BMJ Open

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Journal:	*BMJ Open*
Manuscript ID	bmjopen-2019-032107
Article Type:	Research
Date Submitted by the Author:	04-Jun-2019
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Keywords:	New Care Models, Health systems, Implementation, National Health Service, England

Lessons learnt from the implementation of New Care Models in the NHS: A qualitative study of the North East Vanguards Programme

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Keywords: New Care Models, Health systems, Implementation, National Health Service, England

Word count: 3994

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ABSTRACT

Objectives To examine lessons learnt from the implementation of five Vanguard initiatives in the North East region of England.

Design Data collection comprised semi-structured interviews with key informants at each site.

Setting The study took place across six Local Authority areas in the North East of England and within six Clinical Commissioning Group (CCG) responsible for the delivery of each Vanguards' aims and objectives.

Participants Sixty-six interviewees with participants from five Vanguard initiatives in the North East of England including senior clinicians, project leads and directors, commissioners and health care managers.

Results While the context for each Vanguard is separate and distinct, there also exists a set of common issues which have a regional dimension. Participants felt that the national programme helped to raise the profile of local change initiatives and also contributed to the wider understanding of regional service integration issues. At the same time our findings demonstrate that all five sites experienced, and were subject to, unrealistic pressure placed upon them to deliver outcomes. Of particular concern among all sites was the sheer scale and pace of change occurring at the same time as the NHS was being tasked with making significant, if unrealistic, efficiency savings.

Conclusions It is too early to conclude with any confidence that a successful outcome for the NCM programme will be forthcoming. While early indications show some encouraging signs of promise, the overall context in which the complex and ambitious changes are being implemented remains both fragile and fluid.

Strengths and limitations of this study

- This is the only regional study to explore factors shaping the implementation of five Vanguard initiatives in England.
- The findings provide insights relevant to the implementation of different Vanguard initiatives.
- Data were collected from a broad range of stakeholders across healthcare and social care.
- The majority of participants had a senior role and were directly involved in the implementation of each Vanguard. Service users were not recruited for this study.

INTRODUCTION

Following publication of the *NHS Five Year Forward View* (5YFV) in 2014, a Vanguard programme was introduced by NHS England (the executive non-departmental public body of the Department of Health and Social Care which oversees the NHS) to test different approaches to health and social care service delivery.[1] These reform initiatives have typically taken place under the banner of Triple Aim thinking with its focus on population health, effective patient-centred care, and per capita cost.[2] The NHS invited individual organisations , including those with voluntary and community sector involvement, to apply to become pilot sites for the New Care Models (NCMs) programme. Overall, 50 pilot sites (typically referred to as Vanguards) were established across England charged with the task of designing and delivering a range of NCMs aimed at tackling deep-seated problems of a type facing all health systems to a greater or lesser degree. These include: managing rising demand on accident and emergency services, keeping people out of hospital, effecting rapid discharge for those no longer in need of acute care, integrating health and social care, reducing silo working, and giving higher priority to prevention. The NCMs proposed changes that sought new ways of working and joining up care across a whole system driven by those on the front-line.

This paper reports on qualitative research exploring factors shaping the implementation of five NCM initiatives in the North East region of England: Multispecialty Community Providers (MCP); Integrated Primary and Acute Care Systems (PACS; Acute Care Collaboration (ACC) Enhanced Health in Care Homes (EHCH); and Urgent and Emergency Care (UEC) (see Table 1 for a brief description of each NCM). These pilots aimed to reconfigure the way healthcare is organised and delivered by shifting care from acute hospitals to primary or community-based health services and by strengthening health and social care integration. The study was conducted during a time of ongoing policy changes in the NHS, notably developments surrounding integrated policy frameworks such as Sustainability and Transformation Partnerships (STPs), Accountable Care Organisations (ACOs), and Integrated Care Systems (ICSs) [3-6].

SETTING

The study took place across six Local Authority areas in the North East of England and within six Clinical Commissioning Groups (CCG) responsible for the delivery of each Vanguard. The CCGs embraced diverse geographies and incorporated large pockets of both densely populated and dispersed populations. The region is characterised by high levels of socioeconomic deprivation, high prevalence of unhealthy behaviours, and life expectancy for both men and women is lower than the England average. The North East population has an over reliance on hospital based care, at 20% above the national average.[7]

RECRUITMENT AND SAMPLING

Data collection comprised semi-structured interviews (66 in total; see Table 1) with key informants at each site and a detailed review of Trusts' internal documents and policies

related to the implementation of each Vanguard. Stakeholders were identified through the North of England Commissioning Support Unit and from each Vanguard steering group. Potential interviewees were sent an email invitation, which briefly outlined the aims and objectives of the study. Those agreeing to participate were invited to recommend additional candidates for interview. Individuals who agreed to participate in the study were provided with information sheets in advance. Once any questions were answered, participants gave informed consent prior to the start of the interview.

<Table 1 about here>

PATIENT AND PUBLIC INVOLVEMENT

Patients and or public were not involved in this study.

DATA COLLECTION

Face-to-face interviews were conducted between December 2016 and May 2017 and were typically around an hour. A topic guide, informed by published literature on health systems transformation and integrated care, was shared with members of each Vanguard's steering group to ensure its suitability for the interviews. No further topics were added. Interviews ceased once it became clear that no new themes were emerging from the data. Interviews were conducted by two experienced researchers, audio recorded and transcribed.

DATA MANAGEMENT AND ANALYSIS

Transcribed interview data were analysed using thematic analysis.[8] Drawing upon an interpretative approach, themes were developed iteratively and inductively, breaking down and reassembling the data through a coding process. To ensure analytical rigour, two members of the research team independently coded and analysed the qualitative data. These were then reviewed and discussed at wider research team meetings, with any discrepancies resolved through this process. Following the analysis within each site, a comparative case study approach[9] was used to compare and contrast factors shaping the implementation arrangements across all five NCMs. For confidentiality, all participants have been anonymised.

FINDINGS

Analysis of the data generated six broad themes relating to factors shaping the implementation of the five Vanguard initiatives: (1) uncertainty around policy and government targets (2) legitimating return on investment (3) managing organisational governance structures across care settings (4) improving inter-organisational relations and practices (5) building capacity and resources (6) securing commitment and engagement. Our

primary focus is on common issues and concerns across all five models. Unless otherwise stated, the quotations used reflect the general view expressed by interviewees.

THE REGIONAL CONTEXT

Interviewees highlighted aspects of the regional infrastructure and services that provided a favourable basis for Vanguard changes mainly due to the historic collaborative nature of the health community within the North East. All five sites acknowledged that the Vanguard programme provides a significant opportunity for the North East to improve the way services are organised and provided to meet the rapidly changing needs of its population. From a regional perspective, it was recognised among those interviewed that the Vanguards provided a platform for regional collaboration and the sharing of good practice with the potential this offers to strengthen the scale and pace of change, and to do so in a more cost-effective fashion. Moreover, it was acknowledged that the resources provided though each Vanguard helped to raise awareness of the innovative local initiatives underway across the North East.

THEME 1: UNCERTAINTY AROUND POLICY AND GOVERNMENT TARGETS

Our findings demonstrated that each pilot site had different aims and purposes, local arrangements and practices. These factors had to be set against a wider context of significant financial tensions, uncertainty around the direction of policy, and fundamental questions about the future including the impact of more recent policy developments that, as noted earlier, are dominating the agenda.

I think we've had so many central directive changes over the last 18 months that it really hasn't helped with trying to get buy-in. From new care models becoming very much NHS-driven programmes, to Sustainability and Transformation Partnerships superseding local plans, to various things that just create layer upon layer of uncertainty, really - a lot of goal-post changes. (EHCH-Senior Manager 6, CCG)

In this context, it was felt that government's pressure to deliver efficiencies and an undue emphasis on performance can hinder progress:

We've been influenced heavily though by the national direction of travel around standards and improvements and national must-dos, which at times has conflicted with what we've been attempting to do. (UEC-Senior Manager 5, CCG)

Overall, uniting all five pilot sites was their perception of the wider context within which they operated. They were critical in various ways of NHS England, particularly in terms of the unrealistic pressure placed upon them to deliver outcomes. There was a sense in which the pressure being felt was forcing the pilot sites to deliver without the appropriate substantive change being in place or sufficiently embedded and without being able to show sufficient or adequate evidence to support change. In this context, pressure for quick results was a major complaint:

There's been a lot of pressure from NHS England for certain things to be done on frameworks and time series and delivery plan sort of thing, so there is often a push from the office-based vanguard staff that we need to get certain things done. A clinician always puts the patient first whereas a project manager puts the project first, so that can be quite difficult. (EHCH, Senior Manager 14, CCG)

Of particular concern was the sheer scale and pace of change at the same time as the NHS was being tasked with making significant, if unrealistic, efficiency savings. Interviewees in all five pilot sites criticised NHS England for failing to appreciate the length of time 'change' takes.

THEME 2: LEGITIMATING RETURN ON INVESTMENT

A number of interviewees pointed to the benefits of being able to draw upon the support from the national programme but there was evidence of a tension between national pressures and the need to maintain locally driven change. As a participant in the MCP pilot commented:

So the demand to see efficiencies to deliver…feels very top-down from a very high level…particularly in the last year as opposed to the few years before that when we've had time to do a bottom-up drive for designing change. (MCP-Senior Manager 2, CCG)

Discussions regarding the national (ie English) NHS agenda tended to fall broadly into a number of categories. There was a minority group of respondents who acknowledged the invaluable support they believed they had received through being part of the NCM programme. For most however, this clearly was thought to have come at a price. As one respondent in the PACS pilot commented:

There's an incredible level of scrutiny on you to be successful. I think the politics of it play out in the sense of trying to give you enough time to see results but at the same time, wanting results really fast so that they can roll models out nationally…it worries me we get the right answers. (PACS-Senior Manager 3, CCG)

In this context, a number of interviewees criticised the NCM programme's ambitious plans for sustainable transformation during a period of significant financial pressures and uncertainty for the future of the NHS. Within all pilot sites there were concerns that too much was being expected too soon in terms of demonstrating a 'return on investment' in digital capacity.

Nothing really gets time to bed in before the next initiative comes along – they give you £1m and want to know the return on investment is £1.0325!. (UEC-Senior IT Manager 2, CCG)

Availability of resources was considered to be a key factor for the successful implementation of each NCM. However, uncertainty around the availability of funding was evident within all

sites. For example, cuts in the anticipated funding to digital developments have already made an impact.

THEME 3: MANAGING ORGANISATIONAL GOVERNANCE STRUCTURES ACROSS CARE SETTINGS

Although participants felt that the NCM initiatives have the potential to address the problem of silo working across organisations, they also acknowledged that current organisational arrangements could sometimes be a barrier to successful joint working. As one interviewee in the Care Home pilot commented:

At the moment, there's a boundary line that comes in between each thing that you do. "That's health. That's social work." It shouldn't be like that. It should be everybody working together for one outcome for the patient or the service user. (EHCH-Senior Manager 7, CCG)

It was felt that different organisational structural and governance arrangements across different providers could serve as a barrier to the delivery of the programme's aims and objectives. As an interviewee in the UEC pilot commented:

We have two acute trusts and the focus in each acute trust is very different, and the pressures in each acute trust are very different, and they conflict. (UEC-Senior Manager 3, CCG)

Although interviewees reported how successfully relationships had been developed with different sectors, a central focal point of discussions concerned the difficulties that the work and nature of the NCMs could cause with external partners. For example in the case of the ACC pilot the innate competitiveness of hospital trusts ran somewhat counter to acute care collaboration and at times was thought to harbour suspicion and mistrust.

Then, there needs to be a bit of a behavioural shift, because by nature hospital trusts are competitive with each other and counter to the collaborative approach, which is what acute care collaboration is about. Generally, it can be quite parochial. (ACC-Senior Manager 1, CCG)

It had been harder convincing potential partners that the relationship would be built upon collaboration and not competition or indeed acquisition. In this regard, difficulties were highlighted but most felt that lessons had been adequately learned. The following view is typical of those expressed in interviews.

I think it is going back to prior to the Vanguard we were going through a process to acquire xxx. I think that learning has helped us to understand some unintended consequences that we wouldn't want to repeat around culture, and how during major change cultures collide, and what we would do differently. (ACC-Senior Manager 1, CCG)

THEME 4: IMPROVING INTER-ORGANISATIONAL RELATIONS AND PRACTICES

Sharing good practice through the development of multidisciplinary teams (MDT) was felt important along with the growing recognition that joint working was the only way to work in times of severe budget constraints and cuts. However, it was felt that there could be problems when new organisations, or new representatives, came along, in terms of bringing them up-to-date with the intentions and progress of the NCM programme. For some participants the inclusion of many different organisations could also add complexity.

You're pulling together lots of different employers and areas of work which, although all the people in the room might be very up for all working together, once you bring the bigger beasts in, it's not as simple as that ... you're wrestling, then, with lots of different sets of values, ability to change, flexibility... (EHCH-Senior Manager 5, CCG)

Even though relationships between health and social care had been built up over many years, it was thought they had not really materialised on the ground. One respondent reported that the contrast between working within the 'flat structure' of the CCG compared to the bureaucratic and hierarchical structure of the Foundation Trust and local authority was particularly challenging.

So the people who would be my equivalent colleagues, we don't spend any time together - we don't really understand what each other is doing and whether there is any crossover or conflict. (PACS-Senior Manager 4, CCG)

Difficulties in operational relationships were also evident between the acute and community sectors and the seeming lack of enthusiasm among acute clinicians for working in the community.

We still haven't cracked the relationship and models of care about how we pull our secondary care colleagues out working into the community more. We done some decent pilots of it at a local level...but what we haven't done is starting looking at that integration of relationships across the whole county that wraps around that. (PACS-Senior Manager 3, CCG)

Although there were concerns that inter-professional communication and understanding remained a challenge generally it was felt by many that there was evidence that this was shifting.

THEME 5: BUILDING CAPACITY AND RESOURCES

Participants valued the national programme for the 'pump priming' that had allowed plans to get underway and be supported earlier than perhaps would have happened otherwise. However, many of the interviewees were highly critical of the reduction in the programme's financial support with no guarantee of funding over the three years. There was additionally a common perception that the short-term investment was insufficient to sustain the work and

development and that once the financial support disappeared, the programme would continue but its pace would be a good deal slower.

I am not confident with it coming to a sudden end…because if they are not providing any money or any funds how are they going to keep up the impetus on delivery? I don't think we'd stop because we've got that relationship with organisations now - I just don't know if it would continue as extensively as it is doing now. (ACC-Senior Manager 4, CCG)

Aside from resources, time and 'back-fill' of staff were additionally considered to be major barriers. Further, staff had to see the value and benefit of the team.

I think the biggest issue about MDT working is creating the time where people I think are working exceptionally hard. There isn't an additional workforce that you can put in because there is nobody to back-fill…it is less about the money and more about the workforce. (PACS-Senior Manager 1, CCG)

Those professionals whose time was funded (so that they could get cover for sessions) felt this allowed them to attend MDT meetings and participate to a greater extent. As a participant at the Care Homes pilot commented:

One of the benefits is having the time to think about what is useful. Normally as a GP you don't get much time to reflect on the value of what you are doing or why you are doing it, or how you might be doing it. (EHCH-Senior Manager 12, CCG)

However, there appeared to be some resentment that not everyone's time was covered and that for many the tasks undertaken and meetings attended were just assumed to be part of their everyday responsibilities.

THEME 6: SECURING COMMITMENT AND ENGAGEMENT

Amongst all pilot sites, there was much praise for the very high levels of commitment shown by participants. This was felt to lead to much better outcomes, with people keen to meet objectives and to share experiences or learning. In this context, buy-in from organisations or particular professional groups was considered key to success but often a very challenging task. As one participant in the UEC pilot commented:

I think what helps the Vanguard project is the buy-in … getting some of the understanding and the buy-in from some of our local authority partners, has been very challenging. (UEC-Senior Manager 7, CCG)

Although, there was thought to be a lot of committed people within the region, interviewees noted that not all providers had fully signed up to working within the NCM programme. In particular, concerns were raised in the PACS pilot that some Trusts had not yet agreed to participate to the ACO leading one interviewee to comment as follows:

The elephant in the room is the fact that we have a great big hospital trust which still sits in the area…It is a bit of a concern because from a needs perspective the people that go to that hospital tend to be more affluent…we are just going, oh that's a bit hard, let's concentrate on the easy stuff, rather than looking at the whole thing. (PACS-Senior Manager 4, CCG)

Some argued that the programme had been left to key individuals and although other members of staff were kept informed, there was a perception that the understanding had not filtered through into the wider healthcare system. It was hard to make the necessary and at-pace change when full collective ownership was not present. Again, attention was drawn to the perceived isolated pieces of work and accompanying lack of awareness.

I mean the challenge, which we think we crack but we don't really crack is engagement. Engaging health care workers and other leaders in the system…I would say it is a fragile thing, engagement from leaders to healthcare workers, particularly GPs, it has to be developed. (PACS-Senior Manager 9, CCG)

DISCUSSION

Summary of findings

A number of important lessons have emerged from the implementation of the five North East Vanguards. Many are self-evident and not new although that makes them no less important. Some are also in the process of being addressed while others may demand urgent attention, especially at national policy and political levels. Despite the *5YFV*'s emphasis on 'local flexibility'[10] to support implementation, our findings demonstrate that all five sites experienced, and were subject to, unrealistic pressure placed upon them to deliver outcomes. There was a sense in which the pressure coming from the centre (ie 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. In particular, there was a perception that government targets and an undue emphasis on performance were seriously hindering progress.[11-13] The overriding impression, particularly in the PACS pilot, was that there were pockets of excellence and impressive examples of new working but this was not replicated evenly or consistently across the programme as a whole. There was, though, some evidence emerging in terms of the development of local hubs or federations of GPs which were thought to be sustainable. Of particular concern among all pilot sites was the sheer scale and pace of change occurring at the same time as the NHS was being tasked with making significant, if unrealistic, efficiency savings.

In all sites participants felt that the national programme helped to raise the profile of local change initiatives and also contributed to the wider understanding of regional service integration issues. Moreover, it was felt that the programme enhanced or speeded up certain actions (in particular regional MDT involvement). However, the need for a system-wide approach was recognised and an emphasis was placed on collective rather than individual action.[14] At an organisational level, the need for, and importance of, relationship-building was also common to all five sites but in each there appeared to be different obstacles to progress.[14] It was suggested that the national programme helped individual sites to build

inter- and intra-organisational relationships. Nonetheless, common to all five was the significant amount of effort and time that had been put into creating better relationships among partners. In addition, there were tensions between the need for real investment in terms of capacity, capability and finance, the accompanying risk, and the ability to deliver outcomes. In particular, concerns were raised over the lack of additional resources to support transformation efforts.

Strengths and limitations

This study provides insights relevant to the different Vanguard initiatives across England. A particular strength is its region-wide focus which complemented the separate local evaluations[15-21] and produced findings that have a regional dimension with possible implications for future policy and change in the North East. Our data were collected from a broad range of stakeholders across healthcare and social care although a potential limitation is that the majority of participants occupied senior roles and were directly involved in the implementation of each Vanguard. While this might influence generalizability across different stakeholders perspectives, our findings illustrate commonly expressed views across all five Vanguard initiatives. Another potential limitation is that service users were not recruited for this study.

Comparison with other work

Previous studies of health systems transformation have identified factors that are key to the successful implementation of policy, including supportive organisational culture, cooperative inter-organisation networks, clear communication and a willingness to engage with systems leaders.[14] Our key findings echo those reported in an earlier ambitious transformational change initiative undertaken in the North East of England.[22] This occurred prior to the major structural changes imposed on the NHS as a consequence of the Health and Social Care Act 2012 and had it not been for that disruptive legislation the initiative would have continued as there was a high degree of commitment to it and a significant investment of resources and political and managerial capital. Known as the North East Transformation System (NETS), it drew for its inspiration on the Virginia Mason Production System in the US which centred on Lean thinking, tools and approaches. Similar findings in regard to changing the culture, relationship-building and embedding change in a sustainable manner were documented. The learning from such complex change approaches remain valid and pertinent to current transformation efforts.

CONCLUSIONS

This study was conducted within a limited time period during which there has been considerable and continuing policy churn, notably developments surrounding STPs and ICSs [23], accompanied by growing financial pressures on the NHS. Inevitably, this has raised issues and concerns about the sustainability of the positive developments underway across the NCM national programme some of which have been highlighted in this paper. It is too early to conclude with any confidence that a successful outcome for the NCM programme will be forthcoming although the NHS Long Term Plan[24] seeks to build on the earlier vision set out

in the Five year Forward View. While early indications show some encouraging signs of promise, the overall context in which the complex and ambitious changes are being implemented remains both fragile and fluid.

Acknowledgements: We would like to thank all the participants in the North East Vanguards who gave so freely of their time in being interviewed and meeting requests for information. We would like to thank Jean Brown and Kate Melvin for their involvement in conducting the majority of interviews.

Contributions: GM and DH designed the study in collaboration with JE and BH. JB, KM and BH conducted interviews. GM analysed data with input from all authors. GM drafted the article in collaboration with DH. GM is guarantor of the article. All authors critically reviewed the manuscript and approved the final version.

Competing interests: The authors declare that they have no competing interests.

Funding: The paper presents independent research that was funded by the National Health Service England (NHS). This support is gratefully acknowledged.

Data availability statement: The datasets analysed during the study are stored on a secure server and are available from the corresponding author on reasonable request.

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Table 1: List of interviewees

Vanguard	No. of interviews	Interviewees
MCP Vanguard	7	Senior Manager, CCG
MCP Vanguard	1	Senior Manager, LA
MCP Vanguard	3	Senior IT Manager, CCG
PACS Vanguard	11	Senior Manager, CCG
PACS Vanguard	2	Senior IT Manager, CCG
ACC Vanguard	7	Senior Manager, CCG
ACC Vanguard	3	Senior IT Manager, CCG
Enhanced Health in Care Homes Vanguard	14	Senior Manager, CCG
Enhanced Health in Care Homes Vanguard	3	Senior IT Manager, CCG
Urgent and Emergency Care Vanguard	11	Senior Manager, CCG
Urgent and Emergency Care Vanguard	4	Senior IT Manager, CCG
Total	**66**	

BMJ Open

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Journal:	*BMJ Open*
Manuscript ID	bmjopen-2019-032107.R1
Article Type:	Original research
Date Submitted by the Author:	20-Aug-2019
Complete List of Authors:	Maniatopoulos, Gregory ; Newcastle University, Institute of Health and Society; Hunter, David; Newcastle University, Institute of Health and Society Erskine, Jonathan; Durham University Hudson, Bob; University of Kent, Centre for Health Services Studies
Primary Subject Heading:	Health policy
Secondary Subject Heading:	Health services research
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Conclusions It is too early to conclude with any confidence that a successful outcome for the New Care Models (NCMs) programme will be forthcoming. While early indications show some encouraging signs of promise, the overall context in which the complex and ambitious changes are being implemented remains both fragile and fluid.

Strengths and limitations of this study

- This is the only regional study to explore factors shaping the implementation of five Vanguard initiatives in England.
- The findings provide insights relevant to the implementation of different Vanguard initiatives.
- Data were collected from a broad range of stakeholders across healthcare and social care.
- The majority of participants had a senior managerial role and were directly involved in the implementation of each Vanguard. Service users were not recruited for this study.

INTRODUCTION

Following publication of the *NHS Five Year Forward View* (5YFV) in 2014, a Vanguard programme was introduced by NHS England (the executive non-departmental public body of the Department of Health and Social Care which oversees the NHS) to test different approaches to health and social care service delivery.[1] These reform initiatives have typically taken place under the banner of Triple Aim thinking with its focus on population health, effective patient-centred care, and per capita cost.[2] The NHS invited individual organisations , including those with voluntary and community sector involvement, to apply to become pilot sites for the New Care Models (NCMs) programme. Overall, 50 pilot sites (typically referred to as Vanguards) were established across England charged with the task of designing and delivering a range of NCMs aimed at tackling deep-seated problems of a type facing all health systems to a greater or lesser degree. These include: managing rising demand on accident and emergency services, keeping people out of hospital, effecting rapid discharge for those no longer in need of acute care, integrating health and social care, reducing silo working, and giving higher priority to prevention. The NCMs proposed changes that sought new ways of working and joining up care across a whole system driven by those on the front-line.

This paper reports on qualitative research exploring factors shaping the implementation of five NCM initiatives in the North East region of England[3]: Multispecialty Community Providers (MCP); Integrated Primary and Acute Care Systems (PACS; Acute Care Collaboration (ACC) Enhanced Health in Care Homes (EHCH); and Urgent and Emergency Care (UEC) (see Table 1 for a brief description of each NCM). These pilots aimed to reconfigure the way healthcare is organised and delivered by shifting care from acute hospitals to primary or community-based health services and by strengthening health and social care integration. The study was conducted during a time of ongoing policy changes in the NHS, notably developments surrounding integrated policy frameworks such as Sustainability and Transformation Partnerships (STPs), Accountable Care Organisations (ACOs), and Integrated Care Systems (ICSs). [4-7]

SETTING

The study took place across six Local Authority areas in the North East of England and within six Clinical Commissioning Groups (CCG) responsible for the delivery of each Vanguard. The CCGs embraced diverse geographies and incorporated large pockets of both densely populated and dispersed populations. The region is characterised by high levels of socioeconomic deprivation, high prevalence of unhealthy behaviours, and life expectancy for both men and women is lower than the England average. The North East population has an over reliance on hospital based care, at 20% above the national average.[8]

RECRUITMENT AND SAMPLING

Data collection comprised semi-structured interviews (66 in total; see Table 2) with key informants at each site and a detailed review of Trusts' internal documents and policies

related to the implementation of each Vanguard. Stakeholders were identified through the North of England Commissioning Support Unit and from each Vanguard steering group according to their role and involvement in the implementation of each Vanguard and included clinicians, chief executives, commissioner managers, project managers, and other specialists. Participants in all sites were representative of the implementation arrangements of each NCM. Potential interviewees were sent an email invitation, which briefly outlined the aims and objectives of the study. Those agreeing to participate were invited to recommend additional candidates for interview. Individuals who agreed to participate in the study were provided with information sheets in advance. Once any questions were answered, participants gave informed consent prior to the start of the interview. Ethical approval was gained from Newcastle University Research Ethics Committee (ref: 01216/2016).

<Table 2 about here>

PATIENT AND PUBLIC INVOLVEMENT

Patients and/or public were not involved in this study.

DATA COLLECTION

Face-to-face interviews were conducted between December 2016 and May 2017 and were typically around an hour. A topic guide, informed by published literature on health systems transformation and integrated care, was shared with members of each Vanguard's steering group to ensure its suitability for the interviews. No further topics were added. Interviews ceased once it became clear that no new themes were emerging from the data. Interviews were conducted by two experienced qualitative researchers, audio recorded and transcribed.

DATA MANAGEMENT AND ANALYSIS

Transcribed interview data were analysed using thematic analysis[9] ,without the aid of a software programme. Drawing upon an interpretative approach, themes were developed iteratively and inductively, breaking down and reassembling the data through a coding process. To ensure analytical rigour, two members of the research team independently coded and analysed the qualitative data from the 66 semi-structured interviews completed. These were then reviewed and discussed at wider research team meetings, with any discrepancies resolved through this process. Following the analysis within each site, a comparative case study approach[10] was used to compare and contrast factors shaping the implementation arrangements across all five NCMs. For confidentiality, all participants have been anonymised.

FINDINGS

Analysis of the data generated six broad themes relating to factors shaping the implementation of the five Vanguard initiatives: (1) uncertainty around policy and future

change (2) financial pressures and legitimating return on investment (3) managing organisational governance structures across care settings (4) improving inter-organisational relations and practices (5) building capacity and resources (6) securing commitment and engagement. Our primary focus is on common issues and concerns across all five models. Unless otherwise stated, the quotations used reflect the general view expressed by interviewees.

THE REGIONAL CONTEXT

Interviewees highlighted aspects of the regional infrastructure and services that provided a favourable basis for Vanguard changes mainly due to the historic collaborative nature of the health community within the North East. All five sites acknowledged that the Vanguard programme provides a significant opportunity for the North East to improve the way services are organised and provided to meet the rapidly changing needs of its population. From a regional perspective, it was recognised among those interviewed that the Vanguards provided a platform for regional collaboration and the sharing of good practice with the potential this offers to strengthen the scale and pace of change, and to do so in a more cost-effective fashion. Moreover, it was acknowledged that the resources provided through each Vanguard helped to raise awareness of the innovative local initiatives underway across the North East.

THEME 1: UNCERTAINTY AROUND POLICY AND FUTURE CHANGE

Our findings demonstrated that each pilot site had different aims and purposes, local arrangements and practices. These factors had to be set against a wider context of significant financial tensions, uncertainty around the direction of policy, and fundamental questions about the future including the impact of more recent policy developments that, as noted earlier, are dominating the agenda.

I think we've had so many central directive changes over the last 18 months that it really hasn't helped with trying to get buy-in. From new care models becoming very much NHS-driven programmes, to Sustainability and Transformation Partnerships superseding local plans, to various things that just create layer upon layer of uncertainty, really - a lot of goal-post changes. (EHCH-Senior Manager 6, CCG)

In this context, it was felt that government's pressure to deliver efficiencies and an undue emphasis on performance can hinder progress:

We've been influenced heavily though by the national direction of travel around standards and improvements and national must-dos, which at times has conflicted with what we've been attempting to do. (UEC-Senior Manager 5, CCG)

Overall, uniting all five pilot sites was their perception of the wider context within which they operated. They were critical in various ways of NHS England, particularly in terms of the unrealistic pressure placed upon them to deliver outcomes. There was a sense in which the pressure being felt was forcing the pilot sites to deliver without the appropriate substantive

change being in place or sufficiently embedded and without being able to show sufficient or adequate evidence to support change. In this context, pressure for quick results was a major complaint:

There's been a lot of pressure from NHS England for certain things to be done on frameworks and time series and delivery plan sort of thing, so there is often a push from the office-based vanguard staff that we need to get certain things done. A clinician always puts the patient first whereas a project manager puts the project first, so that can be quite difficult. (EHCH, Senior Manager 14, CCG)

Of particular concern was the sheer scale and pace of change at the same time as the NHS was being tasked with making significant, if unrealistic, efficiency savings. Interviewees in all five pilot sites criticised NHS England for failing to appreciate the length of time 'change' takes.

THEME 2: FINANCIAL PRESSURES AND LEGITIMATING RETURN ON INVESTMENT

A number of interviewees pointed to the benefits of being able to draw upon the support from the national programme but there was evidence of a tension between national pressures and the need to maintain locally driven change. As a participant in the MCP pilot commented:

So the demand to see efficiencies to deliver…feels very top-down from a very high level…particularly in the last year as opposed to the few years before that when we've had time to do a bottom-up drive for designing change. (MCP-Senior Manager 2, CCG)

Discussions regarding the national (ie English) NHS agenda tended to fall broadly into a number of categories. There was a minority group of respondents who acknowledged the invaluable support they believed they had received through being part of the NCM programme. For most however, this clearly was thought to have come at a price. As one respondent in the PACS pilot commented:

There's an incredible level of scrutiny on you to be successful. I think the politics of it play out in the sense of trying to give you enough time to see results but at the same time, wanting results really fast so that they can roll models out nationally…it worries me we get the right answers. (PACS-Senior Manager 3, CCG)

In this context, a number of interviewees criticised the NCM programme's ambitious plans for sustainable transformation during a period of significant financial pressures and uncertainty for the future of the NHS. Within all pilot sites there were concerns that too much was being expected too soon in terms of demonstrating a 'return on investment' in digital capacity.

Nothing really gets time to bed in before the next initiative comes along – they give you £1m and want to know the return on investment is £1.0325!. (UEC-Senior IT Manager 2, CCG)

Availability of resources was considered to be a key factor for the successful implementation of each NCM. However, uncertainty around the availability of funding was evident within all sites. For example, cuts in the anticipated funding to digital developments have already made an impact.

THEME 3: MANAGING ORGANISATIONAL GOVERNANCE STRUCTURES ACROSS CARE SETTINGS

Although participants felt that the NCM initiatives have the potential to address the problem of silo working across organisations, they also acknowledged that current organisational arrangements could sometimes be a barrier to successful joint working. As one interviewee in the Care Home pilot commented:

At the moment, there's a boundary line that comes in between each thing that you do. "That's health. That's social work." It shouldn't be like that. It should be everybody working together for one outcome for the patient or the service user. (EHCH-Senior Manager 7, CCG)

It was felt that different organisational structural and governance arrangements across different providers could serve as a barrier to the delivery of the programme's aims and objectives. As an interviewee in the UEC pilot commented:

We have two acute trusts and the focus in each acute trust is very different, and the pressures in each acute trust are very different, and they conflict. (UEC-Senior Manager 3, CCG)

Although interviewees reported how successfully relationships had been developed with different sectors, a central focal point of discussions concerned the difficulties that the work and nature of the NCMs could cause with external partners. For example in the case of the ACC pilot the innate competitiveness of hospital trusts ran somewhat counter to acute care collaboration and at times was thought to harbour suspicion and mistrust.

Then, there needs to be a bit of a behavioural shift, because by nature hospital trusts are competitive with each other and counter to the collaborative approach, which is what acute care collaboration is about. Generally, it can be quite parochial. (ACC-Senior Manager 1, CCG)

It had been harder convincing potential partners that the relationship would be built upon collaboration and not competition or indeed acquisition. In this regard, difficulties were highlighted but most felt that lessons had been adequately learned. The following view is typical of those expressed in interviews.

I think it is going back to prior to the Vanguard we were going through a process to acquire xxx. I think that learning has helped us to understand some unintended consequences that we wouldn't want to repeat around culture, and how during major change cultures collide, and what we would do differently. (ACC-Senior Manager 1, CCG)

THEME 4: IMPROVING INTER-ORGANISATIONAL RELATIONS AND PRACTICES

Sharing good practice through the development of multidisciplinary teams (MDT) was felt important along with the growing recognition that joint working was the only way to work in times of severe budget constraints and cuts. However, it was felt that there could be problems when new organisations, or new representatives, came along, in terms of bringing them up-to-date with the intentions and progress of the NCM programme. For some participants the inclusion of many different organisations could also add complexity.

You're pulling together lots of different employers and areas of work which, although all the people in the room might be very up for all working together, once you bring the bigger beasts in, it's not as simple as that ... you're wrestling, then, with lots of different sets of values, ability to change, flexibility... (EHCH-Senior Manager 5, CCG)

Even though relationships between health and social care had been built up over many years, it was thought they had not really materialised on the ground. One respondent reported that the contrast between working within the 'flat structure' of the CCG compared to the bureaucratic and hierarchical structure of the Foundation Trust and local authority was particularly challenging.

So the people who would be my equivalent colleagues, we don't spend any time together - we don't really understand what each other is doing and whether there is any crossover or conflict. (PACS-Senior Manager 4, CCG)

Difficulties in operational relationships were also evident between the acute and community sectors and the seeming lack of enthusiasm among acute clinicians for working in the community.

We still haven't cracked the relationship and models of care about how we pull our secondary care colleagues out working into the community more. We done some decent pilots of it at a local level...but what we haven't done is starting looking at that integration of relationships across the whole county that wraps around that. (PACS-Senior Manager 3, CCG)

Although there were concerns that inter-professional communication and understanding remained a challenge generally it was felt by many that there was evidence that this was shifting.

THEME 5: BUILDING CAPACITY AND RESOURCES

Participants valued the national programme for the 'pump priming' that had allowed plans to get underway and be supported earlier than perhaps would have happened otherwise. However, many of the interviewees were critical of the uncertainty in the programme's

financial support with no guarantee of funding over the three years. There was additionally a common perception that the short-term investment was insufficient to sustain the work and development and that once the financial support disappeared, the programme would continue but its pace would be a good deal slower.

I am not confident with it coming to a sudden end…because if they are not providing any money or any funds how are they going to keep up the impetus on delivery? I don't think we'd stop because we've got that relationship with organisations now - I just don't know if it would continue as extensively as it is doing now. (ACC-Senior Manager 4, CCG)

Aside from resources, time and 'back-fill' of staff were additionally considered to be major barriers. Further, staff had to see the value and benefit of the team.

I think the biggest issue about MDT working is creating the time where people I think are working exceptionally hard. There isn't an additional workforce that you can put in because there is nobody to back-fill…it is less about the money and more about the workforce. (PACS-Senior Manager 1, CCG)

Those professionals whose time was funded (so that they could get cover for sessions) felt this allowed them to attend MDT meetings and participate to a greater extent. As a participant at the Care Homes pilot commented:

One of the benefits is having the time to think about what is useful. Normally as a GP you don't get much time to reflect on the value of what you are doing or why you are doing it, or how you might be doing it. (EHCH-Senior Manager 12, CCG)

However, there appeared to be some resentment that not everyone's time was covered and that for many the tasks undertaken and meetings attended were just assumed to be part of their everyday responsibilities.

THEME 6: SECURING COMMITMENT AND ENGAGEMENT

Amongst all pilot sites, there was much praise for the very high levels of commitment shown by participants. This was felt to lead to much better outcomes, with people keen to meet objectives and to share experiences or learning. In this context, buy-in from organisations or particular professional groups was considered key to success but often a very challenging task. As one participant in the UEC pilot commented:

I think what helps the Vanguard project is the buy-in … getting some of the understanding and the buy-in from some of our local authority partners, has been very challenging. (UEC-Senior Manager 7, CCG)

Although, there was thought to be a lot of committed people within the region, interviewees noted that not all providers had fully signed up to working within the NCM programme. In particular, concerns were raised in the PACS pilot that some Trusts had not yet agreed to participate to the ACO leading one interviewee to comment as follows:

The elephant in the room is the fact that we have a great big hospital trust which still sits in the area…It is a bit of a concern because from a needs perspective the people that go to that hospital tend to be more affluent…we are just going, oh that's a bit hard, let's concentrate on the easy stuff, rather than looking at the whole thing. (PACS-Senior Manager 4, CCG)

Some argued that the programme had been left to key individuals and although other members of staff were kept informed, there was a perception that the understanding had not filtered through into the wider healthcare system. It was hard to make the necessary and at-pace change when full collective ownership was not present. Again, attention was drawn to the perceived isolated pieces of work and accompanying lack of awareness.

I mean the challenge, which we think we crack but we don't really crack is engagement. Engaging health care workers and other leaders in the system…I would say it is a fragile thing, engagement from leaders to healthcare workers, particularly GPs, it has to be developed. (PACS-Senior Manager 9, CCG)

DISCUSSION

Summary of findings

A number of important lessons have emerged from the implementation of the five North East Vanguards (see Table 3). Many are self-evident and not new although that makes them no less important. Some are also in the process of being addressed while others may demand urgent attention, especially at national policy and political levels. Health system transformation is difficult work and takes time.[11-12] Attention to the key messages cannot guarantee success but is likely to strengthen the chances of transformation being achieved.

<Table 3 about here>

Despite the *5YFV*'s emphasis on 'local flexibility'[13] to support implementation, our findings demonstrate that all five sites experienced, and were subject to, unrealistic pressure placed upon them to deliver outcomes. There was a sense in which the pressure coming from the centre (ie NHS England) 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. In particular, there was a perception that government targets to deliver efficiencies and an undue emphasis on performance were seriously hindering progress.[14-16] The overriding impression, particularly in the PACS pilot, was that there were pockets of excellence and impressive examples of new working but this was not replicated evenly or consistently across the programme as a whole. There was, though, some evidence emerging in terms of the development of local hubs or federations of GPs which were thought to be sustainable. Of particular concern among all pilot sites was the sheer scale and pace of change occurring at the same time as the NHS was being tasked with making significant, if unrealistic, efficiency savings.

In all sites participants felt that the national programme helped to raise the profile of local change initiatives and also contributed to the wider understanding of regional service integration issues. Moreover, it was felt that the programme enhanced or sped up certain actions (in particular regional MDT involvement). However, the need for a system-wide approach was recognised and an emphasis was placed on collective rather than individual action.[17] At an organisational level, the need for, and importance of, relationship-building was also common to all five sites but in each there appeared to be different obstacles to progress.[18] It was suggested that the national programme helped individual sites to build inter- and intra-organisational relationships. Nonetheless, common to all five was the significant amount of effort and time that had been put into creating better relationships among partners. In addition, there were tensions between the need for real investment in terms of capacity, capability and finance, the accompanying risk, and the ability to deliver outcomes. In particular, concerns were raised over the lack of additional resources to support transformation efforts.

Our findings have demonstrated the need for a fuller and deeper understanding of developments by exploring in greater depth the development of STPs, ACOs and ICSs that are now occupying centre stage in NHS England's transformation efforts. In addition, there is a need to explore the wider national policy context as well as to understand the perceptions of front-line staff and service users in order to establish the degree of alignment or, conversely, to identify where policy and practice is at risk of pushing or pulling against each other. Furthermore, in a context where devolution is a live and evolving issue in England in places like Greater Manchester, the West Midlands and other areas, we recommend that further research is needed to examine and understand the current implementation of the Vanguards programme with a view to establishing how far, if at all, the regional dimension is a significant factor in transformation efforts and one perhaps meriting additional support and attention.[19]

Strengths and limitations

This study provides insights relevant to the different Vanguard initiatives across England. A particular strength is its region-wide focus which complemented the separate local evaluations[20-25] and produced findings that have a regional dimension with possible implications for future policy and change in the North East. Our data were collected from a broad range of stakeholders across healthcare and social care although a potential limitation is that the majority of participants occupied senior roles and were directly involved in the implementation of each Vanguard. While this might influence generalizability across different stakeholders perspectives, our findings illustrate commonly expressed views across all five Vanguard initiatives. Another potential limitation is that service users were not recruited for this study.

Comparison with other work

Previous studies of health systems transformation have identified factors that are key to the successful implementation of policy, including supportive organisational culture, cooperative inter-organisation networks, clear communication and a willingness to engage with systems leaders.[17] Our key findings echo those reported in an earlier ambitious transformational change initiative undertaken in the North East of England. [26]This occurred prior to the major

structural changes imposed on the NHS as a consequence of the Health and Social Care Act 2012 and had it not been for that disruptive legislation the initiative would have continued as there was a high degree of commitment to it and a significant investment of resources and political and managerial capital. Known as the North East Transformation System (NETS), it drew for its inspiration on the Virginia Mason Production System in the US which centred on Lean thinking, tools and approaches. Similar findings in regard to changing the culture, relationship-building and embedding change in a sustainable manner were documented. The learning from such complex change approaches remain valid and pertinent to current transformation efforts.

CONCLUSIONS

This study was conducted within a limited time period during which there has been considerable and continuing policy churn, notably developments surrounding STPs and ICSs [27], accompanied by growing financial pressures on the NHS. Inevitably, this has raised issues and concerns about the sustainability of the positive developments underway across the NCM national programme some of which have been highlighted in this paper. It is too early to conclude with any confidence that a successful outcome for the NCM programme will be forthcoming although the NHS Long Term Plan[28] seeks to build on the earlier vision set out in the Five year Forward View. While early indications show some encouraging signs of promise, the overall context in which the complex and ambitious changes are being implemented remains both fragile and fluid.

Acknowledgements: We would like to thank all the participants in the North East Vanguards who gave so freely of their time in being interviewed and meeting requests for information. We would like to thank Jean Brown and Kate Melvin for their involvement in conducting the majority of interviews.

Contributions: GM and DJH designed the study in collaboration with JE and BH. JB, KM and BH conducted interviews. GM analysed data with input from all authors. GM drafted the article in collaboration with DJH. GM is guarantor of the article. All authors critically reviewed the manuscript and approved the final version.

Competing interests: The authors declare that they have no competing interests.

Funding: The paper presents independent research that was funded by the National Health Service England (NHS) through the support of the North East Commissioning Support Unit (NECS). This funding is gratefully acknowledged as is the support received from NECS for the duration of the study.

Ethics approval: Ethical approval was gained from Newcastle University Research Ethics Committee (ref: 01216/2016). NHS Research Ethics approval was not required for this study.

Data availability statement: The datasets analysed during the study are stored on a secure server and are available from the corresponding author on reasonable request.

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Table 1: Vanguard Sites

Vanguard	Aim of programme
Multispecialty Community providers (MCPs)	The Vanguard aims to move care out of the hospital into the community. It involved the implementation of an out of hospital model of care focusing on: people staying independent and well for as long as possible; people living longer with a better quality of life with long term conditions; people supported to recover from episodes of ill health and following injury; resilient communities and high levels of public satisfaction. The MCP Vanguard began in April 2015 although pre-Vanguard elements began implementation from 2013.
Primary and Acute Care Systems (PACS)	The Vanguard aims to develop a new variant of 'vertically integrated' care allowing single organisations to provide joined up GP, hospital, community and mental health services. It involved the development of a new Urgent and Emergency Care Hospital and the development of an 'enhanced care teams' pilot and new workforce models (Transforming Primary Care). The PACS Vanguard began in June 2015 and the Trust became the first Accountable Care Organisation in the region – effective from April 2017.
Acute Care Collaboration Vanguard (ACC)	The Vanguard aims to link local hospitals together to improve their clinical and financial viability, reducing variation in care and efficiency. It aims to widen the support and services (i.e. commercial/contractual services, consultancy/advisory as well as a range of clinical and corporate services) the Trust can provide to other parts of the NHS through acquiring and/or merging with other hospital Trusts. The ACC Vanguard was finalised in January 2016.
Enhanced Health in Care Homes Vanguard (EHCH)	The Vanguard aims to offer older people better, joined up health, care and rehabilitation services. It aims to develop a sustainable, high quality new care model for people in community beds and receiving home based care services across a metropolitan area with a new outcome based contract and payment system that supports the development of the Provider Alliance Network (PAN) delivery vehicle. The Vanguard started March 2015 although some features had been implemented pre-Vanguard status.
Urgent and Emergency Care Vanguard (UEC)	The Vanguard aims to improve the coordination of urgent and emergency care as a whole system, ensuring people can access the most appropriate service, first time. The Vanguard status was awarded in July 2015 and the programme has been fully operational since November 2016. Most initiatives went live in December 2016.

Table 2: List of interviewees

Vanguard	No. of interviews	Interviewees
MCP Vanguard	7	Senior Manager, CCG
MCP Vanguard	1	Senior Manager, LA
MCP Vanguard	3	Senior IT Manager, CCG
PACS Vanguard	11	Senior Manager, CCG
PACS Vanguard	2	Senior IT Manager, CCG
ACC Vanguard	7	Senior Manager, CCG
ACC Vanguard	3	Senior IT Manager, CCG
Enhanced Health in Care Homes Vanguard	14	Senior Manager, CCG
Enhanced Health in Care Homes Vanguard	3	Senior IT Manager, CCG
Urgent and Emergency Care Vanguard	11	Senior Manager, CCG
Urgent and Emergency Care Vanguard	4	Senior IT Manager, CCG
Total	**66**	

Table 3: Key Learning Points and Messages for Development

Learning Points	Messages for Development
Importance of encouraging and valuing local flexibility and context	Avoid micro-management from centre; allow the front line the space needed to own the changes and discover what works for it
Allow sufficient time for changes to become embedded	Resist the undue emphasis on meeting targets and being seen to perform and get quick results
Uneven development evident in 5 Vanguards; it was not replicated consistently	Achieve consistency by providing opportunities for regional bodies to encourage learning
Relationship-building is key in intra- and inter-organisational working	Invest in nurturing and maintaining relationships, including leadership
Value of a collective approach	Acknowledge important role for regional bodies to spread learning and break silos
Importance of investment to support transformation efforts; Vanguards have been affected by uncertainty over ongoing availability of transformation funds	Ensure adequate and secure resourcing is available for length of time required
Previous transformation initiatives (eg NETS) offer valuable lessons relevant to Vanguards but these are invariably overlooked or ignored	Rediscover valid lessons from previous reforms that have been evaluated and documented, paying close attention to what works and doesn't work and why

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	Page/line no(s).
Title and abstract	
Title - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	Pg. 1 lines 3-4 Pg. 2 lines 3-7
Abstract - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	Pg. 2 lines 10-56
Introduction	
Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	Pg. 3 lines 5-23
Purpose or research question - Purpose of the study and specific objectives or questions	Pg. 3 lines 26-38
Methods	
Qualitative approach and research paradigm - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**	Pg. 3 line 58-60 Pg. 4 line 3-11
Researcher characteristics and reflexivity - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	Pg. 3 line 58-60 Pg. 4 line 3-11
Context - Setting/site and salient contextual factors; rationale**	Pg. 3 lines 45-52
Sampling strategy - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**	Pg. 3 line 58-60 Pg. 4 line 3-11 Pg. 4 line 26-32
Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	Pg. 4 line 3-11
Data collection methods - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**	Pg. 4 line 26-32

Data collection instruments and technologies - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	Pg. 4 line 26-32
Units of study - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	Pg. 3 line 58-60 Pg. 4 line 3-11
Data processing - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts	Pg. 4 lines 38-48
Data analysis - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**	Pg. 4 lines 38-48
Techniques to enhance trustworthiness - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale**	Pg. 4 lines 38-48

Results/findings

Synthesis and interpretation - Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	Pg. 4-10 lines 54-20
Links to empirical data - Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	Pg. 4-10 lines 54-20

Discussion

Integration with prior work, implications, transferability, and contribution(s) to the field - Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	Pg.10 lines 28-60 Pg.11 lines 2-10 Pg.11 lines 32-48
Limitations - Trustworthiness and limitations of findings	Pg. 11 lines 16-26

Other

Conflicts of interest - Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	Pg. 13 lines 15
Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting	Pg. 13 lines 17-18

*The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

**The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

Reference:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. Academic Medicine, Vol. 89, No. 9 / Sept 2014 DOI: 10.1097/ACM.0000000000000388