement for STPs to demonstrate that that were going to roll out MCPs, PACS and ECHs) and the commitment to robust evaluation designed to explore in depth whether or not new care models delivered better outcomes. This contradiction is made more acute by the narrowing of national focus on outcomes down to a small number of measures of hospital use, as it is possible that Vanguard teams may have been delivering service improvements not captured by these metrics.

## **Discussion and conclusions**

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

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

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

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

### **Lessons for policy**

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

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

However, other issues were not always helpful such as: Data availability and sharing issues; The rapid pace of the programme overall; Undertaking multiple local evaluations was an expensive and time-consuming approach, which requires further assessment.

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

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

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

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

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