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## Care home services at the vanguard: stakeholder views on the development and evaluation of novel, integrated approaches to enhancing health care in care homes.

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3 **Care home services at the vanguard: stakeholder views on the development and**  
4 **evaluation of novel, integrated approaches to enhancing health care in care homes**  
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## Abstract

**Objectives** To explore stakeholders' understanding of novel integrated approaches to enhancing care in care homes (a care home 'vanguard') and identify priorities for evaluation.

**Design** Interviews with commissioners and providers of services to/within care homes, and local third sector organisations with thematic analysis.

**Setting** A Clinical Commissioning Group (CCG) area in England.

**Participants** 30 interviewees from: care homes, the health service and local authority, third sector (10 care home managers, local (CCG) and national (NHS England) vanguard leads, health and social service commissioners, specialist nurses, general practitioners, geriatricians, social worker).

**Results** The vision for the new programme was shared by stakeholders, with importance attached to equitable access to high quality care. Support for the programme was described as being 'the right thing to do', inferring a moral imperative to the work. However, the practical implications of key aspects, such as integrated working, were not clearly understood and the programme was perceived by some as being imposed, top down, from the health service. Barriers and facilitators to change were identified across themes of communication, outcomes, trust and complexity. Importance was attached to the measurement of intangible but important aspects of success, such as the level of collaboration. Interviewees understood that outcome-based commissioning was one elements of the new programme, but discussion of their aspirations and practices revealed values and beliefs that were more compatible with a system based on trust.

## Conclusions

Innovation in service delivery requires organisations to adopt common priorities and share responsibility for success. The vanguard programme is working to ensure health and local authorities have this commitment, but engaging care homes that may feel isolated from the welfare system, needs sustained dialogue over the longer term. Evaluation of the programme needs to measure what is important to stakeholders, and not focus too closely on resource consumption.

## Strengths and limitations

To our knowledge, this is the first study to explore aspects of an English vanguard initiative prior to implementation. The findings provide insights that should be relevant across the different vanguard programmes. We were successful in obtaining a broad representation of stakeholders across health and social care. However, it is important to note that only one participant was recruited from the charitable sector.

## Introduction

The health and social care needs of residents in long-term settings are increasing in complexity, as the number of older adults in the population grows.<sup>1 2</sup> Bed numbers in care homes have remained stable in recent years, and the average age of residents is 85 years.<sup>2</sup> Multiple morbidities are common; it is estimated that four out of five care home residents have a cognitive impairment whilst a similar proportion live with incontinence.<sup>3 4</sup> Despite presenting some of the most challenging problems in primary care, care home residents are believed to have poorly coordinated services, worse management of long-term conditions, and inequitable access to hospital care, compared to community dwelling older adults.<sup>5 6</sup>

Integrated working between health and social care is advocated as an appropriate, cost-effective way of improving quality in care homes.<sup>7-9</sup> However, integrated care has been defined and implemented in many different ways. NHS England describe it as person-centred, coordinated, and tailored to the needs and preferences of the individual and their family.<sup>10</sup> To date, efforts to integrate care in a range of different countries and systems have produced limited evidence of improved outcomes.<sup>11</sup> A number of possible explanations have been proposed, including inadequate resources, the adoption of piecemeal rather than whole-system change<sup>5 12 13</sup>, and a failure to adequately involve service users and families.<sup>14</sup>

The UK policy response to rising demands for better quality of care, has included development of new, integrated ways of working.<sup>15</sup> Investment in 50 different 'vanguard' programmes in England has focused on integrating primary and acute care, multispecialty community providers, urgent and emergency care, and acute care collaborations. Six sites were selected to enhance health in care homes.<sup>16</sup> Evaluation of any new intervention is essential to provide reliable evidence to inform commissioning choices.<sup>17</sup> It is even more

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3 important in the case of the vanguard programme, as the new models aim to be replicable  
4 across England. Programmes that bring together health and social care may be particularly  
5 challenging to evaluate. Multiple stakeholders may not agree on outcomes, information  
6 collection across settings can be difficult, and appropriate sources of data may not be readily  
7 available.<sup>18</sup> Many integrated care programmes aim to reduce resource use, and changes in  
8 unplanned admissions to hospital is a commonly measured outcome. Less tangible concepts,  
9 such as trust and collaboration between organisations have also been proposed as indicators  
10 of success.<sup>19</sup> There is a growing consensus around the need to scrutinise processes involved  
11 in any intervention, including feasibility and acceptability. Recent methodological  
12 developments, such as realist evaluation, have emphasised the importance of taking time to  
13 understand the complexities of the local context.<sup>17 20</sup>

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23 The proposed programme of change under investigation in this study consists of different  
24 work streams that encompass commissioning and service provision, care pathways,  
25 workforce and evaluation (Box 1).  
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34 This paper reports on qualitative research aiming to inform the evaluation of a new model of  
35 integrated care for care homes (care home vanguard) in England. At the time of the study,  
36 the vanguard programme was in the first year of development and had not officially started.  
37 Study objectives were to:  
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42 a) Explore stakeholders' understanding, perceptions and expectations of the  
43 new programme, how it will be implemented, and the mechanisms by which it may  
44 effect change in the local context.  
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46 b) Identify the priorities for evaluation of the programme.  
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## 50 51 **Method**

52 Semi-structured interviews were conducted with 30 stakeholders in the local care home  
53 vanguard. Stakeholders were identified by the Clinical Commissioning Group (CCG) from (i)  
54 the vanguard steering group, (ii) local services that were involved in the commissioning or  
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3 delivery of care for residents of long-term care, (iii) organisations with an interest in the care  
4 and wellbeing of residents. The CCG acted as gatekeepers and sent introductory emails to  
5 potential participants. A researcher (RS, (Research Associate, PhD health services research,  
6 female, experienced in qualitative studies)) contacted potential participants directly by  
7 email or telephone and invited participation. Non-responders (n=14) were reminded after  
8 one week. Interviewees who were care home managers were asked to nominate colleagues  
9 from different homes, to boost recruitment from this setting. No inclusion or exclusion  
10 criteria were employed.

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22 Interviews were conducted in March-April 2016, by telephone or in person (at the  
23 participant's workplace in a private area), and lasted 30-60 minutes. A topic guide was  
24 developed, informed by published literature and the requirements of the research  
25 commissioners (see Box 2). It was piloted with members of the research team.  
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31 Box 2 here  
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34 All interviews were conducted by the same qualitative researcher (RS), audio recorded and  
35 transcribed. All transcripts were anonymised.  
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### 38 39 **Data analysis**

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41 A thematic analysis was conducted, using NVivo version 11 software to manage data. The  
42 interview transcripts were read and reread to familiarise ourselves with the text. The  
43 interviewer coded every transcript line by line, and a subset (10/30) of transcripts were  
44 coded by a second researcher (BH). Emergent themes were identified in discussion with the  
45 research team, and linked together to form a final set of higher level themes. A data driven  
46 approach to the development of a coding framework was chosen, because our topic guide  
47 had been strongly influenced by the needs of the vanguard team, and we needed to ensure  
48 that any unrecognised issues of concern to the interviewees were included in the analysis.  
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## Findings

Participants were all stakeholders in the vanguard programme. Each had an interest in, or were engaged in, the commissioning or delivery of care for older people in care homes. Findings are presented across four themes: (i) understanding of the proposed changes; (ii) communication; (iii) outcomes; and (iv) trust and complexity. Quotations are presented to illustrate commonly expressed views, or unusual or contrasting perspectives.

### *The local context*

Interviewees described an area of great social disadvantage. The local economy had lost industries over many years, and had not fared well in recent public spending reviews. Long-term deprivation meant that levels of ill health were high, and the proportion of self-funding care home residents was believed to be lower than in other areas of the country. These factors were thought to present the vanguard with a particular set of challenges.

Interviewees highlighted aspects of the local infrastructure and services that provided a favourable basis for vanguard changes. The small geographical size, single local authority and single hospital (NHS Trust) were all expected to simplify relationships and communication. General practices in the area had a history of working well together. Relationships between hospital and community services were also good. Some felt that the generous provision of care home beds in this area meant that services did not have to strive hard to support patients in their own homes.

### ***Theme 1. Understanding of the proposed changes***

#### *A shared vision*

A majority of the interviewees shared a vision of improved care and quality of life for older people in the vanguard area. The CCG had aspirations for equitable access to care - 'the right care, delivered by the right person at the right time' and 'one bed, one outcome'. Others shared these sentiments. Support for the vanguard was described by more than one interviewee, as being 'the right thing to do', inferring a moral imperative to the work.



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3 *The person is at the centre of it and if they need a \*\*\*\*\* wheelchair or a dietician,*  
4 *then they should get it. Not about who pays, what the financial consequences are.*  
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6 [Care home manager (8)]  
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10 Interviewees were frank in their admissions of how little they understood about the  
11 vanguard programme, and how the vision would be achieved. This was attributed by some  
12 to the CCG's desire to involve a wide range of stakeholders in service design and  
13 development, and the resulting inertia in getting started. Others blamed a lack of clarity  
14 from NHS England, which filtered down into local vanguards. This uncertainty limited  
15 external discussions about the programme.  
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22 The majority of care home managers were familiar with the headline proposals, even if they  
23 had little idea of how the vanguard would influence their work. Staff turnover was a  
24 common issue; some care homes had new managers in post, which meant that initiatives  
25 (including vanguard) were not seized upon. Care home managers talked about the pressing  
26 issues that they faced daily, particularly staffing and liaising with care providers from  
27 different sectors. This limited the capacity of some of them to engage with the vanguard.  
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### 32 33 34 *A top-down health programme?*

35 Strategic involvement of local and national bodies was highlighted as a major strength of the  
36 vanguard. However, engagement of a broad constituency also raised questions about  
37 differing organisational agendas, and the threats that this may pose. A number of  
38 interviewees from outside the NHS expressed a perception that the vanguard was a health-  
39 dominated programme, imposed from above. This was explained in terms of historic links  
40 between care homes and general practitioners, and the fact that the vanguard is building on  
41 existing work rather than starting from scratch. There were concerns that a focus on health  
42 budgets and failure to align agendas would represent a missed opportunity to capitalise on  
43 an opportunity for radical change.  
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53 *Vanguard in [Town 1] could be seen to be the catalyst for this real localised joined up*  
54 *working. But this is all just about health budgets. And it is all just about health driven*  
55 *issues. And I think that is the massive missing agenda. Because if you could get the*  
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3 *Local Authority and Health to work on this, then they could be seen as an exemplar*  
4 *throughout the country.* [Local authority (3)]  
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8 The perceived imposition of vanguard was discussed in relation to changes to  
9 commissioning and contracting, and how these would be resisted by care homes if they  
10 were not fully engaged.  
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### 13 14 15 **Theme 2. Communication**

16 Communication was one of the most frequently mentioned influences on the success of the  
17 vanguard. Interviewees were concerned with the way in which information was  
18 communicated, as well as the content. Most talked of information-sharing relating to the  
19 vanguard changes, but a significant minority also aired their views on patient or resident  
20 related communication between health services and care homes, and different parts of the  
21 health service.  
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#### 27 28 29 *A shared language*

30 The absence of a shared language amongst vanguard stakeholders was noted by a number  
31 of interviewees. Discussion in meetings and the vanguard documentation was described as  
32 jargon filled, and potentially inaccessible to people from care homes and the third sector in  
33 particular. Some felt this limited their ability to engage in discussion and participate in the  
34 development of the vanguard.  
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40 The vanguard programme was acknowledged to be in development, so expectations of  
41 progress were modest. However, for some, their own lack of clarity as to the expected  
42 outcomes made communication about the vanguard difficult, within their own  
43 organisations.  
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#### 48 49 *Information sharing*

50 Prompt and widespread diffusion of information about vanguard was felt to be an  
51 important way of ensuring that care homes and others were engaged with the process.  
52 Information sharing was identified as a practical aspect of communication that could  
53 present a significant barrier. Many spoke of being unable to access electronic care records  
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3 from other care settings. This created delays in obtaining information and duplication of  
4 effort for many healthcare professionals.  
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8 *I think there needs to be better sharing of information. Around the access to our GP*  
9 *records. For people being able to look in, to know what I've done, or what I've said,*  
10 *so that there's no duplication of information.* [General  
11 practitioner (2)]  
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16 Nurses and care home managers reported delays in receiving records, and administrative  
17 barriers to records moving with patients. A number of participants also made a connection  
18 between transfer of information and patient or resident safety.  
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### 23 **Theme 3. Evaluation of outcome measures of success**

24 Interviewees proposed a range of measures to evaluate the vanguard intervention,  
25 reflecting concerns with structural aspects of the new model of care, the process of  
26 implementation and selected outcomes. Possible evaluation measures emerged across the  
27 interviews, at different organisational levels (individual, service, organisation and whole  
28 system) and perspectives (residents, staff, families). Where quantitative measures were  
29 proposed, someone, often the same interviewee, often suggested a complementary  
30 qualitative measure to understand or contextualise the information. Table 2 illustrates how  
31 some of the proposed measures fit together.  
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44 In addition to measures that the interviewees expected to be part of any evaluation, such as  
45 the number of hospital admissions, issues such as collaboration and trust between  
46 stakeholders were suggested as critical to the development of the vanguard programme.  
47 Several interviewees emphasised the need to measure what was important, not what was  
48 easy to record.  
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54 *If we could measure collaboration, I think it would be hugely beneficial, because I*  
55 *think that not only evaluates how the programme's developing, but potentially*  
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3 *collaboration is the solution to improving care and quality for patients, and value in*  
4 *the system.* [General practitioner (5)]  
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8 Many mentioned the importance of person-centred outcomes, with an older population  
9 living happier and healthier lives as a measure of success. None of the interviewees offered  
10 a clear definition of person-centred, or reflected on how system and organisational  
11 outcomes might relate to changes for individuals. Concerns were expressed about the  
12 practical difficulties of capturing information from care homes and residents, including  
13 residents without capacity, and the difficulty of interpreting information provided by  
14 proxies, such as family members.  
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#### 20 21 22 **Theme 4. Trust and complexity**

23 Interviewees expressed a desire to see the vanguard programme bring different parts of the  
24 care community together, with a common purpose. The talk of shared vision, and changes  
25 to hearts and minds, points to the expressed desire for trusting, collaborative relationships.  
26 The current reality for care homes, appeared to be some way from this goal. Relationships  
27 between care homes and both health and local authorities were discussed in terms of  
28 mistrust and misunderstanding. This came from two key sources; the relationships that had  
29 developed over years of funding negotiations with the local authority, and the care homes'  
30 experiences of regular interactions with the health service.  
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#### 39 *Relationships with external services*

40 Some care home managers felt that colleagues in the health sector did not respect their  
41 judgement, and that care home staff were not trusted to provide a reliable report on a  
42 resident's symptoms or health care needs. This was a particular concern with hospitals and  
43 the out of hours service. Relationships with GPs were generally reported in positive terms,  
44 but one care home manager described how GPs may not always appreciate the limits of the  
45 care home's expertise in health matters.  
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53 *We've had odd times where the GPs are like, "You don't need to bother me with this.*  
54 *There's nothing really wrong with them," and you're like, "Well, I know you know*  
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3 *that, but we didn't know that.* [Care home  
4 manager (5)]  
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8 Much of the dissatisfaction expressed by care homes concerned the processes involved in  
9 the care system, predominantly the NHS. The absence of an individual to take responsibility  
10 or coordinate a resident's care journey through external services, was a concern.  
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14 The vanguard programme was seen as having the potential to address some of these  
15 concerns, improving care processes and efficiency of care pathways and enhancing trust  
16 between the sectors. Scrutiny of discharge transitions was presented as an example of how  
17 the vanguard might be able to effect change.  
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23 *I think the process of discharge from the hospital could be measured better. Has*  
24 *there been an assessment done? Is the person being discharged with their*  
25 *medication, a discharge letter or any follow-up referrals?* [Care  
26 home manager (7)]  
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32 For the care home managers, funding issues were a negative influence on relationships  
33 between the local authority and care homes, and a source of mistrust. Care home managers  
34 expressed feelings of exasperation at what they perceived to be the local authority's failure  
35 to appreciate the pressures that they faced. Unfavourable comparisons were made with the  
36 funding agreements reached in neighbouring areas.  
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#### 42 *Complexity*

43 The vanguard was portrayed as far-reaching, involving changes to an already complicated  
44 system of health and social care. Concerns were expressed about the unintended  
45 consequences of integration between NHS and social care services;  
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50 *My concern about [vanguard] is the NHS is a big monster at the moment that nobody*  
51 *controls. If you then amalgamated it with social services, it becomes a bigger*  
52 *monster that nobody can control.* [Care home  
53 manager (3)]  
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These concerns continued into the evaluation of large-scale changes, particularly attributing changes in different parts of the care pathway to patient outcomes. Some were concerned that they may be judged on outcomes over which they had little control. Measuring whole-system outcomes was difficult, and risked encouraging perverse incentives. Interviewees identified a need to ensure that changes in the care pathway were linked, in order to contribute to improvements for residents.

*It's separate components, provided by separate providers, under separate contracts. That can do two injurious things, one of which is a fragmented experience of care, but the other, and perhaps more important thing, is that it can create perverse incentives in the delivery of care.*

[Local authority (4)]

Navigating complex systems was a source of frustration for clinical staff, who felt that long-standing processes and systems were bureaucratic and unwieldy. Vanguard was perceived as an opportunity to resolve some of these problems and improve clinicians' ability to provide good patient care.

*What I really hope [vanguard] will do, actually, is to get round some of the bureaucracy that we're currently dealing with. That vanguard will have the weight to make changes.*

[General practitioner (2)]

## Discussion

### **Summary of findings**

This study identified a consensus across a broad constituency that the ways in which services are provided for care home residents needed to change, and a shared belief in the benefits of closer working between health and social care. The vision of the vanguard programme was supported overall, but the programme was perceived by some as being imposed, top down, from the health service. Some aspects, such as outcomes-based commissioning were not well understood, even by staff closely linked to the work. Barriers

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3 and facilitators to change were identified around communication, outcomes, trust and  
4 complexity. Great importance was attached to the measurement of intangible but  
5 important aspects of success, such as the level of collaboration.  
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10 A number of barriers to implementing a better system were identified, and most were  
11 regarded as challenging to overcome. Engaging people in a shared venture, when they are  
12 drawn from diverse professional backgrounds and employed by organisations with differing  
13 priorities, is not straightforward. Participants shared an interest in improving the wellbeing  
14 of older people in care homes, but the daily pressures of their work limited their  
15 involvement in new initiatives. Some of the anticipated problems, such as information  
16 sharing, had potential practical solutions. Others were more abstract. Many respondents  
17 talked of the need to promote collaboration and ensure shared values, but there were few  
18 ideas of how to achieve this in practice.  
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27 Understanding how a new model of care is going to influence outcomes for care home  
28 residents is likely to increase support for change. In this study, the vanguard initiative was  
29 seen as an opportunity to throw off some long established but unhelpful ways of working.  
30 Getting key players talking was one of the ways it was expected to effect change, along with  
31 breaking down barriers to shared information and records, reducing bureaucracy, and  
32 promoting the role of the care home in the wider system. This study identified the concerns  
33 of care home managers, including a perception that they are outsiders in the process of  
34 service development. We interviewed one third of care home managers in the vanguard  
35 area, and found great diversity in the level of awareness and understanding of the vanguard.  
36 This suggests a need to devote resources to developing relationships, as involvement of the  
37 care home sector will clearly be essential to the long term success of any changes. A  
38 programme evaluation that is meaningful to different stakeholders may be another way of  
39 fostering engagement. In this case, evaluation priorities focused on person-centred care.  
40 There was broad support for having a matrix of qualitative and quantitative outcome  
41 measures at different organisational levels, shared across different settings. Meeting  
42 resident and family expectations is an implicit goal for most services, and this was supported  
43 as a programme outcome.  
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### Comparison with other work

Previous evaluations of integrated care have identified issues that are key to ensuring success, including effective leadership, clear communication, and a willingness to collaborate and engage with colleagues.<sup>18</sup> This study reinforced the importance of some of these factors. Messages from the national team were reported to sometimes lack clarity and consistency, which adversely affected local understanding of the vanguard requirements. This echoes the findings of a recent review of integrated programmes, that linked poor understanding of outcomes with limited insight into how the programme will effect change.<sup>18</sup> It is also consistent with previous work that stressed the importance of defining outcomes that matter to the service users and their families.<sup>14 18</sup>

### Conclusions

Innovation in service delivery for care homes requires some alignment of organisational agendas across health and social care. This study has emphasised how much effort this requires, even in a geographical area where local authority and health organisations already work well together. The benefits of engaging the care home sector in change that they want and support are obvious, but the varied nature of the sector, current pressures and historical isolation from the NHS, make this a challenge. Evaluation of new programmes need to capture what is important to people receiving and providing care, and not to simply provide evidence of reduction in resource consumption for the funders. The less tangible benefits, such as trust and collaboration should not be overlooked, even if difficult to measure.

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For peer review only

**Box 1 Components of the local Care Home Vanguard programme**

- Development of enhanced care pathway
- Workforce and training workstream
- Engagement and communication strategy
- Development of an outcomes framework
- Outcomes-based contracting and payment system
- Establishment of a Provider Alliance Network
- Evaluation and monitoring

**Box 2 Interview topics**

- Understanding and perceptions of the proposed new model of care
- Barriers and facilitators to implementing change
- Anticipated consequences for residents, staff, and others
- How and why the new models might bring about change
- How the vanguard should be evaluated

**Table 1 Interviewees – Role in the local Care Home Vanguard**

Role	n
Care home manager	10
General practitioner	5
Community geriatrician	2
Older person's specialist nurse	2
GP Transformation Team	1
Third sector	1
Clinical Commissioning Group employee (leads for contracting, communications & engagement, vanguard manager, vanguard lead nurse)	4
Local authority (social worker, director of health & wellbeing, leads for vanguard and legal services)	4
NHS England vanguard team lead	1
<b>Total:</b>	<b>30</b>

**Table 2 Matrix of evaluation measures – selected examples proposed by interviewees in the local Care Home Vanguard study**

	Structure		Process		Outcome	
	Quantitative	Qualitative	Quantitative	Qualitative	Quantitative	Qualitative
<b>Individual</b>			How many people are involved with a resident (relational continuity)  Medication reviews completed  Does the resident have a care plan in place?	Quality of staff resident interaction  How do the care home staff feel about the support they get from NHS relating to medication?	Falls  Pressure sores  BMI  Nutrition Hydration	Resident wellbeing  Death in preferred place of care
<b>Service</b>	Staff retention	The role of skills development in staff retention	How many safeguarding alerts in a care home	How are safeguarding alerts dealt with?		
<b>System</b>			Delayed discharges	Discharge processes		

## COREQ checklist

Care home services at the vanguard: stakeholder views on the development and evaluation of novel, integrated approaches to enhancing health care in care homes.

No. Item	Guide questions/description	Reported on Page #
<b>Domain 1: Research team and reflexivity</b>		
<i>Personal Characteristics</i>		
1. Inter viewer/facilitator	Which author/s conducted the inter view or focus group?	Rachel Stocker (page 5)
2. Credentials	What were the researcher's credentials? E.g. PhD, MD	PhD (page 5)
3. Occupation	What was their occupation at the time of the study?	Research Associate (page 5)
4. Gender	Was the researcher male or female?	Female (page 5)
5. Experience and training	What experience or training did the researcher have?	PhD and experience with qualitative research studies (page 5)
<i>Relationship with participants</i>		
6. Relationship established	Was a relationship established prior to study commencement?	No (page 5)
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	Participants knew nothing personal about the interviewer other than her name.
8. Interviewer characteristics	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	None applicable
<b>Domain 2: study design</b>		
<i>Theoretical framework</i>		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	A data-driven approach using thematic analysis and constant comparison (page 5)
<i>Participant selection</i>		
10. Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball	Purposive (page 4-5)
11. Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	Email (page 5)
12. Sample size	How many participants were in the study?	30 (page 4)
13. Non-participation	How many people refused to participate or dropped out? Reasons?	None refused to participate.
<i>Setting</i>		
14. Setting of data	Where was the data collected? e.g. home,	Telephone

collection	clinic, workplace	interviews, and face to face interviews at workplaces (page 5)
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	No (page 5)
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	See Table 1 (page 16)
<i>Data collection</i>		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	An interview topic guide was developed and piloted (page 5)
18. Repeat interviews	Were repeat inter views carried out? If yes, how many?	No
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	Audio (page 5)
20. Field notes	Were field notes made during and/or after the inter view or focus group?	After interviews (page 5)
21. Duration	What was the duration of the inter views or focus group?	30-60 minutes for interviews (page 5)
22. Data saturation	Was data saturation discussed?	No
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	No
<b>Domain 3: analysis and findings</b>		
<i>Data analysis</i>		
24. Number of data coders	How many data coders coded the data?	2 (page 5)
25. Description of the coding tree	Did authors provide a description of the coding tree?	N/A
26. Derivation of themes	Were themes identified in advance or derived from the data?	Derived from the data (page 5)
27. Software	What software, if applicable, was used to manage the data?	NVivo 11 (page 5)
28. Participant checking	Did participants provide feedback on the findings?	No
<i>Reporting</i>		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	Yes and yes (page 6 onwards)
30. Data and findings consistent	Was there consistency between the data presented and the findings?	Yes
31. Clarity of major themes	Were major themes clearly presented in the findings?	Yes
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	Yes

# BMJ Open

## Care home services at the vanguard: a qualitative study exploring stakeholder views on the development and evaluation of novel, integrated approaches to enhancing health care in care homes.

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<b>Primary Subject Heading</b>:	Health services research
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Keywords:	Health policy < HEALTH SERVICES ADMINISTRATION & MANAGEMENT, QUALITATIVE RESEARCH, health services for the aged, Residential Facilities, Delivery of Health Care, Integrated

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3 **Care home services at the vanguard: a qualitative study exploring stakeholder views on**  
4 **the development and evaluation of novel, integrated approaches to enhancing health care**  
5 **in care homes**  
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32

33  
34 Word count: 4370  
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36

37 **Abstract**

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39 **Objectives** To explore stakeholders' understanding of novel integrated approaches to  
40 enhancing care in care homes (a care home 'vanguard') and identify priorities for  
41 evaluation.  
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44 **Design** A qualitative study, using semi-structured interviews with commissioners and service  
45 providers to/within care homes, and third sector organisations with thematic analysis.  
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47

48 **Setting** A Clinical Commissioning Group (CCG) area in England.

49 **Participants** Thirty interviewees from: care homes, the National Health Service (England)  
50 and local authority, third sector (10 care home managers, 5 general practitioners, 4 CCG  
51 employees, 4 local authority employees, 1 national (NHS England) vanguard lead, 2  
52 specialist nurses, 2 geriatricians, 1 third sector, 1 health manager).  
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3 **Results** The vision for the new programme was shared by stakeholders, with importance  
4 attached to equitable access to high quality care. Support for the programme was described  
5 as being ‘the right thing to do’, inferring a moral imperative. However, the practical  
6 implications of key aspects, such as integrated working, were not clearly understood and  
7 the programme was perceived by some as being imposed, top down, from the health  
8 service. Barriers and facilitators to change were identified across themes of communication,  
9 outcomes, trust and complexity. Importance was attached to the measurement of  
10 intangible aspects of success, such as collaboration. Interviewees understood that outcome-  
11 based commissioning was one element of the new programme, but discussion of their  
12 aspirations and practices revealed values and beliefs more compatible with a system based  
13 on trust.

### 21 **Conclusions**

22 Innovation in service delivery requires organisations to adopt common priorities and share  
23 responsibility for success. The vanguard programme is working to ensure health and local  
24 authorities have this commitment, but engaging care homes that may feel isolated from the  
25 welfare system, needs sustained dialogue over the longer term. Evaluation of the  
26 programme needs to measure what is important to stakeholders, and not focus too closely  
27 on resource consumption.

### 35 **Strengths and limitations**

- 37 • This is the first study to explore aspects of an English vanguard initiative prior to  
38 implementation.
- 39 • The findings provide insights relevant to the different vanguard programmes  
40 throughout England.
- 41 • Perspectives from a wide range of stakeholders across health and social care were  
42 included.
- 43 • A limitation is that only one participant was recruited from the third sector.

### 49 **Introduction**

50 The health and social care needs of residents in long-term care settings are increasing in  
51 complexity, as the number of older adults in the population grows.<sup>1 2</sup> Bed numbers in care  
52 homes have remained stable in recent years, and the average age of residents is 85 years.<sup>2</sup>

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3 Multiple morbidities are common; it is estimated that four out of five care home residents  
4 have a cognitive impairment whilst a similar proportion live with incontinence.<sup>3 4</sup> Despite  
5 presenting some of the most challenging problems in primary care, care home residents are  
6 believed to have poorly coordinated services, worse management of long-term conditions,  
7 and inequitable access to hospital care, compared to community dwelling older adults.<sup>5 6</sup>  
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12 Integrated working between health and social care is advocated as an appropriate, cost-  
13 effective way of improving quality of health care in care homes.<sup>7-9</sup> However, integrated care  
14 has been defined and implemented in many different ways. NHS England describe it as  
15 person-centred, coordinated, and tailored to the needs and preferences of the individual  
16 and their family.<sup>10</sup> To date, efforts to integrate care in a range of different countries and  
17 health and social care systems have produced limited evidence of improved outcomes.<sup>11</sup> A  
18 number of possible explanations have been proposed, including inadequate resources, the  
19 adoption of piecemeal rather than whole-system change<sup>5 12 13</sup>, and a failure to adequately  
20 involve service users and families.<sup>14</sup>  
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30 The UK policy response to rising demands for better quality of care, has included  
31 development of new, integrated ways of working.<sup>15</sup> Investment in 50 different 'vanguard'  
32 programmes by NHS England in 2014 has focused on integrating primary and acute care,  
33 multispecialty community providers, urgent and emergency care, and acute care  
34 collaborations. Six sites were selected to enhance health in care homes, whereby residents  
35 are offered more integrated and coordinated health care by joining up health and social care  
36 services at a systemic level.<sup>16</sup> Evaluation of any new intervention is essential to provide  
37 reliable evidence to inform commissioning choices.<sup>17</sup> It is even more important in the case of  
38 the vanguard programme, as the new models aim to be replicable across England.  
39 Programmes that bring together health and social care may be particularly challenging to  
40 evaluate. Multiple stakeholders may not agree on outcomes, information collection across  
41 settings can be difficult, and appropriate sources of data may not be readily available.<sup>18</sup>  
42 Many integrated care programmes aim to reduce resource use, and changes in unplanned  
43 admissions to hospital is a commonly measured outcome.<sup>19</sup> Less tangible concepts, such as  
44 trust and collaboration between organisations have also been proposed as indicators of  
45 success.<sup>20</sup> There is a growing consensus around the need to scrutinise processes involved in  
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any intervention, including feasibility and acceptability. Recent methodological developments, such as realist evaluation, have emphasised the importance of taking time to understand the complexities of the local context.<sup>17 21</sup>

The proposed programme of change under investigation in this study consists of different work streams that encompass commissioning and service provision, care pathways, workforce and evaluation (Box 1).

Box 1 here

This paper reports on qualitative research aiming to inform the future evaluation of a new model of integrated care for care homes (care home vanguard) in England. At the time of the study, the vanguard programme was in the first year of development and had not officially started. In addition to identifying priorities and metrics for future evaluation, the vanguard team were developing and refining logic models to systematically consider the key components of the new care model, and preparing for a full launch of the initiative. Study objectives were to:

- a) Explore stakeholders' understanding, perceptions and expectations of the new programme, how it will be implemented, and how it might change care in the local context.
- b) Identify the priorities for evaluation of the programme.

### Method

Approval was granted by Newcastle University Faculty of Medical Sciences Research Ethics Committee.

### Setting

The study took place in a single Local Authority administrative area and within a single CCG within a post-industrial urban location characterised by large scale socio-economic deprivation and poor health which has suffered disproportionately due to austerity-driven public sector funding cuts.

### Recruitment and sampling

Semi-structured interviews were conducted with 30 stakeholders in the local care home vanguard. Stakeholders were identified by the Clinical Commissioning Group (CCG) from (i) the vanguard steering group, (ii) local services that were involved in the commissioning or delivery of care for residents of long-term care, (iii) organisations with an interest in the care and wellbeing of residents. The CCG acted as gatekeepers and sent introductory emails to potential participants, then provided the research team with relevant contact details. One of the researchers (RS) purposively sampled potential participants (n=61) using the list of contact details provided by the CCG, and contacted them directly by email or telephone to invite participation, with a covering letter and participant information sheet. Non-responders (n=14) were reminded after one week. Twenty-eight respondents agreed to participate. Interviewees who were care home managers were asked to nominate colleagues from different homes, to boost recruitment from this setting (snowball sampling); two further care home managers were recruited. No inclusion or exclusion criteria were employed. Participants' roles in the care home vanguard are detailed in Table 1.

Table 1 here

### Data collection

Interviews were conducted in March-April 2016, by telephone or in person (at the participant's workplace in a private area), and lasted 30-60 minutes. A topic guide was developed, informed by published literature on implementing new models of integrated care for the elderly, and the requirements of the research commissioners (see Box 2). It was piloted with members of the research team, and no further topics were added.

Box 2 here

Written informed consent was obtained for all participants. All interviews were conducted by the same qualitative researcher (RS), audio recorded and transcribed. All transcripts were anonymised.

### **Data management and analysis**

A thematic analysis<sup>22</sup> was conducted, using NVivo version 11 software to manage data. The interview transcripts were read and reread to familiarise ourselves with the text. The interviewer coded every transcript line by line, and a subset (10/30) of transcripts were coded by a second researcher (BH). Emergent themes were identified in discussion with the research team, and linked together to form a final set of higher level themes. A data driven approach to the development of a coding framework was chosen, because our topic guide had been strongly influenced by the needs of the vanguard team, and we needed to ensure that any unrecognised issues of concern to the interviewees were included in the analysis. Interviews ceased once it became clear that no new themes were emerging from the data.

### **Findings**

Participants were all stakeholders in the vanguard programme. Each had an interest in, or were engaged in, the commissioning or delivery of care for older people in care homes. Findings are presented across four higher-level themes which emerged from the data: (i) understanding of the proposed changes; (ii) communication; (iii) outcomes; and (iv) trust and complexity. Verbatim quotations are presented to illustrate commonly expressed views, or unusual or contrasting perspectives.

#### *The local context*

Interviewees highlighted aspects of the local infrastructure and services that provided a favourable basis for vanguard changes. The small geographical size, single local authority and single hospital (NHS Trust) were all expected to simplify relationships and communication. General practices in the area had a history of working well together. Relationships between hospital and community services were also good. Some felt that the generous provision of care home beds in this area meant that services did not have to strive hard to support patients in their own homes.

#### ***Theme 1. Understanding of the proposed changes***

##### *A shared vision*

A majority of the interviewees shared a vision of improved care and quality of life for older people in the vanguard area. The CCG had aspirations for equitable access to care - 'the

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3 right care, delivered by the right person at the right time' and 'one bed, one outcome'.  
4 Others shared these sentiments. Support for the vanguard was described by more than one  
5 interviewee, as being 'the right thing to do', inferring a moral imperative to the work.  
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10 *The person is at the centre of it and if they need a \*\*\*\*\* wheelchair or a dietician,*  
11 *then they should get it. Not about who pays, what the financial consequences are.*  
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13 [Care home manager (8)]  
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16 Interviewees were frank in their admissions of how little they understood about the  
17 vanguard programme, and how the vision would be achieved. This was attributed by some  
18 to the CCG's desire to involve a wide range of stakeholders in service design and  
19 development, and the resulting inertia in getting started. Others blamed a lack of clarity  
20 from NHS England, which filtered down into local vanguards. This uncertainty limited  
21 external discussions about the programme.  
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28 The majority of care home managers were familiar with the headline proposals, even if they  
29 had little idea of how the vanguard would influence their work. Staff turnover was a  
30 common issue; some care homes had new managers in post, which meant that initiatives  
31 (including vanguard) were not seized upon. Care home managers talked about the pressing  
32 issues that they faced daily, particularly staffing and liaising with care providers from  
33 different sectors. This had consequences for their ability to fully engage with the vanguard.  
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#### 40 *A top-down health programme?*

41 Strategic involvement of local and national bodies was highlighted as a major strength of the  
42 vanguard. However, engagement of a broad constituency also raised questions about  
43 differing organisational agendas, and the threats that this may pose. A number of  
44 interviewees from outside the NHS expressed a perception that the vanguard was a health-  
45 dominated programme, imposed from above.  
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52 *It feels like it might be being imposed, as opposed to it coming out of the experience*  
53 *of people working in care homes.*  
54 [Third sector (1)]  
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3 This feeling of imposition was explained in terms of historic links between care homes and  
4 general practitioners, and the fact that the vanguard is building on existing work rather than  
5 starting from scratch. There were concerns that a focus on health budgets and failure to  
6 align agendas would represent a missed opportunity to capitalise on an opportunity for  
7 radical change.  
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13 *Vanguard in [Town 1] could be seen to be the catalyst for this real localised joined up*  
14 *working. But this is all just about health budgets. And it is all just about health driven*  
15 *issues. And I think that is the massive missing agenda. Because if you could get the*  
16 *Local Authority and Health to work on this, then they could be seen as an exemplar*  
17 *throughout the country.* [Local authority (3)]  
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23 The perceived imposition of vanguard was discussed in relation to changes to  
24 commissioning and contracting, and how these would be resisted by care homes if they  
25 were not fully engaged.  
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## 32 **Theme 2. Communication**

33 Communication was one of the most frequently mentioned influences on the success of the  
34 vanguard. Interviewees were concerned with the way in which information was  
35 communicated, as well as the content. Most talked of information-sharing relating to the  
36 vanguard changes, but a significant minority also aired their views on patient or resident  
37 related communication between health services and care homes, and different parts of the  
38 health service.  
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### 45 *A shared language*

46 The absence of a shared language amongst vanguard stakeholders was noted by a number  
47 of interviewees. Discussion in meetings and the vanguard documentation was described as  
48 jargon filled, and potentially inaccessible to people from care homes and the third sector in  
49 particular. Some felt this limited their ability to engage in discussion and participate in the  
50 development of the vanguard.  
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3 *The language that's being used in some of the work planning, I think is extremely*  
4 *inaccessible. I don't think people understand. [...] It's got a very clinical CCG kind of*  
5 *look to it. [...] I just find it difficult when people jargon things up [...] because it feels*  
6 *like it's done and dusted, which it shouldn't be.* [Third sector (1)]  
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11 The vanguard programme was acknowledged to be in development, so expectations of  
12 progress were modest. However, for some, their own lack of clarity as to the expected  
13 outcomes made communication about the vanguard difficult, within their own  
14 organisations.  
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### 18 *Information sharing*

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20 Prompt and widespread diffusion of information about vanguard was felt to be an  
21 important way of ensuring that care homes and others were engaged with the process.  
22 Information sharing was identified as a practical aspect of communication that could  
23 present a significant barrier. Many spoke of being unable to access electronic care records  
24 from other care settings. This created delays in obtaining information and duplication of  
25 effort for many healthcare professionals.  
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34 *I think there needs to be better sharing of information. Around the access to our GP*  
35 *records. For people being able to look in, to know what I've done, or what I've said,*  
36 *so that there's no duplication of information.* [General  
37 practitioner (2)]  
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42 Nurses and care home managers reported delays in receiving records, and administrative  
43 barriers to records moving with patients. A number of participants also made a connection  
44 between transfer of information and patient or resident safety.  
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### 49 **Theme 3. Evaluation of outcome measures of success**

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51 Interviewees proposed a range of measures to evaluate the vanguard intervention,  
52 reflecting concerns with structural aspects of the new model of care, the process of  
53 implementation and selected outcomes. Possible evaluation measures emerged across the  
54 interviews, at different organisational levels (individual, service, organisation and whole  
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3 system) and perspectives (residents, staff, families). Where quantitative measures were  
4 proposed, someone, often the same interviewee, often suggested a complementary  
5 qualitative measure to understand or contextualise the information. Table 2 illustrates how  
6 some of the proposed measures fit together.  
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11 Table 2 here  
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15 In addition to measures that the interviewees expected to be part of any evaluation, such as  
16 the number of hospital admissions, issues such as collaboration and trust between  
17 stakeholders were suggested as critical to the development of the vanguard programme.  
18 Several interviewees emphasised the need to measure what was important, not what was  
19 easy to record.  
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24  
25 *If we could measure collaboration, I think it would be hugely beneficial, because I*  
26 *think that not only evaluates how the programme's developing, but potentially*  
27 *collaboration is the solution to improving care and quality for patients, and value in*  
28 *the system.*  
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30 [General practitioner (5)]  
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34 Many mentioned the importance of person-centred outcomes, i.e. health and wellbeing  
35 goals defined by care home residents themselves and their families and carers as being the  
36 most important to reach, with an older population living happier and healthier lives as a  
37 measure of success. None of the interviewees offered a clear definition of person-centred,  
38 or reflected on how system and organisational outcomes might relate to changes for  
39 individuals. Concerns were expressed about the practical difficulties of capturing  
40 information from care homes and residents, including residents without capacity, and the  
41 difficulty of interpreting information provided by proxies, such as family members, as they  
42 may not necessarily mirror the resident's experiences.  
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#### 50 51 **Theme 4. Trust and complexity**

52 Interviewees expressed a desire to see the vanguard programme bring different parts of the  
53 care community together, with a common purpose. The talk of shared vision, and changes  
54 to hearts and minds, points to the expressed desire for trusting, collaborative relationships.  
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3 The current reality for care homes, appeared to be some way from this goal. Relationships  
4 between care homes and both health and local authorities were discussed in terms of  
5 mistrust and misunderstanding. This came from two key sources; the relationships that had  
6 developed over years of funding negotiations with the local authority, and the care homes'  
7 experiences of regular interactions with the health service.  
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### 11 12 13 *Relationships with external services*

14 Some care home managers felt that colleagues in the health sector did not respect their  
15 judgement, and that care home staff were not trusted to provide a reliable report on a  
16 resident's symptoms or health care needs. This was a particular concern with hospitals and  
17 the out of hours service. Relationships with GPs were generally reported in positive terms,  
18 but one care home manager described how GPs may not always appreciate the limits of the  
19 care home's expertise in health matters.  
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27 *We've had odd times where the GPs are like, "You don't need to bother me with this.*  
28 *There's nothing really wrong with them," and you're like, "Well, I know you know*  
29 *that, but we didn't know that."* [Care home  
30 manager (5)]  
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36 Much of the dissatisfaction expressed by care homes concerned the processes involved in  
37 the care system, predominantly the NHS. The absence of an individual to take responsibility  
38 or coordinate a resident's care journey through external services, was a concern.  
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42 The vanguard programme was seen as having the potential to address some of these  
43 concerns, improving care processes and efficiency of care pathways and enhancing trust  
44 between the sectors. Scrutiny of discharge transitions was presented as an example of how  
45 the vanguard might be able to effect change.  
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50  
51 *I think the process of discharge from the hospital could be measured better. Has*  
52 *there been an assessment done? Is the person being discharged with their*  
53 *medication, a discharge letter or any follow-up referrals?* [Care  
54 home manager (7)]  
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4 For the care home managers, funding issues were a negative influence on relationships  
5 between the local authority and care homes, and a source of mistrust. Care home managers  
6 expressed feelings of exasperation at what they perceived to be the local authority's failure  
7 to appreciate the pressures that they faced. Unfavourable comparisons were made with the  
8 funding agreements reached in neighbouring areas.  
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### 13 *Complexity*

14 The vanguard was portrayed as far-reaching, involving changes to an already complicated  
15 system of health and social care. Concerns were expressed about the unintended  
16 consequences of integration between NHS and social care services;  
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23 *My concern about [vanguard] is the NHS is a big monster at the moment that nobody*  
24 *controls. If you then amalgamated it with social services, it becomes a bigger*  
25 *monster that nobody can control.* [Care home  
26 manager (3)]  
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31 These concerns continued into the evaluation of large-scale changes, particularly attributing  
32 changes in different parts of the care pathway to patient outcomes. Some were concerned  
33 that they may be judged on outcomes over which they had little control. Measuring whole-  
34 system outcomes was difficult, and risked encouraging perverse incentives. Interviewees  
35 identified a need to ensure that changes in the care pathway were linked, in order to  
36 contribute to improvements for residents.  
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43 *It's separate components, provided by separate providers, under separate contracts.*  
44 *That can do two injurious things, one of which is a fragmented experience of care,*  
45 *but the other, and perhaps more important thing, is that it can create perverse*  
46 *incentives in the delivery of care.*  
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49 [Local authority (4)]  
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54 Navigating complex systems was a source of frustration for clinical staff, who felt that long-  
55 standing processes and systems were bureaucratic and unwieldy. Vanguard was perceived  
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3 as an opportunity to resolve some of these problems and improve clinicians' ability to  
4 provide good patient care.  
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8 *What I really hope [vanguard] will do, actually, is to get round some of the*  
9 *bureaucracy that we're currently dealing with. That vanguard will have the weight to*  
10 *make changes.* [General  
11  
12 practitioner (2)]  
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## 16 Discussion

### 17 **Summary of findings**

18  
19 This study identified a consensus across a broad constituency that the ways in which  
20 services are provided for care home residents needed to change, and a shared belief in the  
21 benefits of closer working between health and social care. The vision of the vanguard  
22 programme was supported overall, but the programme was perceived by some as being  
23 imposed, top down, from the health service. Some aspects, such as outcomes-based  
24 commissioning were not well understood, even by staff closely linked to the work. Barriers  
25 and facilitators to change were identified around communication, outcomes, trust and  
26 complexity. Great importance was attached to the measurement of intangible but  
27 important aspects of success, such as the level of collaboration.  
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37 A number of barriers to implementing a better system were identified, and most were  
38 regarded as challenging to overcome. Engaging people in a shared venture, when they are  
39 drawn from diverse professional backgrounds and employed by organisations with differing  
40 priorities, is not straightforward. Participants shared an interest in improving the wellbeing  
41 of older people in care homes, but the daily pressures of their work limited their  
42 involvement in new initiatives. Some of the anticipated problems, such as information  
43 sharing, had potential practical solutions. Others were more abstract. Many respondents  
44 talked of the need to promote collaboration and ensure shared values, but there were few  
45 ideas of how to achieve this in practice.  
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54 Understanding how a new model of care is going to influence outcomes for care home  
55 residents is likely to increase support for change. In this study, the vanguard initiative was  
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3 seen as an opportunity to throw off some long established but unhelpful ways of working.  
4 Getting key players talking was one of the ways it was expected to effect change, along with  
5 breaking down barriers to shared information and records, reducing bureaucracy, and  
6 promoting the role of the care home in the wider system. This study identified the concerns  
7 of care home managers, including a perception that they are outsiders in the process of  
8 service development. We interviewed one third of care home managers in the vanguard  
9 area, and found great diversity in the level of awareness and understanding of the vanguard.  
10 This suggests a need to devote resources to developing relationships, as involvement of the  
11 care home sector will clearly be essential to the long term success of any changes. A  
12 programme evaluation that is meaningful to different stakeholders may be another way of  
13 fostering engagement. In this case, evaluation priorities focused on person-centred care.  
14 There was broad support for having a matrix of qualitative and quantitative outcome  
15 measures at different organisational levels, shared across different settings. This approach  
16 to evaluation generally reflects the strategy suggested by NHS England to evaluate local  
17 vanguards.<sup>19</sup> Meeting resident and family expectations is an implicit goal for most services,  
18 and this was supported as a programme outcome.  
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32 In this study, we sampled participants from a list of vanguard stakeholders provided by the  
33 CCG. This included all of the care home managers in the geographical area. We were keen to  
34 achieve a good representation of stakeholders, and the benefit of working with the CCG to  
35 access participants was evident in the proportion of respondents who agreed to take part.  
36 Approaching stakeholders in conjunction with the CCG may have limited their inclination to  
37 take part and/or express their feelings openly. To overcome this, we stressed to participants  
38 that their contributions are fully anonymised, and were flexible in the timing and location of  
39 interview.  
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### 48 **Comparison with other work**

49 Previous evaluations of integrated care have identified issues that are key to ensuring  
50 success, including effective leadership, clear communication, and a willingness to  
51 collaborate and engage with colleagues.<sup>18</sup> Key findings from the organisational relations  
52 literature<sup>20 23</sup> highlight the importance of trust and complexity, change, roles and  
53 responsibilities at all levels throughout the involved organisations, and this study reinforces  
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3 this significance of this work in relation to future vanguard evaluations. Messages from the  
4 national team were reported to sometimes lack clarity and consistency, which adversely  
5 affected local understanding of the vanguard requirements. This echoes the findings of a  
6 recent review of integrated programmes, that linked poor understanding of outcomes with  
7 limited insight into how the programme will effect change.<sup>18</sup> It is also consistent with  
8 previous work that stressed the importance of defining outcomes that matter to the service  
9 users and their families.<sup>14 18</sup>  
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## 16 **Conclusions**

17 Innovation in service delivery for care homes requires some alignment of organisational  
18 agendas across health and social care. This study has emphasised how much effort this  
19 requires, even in a geographical area where local authority and health organisations already  
20 work well together. The benefits of engaging the care home sector in change that they  
21 want and support are obvious, but the varied nature of the sector, current pressures and  
22 historical isolation from the NHS, make this a challenge. Evaluation of new programmes  
23 need to capture what is important to people receiving and providing care, and not to simply  
24 provide evidence of reduction in resource consumption for the funders. The less tangible  
25 benefits, such as trust and collaboration should not be overlooked, even if difficult to  
26 measure.  
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43

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45 interviews. RS and BH analysed data. RS and BH drafted the article, and CB, KB, RD, SM, & LR  
46 performed critical revision of the article for important intellectual content. RS is guarantor  
47 of the paper. All authors approved the final version to be published.  
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54 **Data Sharing Statement** No additional data are available.  
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**Box 1 Components of the local Care Home Vanguard programme**

- Development of enhanced care pathway
- Workforce and training workstream
- Engagement and communication strategy
- Development of an outcomes framework
- Outcomes-based contracting and payment system
- Establishment of a Provider Alliance Network
- Evaluation and monitoring

**Box 2 Interview topics**

- Understanding and perceptions of the proposed new model of care
- Barriers and facilitators to implementing change
- Anticipated consequences for residents, staff, and others
- How and why the new models might bring about change
- How the vanguard should be evaluated

**Table 1 Interviewees – Role in the local Care Home Vanguard**

Role	n
Care home manager	10
General practitioner	5
Community geriatrician	2
Older person's specialist nurse	2
GP Transformation Team	1
Third sector	1
Clinical Commissioning Group employee (leads for contracting, communications & engagement, vanguard manager, vanguard lead nurse)	4
Local authority (social worker, director of health & wellbeing, leads for vanguard and legal services)	4
NHS England vanguard team lead	1
Total:	<b>30</b>

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**Table 2 Matrix of evaluation measures – selected examples proposed by interviewees in the local Care Home Vanguard study**

	Structure		Process		Outcome	
	Quantitative	Qualitative	Quantitative	Qualitative	Quantitative	Qualitative
<b>Individual</b>			How many people are involved with a resident (relational continuity)  Medication reviews completed  Does the resident have a care plan in place?	Quality of staff resident interaction  How do the care home staff feel about the support they get from NHS relating to medication?	Falls  Pressure sores  BMI  Nutrition Hydration	Resident wellbeing  Death in preferred place of care
<b>Service</b>	Staff retention	The role of skills development in staff retention	How many safeguarding alerts in a care home	How are safeguarding alerts dealt with?		
<b>System</b>			Delayed discharges	Discharge processes		

## COREQ checklist

Care home services at the vanguard: stakeholder views on the development and evaluation of novel, integrated approaches to enhancing health care in care homes.

No. Item	Guide questions/description	Reported on Page #
<b>Domain 1: Research team and reflexivity</b>		
<i>Personal Characteristics</i>		
1. Inter viewer/facilitator	Which author/s conducted the inter view or focus group?	Rachel Stocker (page 5)
2. Credentials	What were the researcher's credentials? E.g. PhD, MD	PhD (page 5)
3. Occupation	What was their occupation at the time of the study?	Research Associate (page 5)
4. Gender	Was the researcher male or female?	Female (page 5)
5. Experience and training	What experience or training did the researcher have?	PhD and experience with qualitative research studies (page 5)
<i>Relationship with participants</i>		
6. Relationship established	Was a relationship established prior to study commencement?	No (page 5)
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	Participants knew nothing personal about the interviewer other than her name.
8. Interviewer characteristics	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	None applicable
<b>Domain 2: study design</b>		
<i>Theoretical framework</i>		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	A data-driven approach using thematic analysis and constant comparison (page 5)
<i>Participant selection</i>		
10. Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball	Purposive (page 4-5)
11. Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	Email (page 5)
12. Sample size	How many participants were in the study?	30 (page 4)
13. Non-participation	How many people refused to participate or dropped out? Reasons?	None refused to participate.
<i>Setting</i>		
14. Setting of data	Where was the data collected? e.g. home,	Telephone

collection	clinic, workplace	interviews, and face to face interviews at workplaces (page 5)
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	No (page 5)
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	See Table 1 (page 16)
<i>Data collection</i>		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	An interview topic guide was developed and piloted (page 5)
18. Repeat interviews	Were repeat inter views carried out? If yes, how many?	No
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	Audio (page 5)
20. Field notes	Were field notes made during and/or after the inter view or focus group?	After interviews (page 5)
21. Duration	What was the duration of the inter views or focus group?	30-60 minutes for interviews (page 5)
22. Data saturation	Was data saturation discussed?	No
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	No
<b>Domain 3: analysis and findings</b>		
<i>Data analysis</i>		
24. Number of data coders	How many data coders coded the data?	2 (page 5)
25. Description of the coding tree	Did authors provide a description of the coding tree?	N/A
26. Derivation of themes	Were themes identified in advance or derived from the data?	Derived from the data (page 5)
27. Software	What software, if applicable, was used to manage the data?	NVivo 11 (page 5)
28. Participant checking	Did participants provide feedback on the findings?	No
<i>Reporting</i>		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	Yes and yes (page 6 onwards)
30. Data and findings consistent	Was there consistency between the data presented and the findings?	Yes
31. Clarity of major themes	Were major themes clearly presented in the findings?	Yes
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	Yes

# BMJ Open

## Care home services at the vanguard: a qualitative study exploring stakeholder views on the development and evaluation of novel, integrated approaches to enhancing health care in care homes.

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Manuscript ID	bmjopen-2017-017419.R2
Article Type:	Research
Date Submitted by the Author:	21-Nov-2017
Complete List of Authors:	Stocker, Rachel; Newcastle University, Institute of Health and Society Bamford, Claire; Newcastle University Brittain, Katie; Northumbria University, Department of Nursing, Midwifery & Health Duncan, Rachel; Newcastle University Moffatt, Suzanne; Newcastle University Robinson, Louise; Institute for Health and Society, Newcastle University Hanratty, Barbara; Newcastle University, Institute of Health and Society / Newcastle University Institute for Ageing
<b>Primary Subject Heading</b>:	Health services research
Secondary Subject Heading:	General practice / Family practice, Health policy, Geriatric medicine, Qualitative research
Keywords:	Health policy < HEALTH SERVICES ADMINISTRATION & MANAGEMENT, QUALITATIVE RESEARCH, health services for the aged, Residential Facilities, Delivery of Health Care, Integrated

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3 **Care home services at the vanguard: a qualitative study exploring stakeholder views on**  
4 **the development and evaluation of novel, integrated approaches to enhancing health care**  
5 **in care homes**  
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30 Facilities; Delivery of Health Care, Integrated  
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34 Word count: 4393  
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37 **Abstract**

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39 **Objectives** To explore stakeholders' understanding of novel integrated approaches to  
40 enhancing care in care homes (a care home 'vanguard') and identify priorities for  
41 evaluation.  
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44 **Design** A qualitative study, using semi-structured interviews with commissioners and service  
45 providers to/within care homes, and third sector organisations with thematic analysis.  
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48 **Setting** A Clinical Commissioning Group (CCG) area in England.

49 **Participants** Thirty interviewees from: care homes, the National Health Service (England)  
50 and local authority, third sector (10 care home managers, 5 general practitioners, 4 CCG  
51 employees, 4 local authority employees, 1 national (NHS England) vanguard lead, 2  
52 specialist nurses, 2 geriatricians, 1 third sector, 1 health manager).  
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3 **Results** The vision for the new programme was shared by stakeholders, with importance  
4 attached to equitable access to high quality care. Support for the programme was described  
5 as being 'the right thing to do', inferring a moral imperative. However, the practical  
6 implications of key aspects, such as integrated working, were not clearly understood and  
7 the programme was perceived by some as being imposed, top down, from the health  
8 service. Barriers and facilitators to change were identified across themes of communication,  
9 outcomes, trust and complexity. Importance was attached to the measurement of  
10 intangible aspects of success, such as collaboration. Interviewees understood that outcome-  
11 based commissioning was one element of the new programme, but discussion of their  
12 aspirations and practices revealed values and beliefs more compatible with a system based  
13 on trust.

### 21 **Conclusions**

22 Innovation in service delivery requires organisations to adopt common priorities and share  
23 responsibility for success. The vanguard programme is working to ensure health and local  
24 authorities have this commitment, but engaging care homes that may feel isolated from the  
25 welfare system, needs sustained dialogue over the longer term. Evaluation of the  
26 programme needs to measure what is important to stakeholders, and not focus too closely  
27 on resource consumption.

### 34 **Strengths and limitations**

- 37 • This is the first study to explore aspects of an English vanguard initiative prior to  
38 implementation.
- 39 • The findings provide insights relevant to the different vanguard programmes  
40 throughout England.
- 41 • Perspectives from a wide range of stakeholders across health and social care were  
42 included.
- 43 • A limitation is that only one participant was recruited from the third sector.

### 48 **Introduction**

49 The health and social care needs of residents in long-term care settings are increasing in  
50 complexity, as the number of older adults in the population grows.<sup>1,2</sup> In the UK, bed numbers  
51 in care homes have remained stable in recent years, and the average age of residents is 85

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3 years.<sup>2</sup> Multiple morbidities are common; it is estimated that four out of five care home  
4 residents have a cognitive impairment whilst a similar proportion live with incontinence.<sup>3 4</sup>  
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6 Despite presenting some of the most challenging problems in primary care, care home  
7 residents are believed to have poorly coordinated services, worse management of long-term  
8 conditions, and inequitable access to hospital care, compared to community dwelling older  
9 adults.<sup>5 6</sup>  
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15 Integrated working between health and social care is advocated as an appropriate, cost-  
16 effective way of improving quality of health care in care homes.<sup>7-9</sup> However, integrated care  
17 has been defined and implemented in many different ways. The National Health Service  
18 (NHS) England describe it as person-centred, coordinated, and tailored to the needs and  
19 preferences of the individual and their family.<sup>10</sup> To date, efforts to integrate care in a range  
20 of different countries and health and social care systems have produced limited evidence of  
21 improved outcomes.<sup>11</sup> A number of possible explanations have been proposed, including  
22 inadequate resources, the adoption of piecemeal rather than whole-system change<sup>5 12 13</sup>,  
23 and a failure to adequately involve service users and families.<sup>14</sup>  
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32 The UK policy response to rising demands for better quality of care, has included  
33 development of new, integrated ways of working.<sup>15</sup> Investment in 50 different 'vanguard'  
34 programmes by NHS England in 2014 has focused on integrating primary and acute care,  
35 multispecialty community providers, urgent and emergency care, and acute care  
36 collaborations. Six sites were selected to enhance health in care homes, whereby residents  
37 are offered more integrated and coordinated health care by combining health and social  
38 care services at a systemic level.<sup>16</sup> Evaluation of any new intervention is essential to provide  
39 reliable evidence to inform commissioning choices.<sup>17</sup> It is even more important in the case of  
40 the vanguard programme, as the new models aim to be replicable across England.  
41 Programmes that bring together health and social care may be particularly challenging to  
42 evaluate. Multiple stakeholders may not agree on outcomes, information collection across  
43 settings can be difficult, and appropriate sources of data may not be readily available.<sup>18</sup>  
44 Many integrated care programmes aim to reduce resource use, and changes in unplanned  
45 admissions to hospital is a commonly measured outcome.<sup>19</sup> Less tangible concepts, such as  
46 trust and collaboration between organisations have also been proposed as indicators of  
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3 success.<sup>20</sup> There is a growing consensus around the need to scrutinise processes involved in  
4 any intervention, including feasibility and acceptability. Recent methodological  
5 developments, such as realist evaluation, have emphasised the importance of taking time to  
6 understand the complexities of the local context.<sup>17 21</sup>  
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11 The proposed programme of change under investigation in this study consists of different  
12 work streams that encompass commissioning and service provision, care pathways,  
13 workforce and evaluation (Box 1).  
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18 Box 1 here  
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22 This paper reports on qualitative research aiming to inform the future evaluation of a new  
23 model of integrated care for care homes (care home vanguard) in England. At the time of the  
24 study, the vanguard programme was in the first year of development and had not officially  
25 started. In addition to identifying priorities and metrics for future evaluation, the vanguard  
26 team were developing and refining logic models to systematically consider the key  
27 components of the new care model, and preparing for a full launch of the initiative. Study  
28 objectives were to:  
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36 a) Explore stakeholders' understanding, perceptions and expectations of the  
37 new programme, how it will be implemented, and how it might change care in the  
38 local context.  
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40 b) Identify the priorities for evaluation of the programme.  
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#### 44 **Method**

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46 Approval was granted by Newcastle University Faculty of Medical Sciences Research Ethics  
47 Committee.  
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#### 50 **Setting**

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52 The study took place in a single Local Authority administrative area and within a single  
53 Clinical Commissioning Group (CCG). This CCG is located within a post-industrial urban  
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3 location characterised by large scale socio-economic deprivation and poor health which has  
4 suffered disproportionately due to austerity-driven public sector funding cuts.  
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### 6 **Recruitment and sampling**

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8 Semi-structured interviews were conducted with 30 stakeholders in the local care home  
9 vanguard. Stakeholders were identified by the CCG from (i) the vanguard steering group, (ii)  
10 local services that were involved in the commissioning or delivery of care for residents of  
11 long-term care, (iii) organisations with an interest in the care and wellbeing of residents. The  
12 CCG acted as gatekeepers and sent introductory emails to potential participants, then  
13 provided the research team with relevant contact details. One of the researchers (RS)  
14 purposively sampled potential participants (n=61) using the list of contact details provided  
15 by the CCG, and contacted them directly by email or telephone to invite participation, with a  
16 covering letter and participant information sheet. Non-responders (n=14) were reminded  
17 after one week. Twenty-eight respondents agreed to participate. Interviewees who were  
18 care home managers were asked to nominate colleagues from different homes, to boost  
19 recruitment from this setting (snowball sampling); two further care home managers were  
20 recruited. No inclusion or exclusion criteria were employed. Participants' roles in the care  
21 home vanguard are detailed in Table 1.  
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34 Table 1 here

### 35 **Data collection**

36 Interviews were conducted in March-April 2016, by telephone or in person (at the  
37 participant's workplace in a private area), and lasted 30-60 minutes. A topic guide was  
38 developed, informed by published literature on implementing new models of integrated  
39 care for the elderly, and the requirements of the research commissioners (see Box 2). It was  
40 piloted with members of the research team, and no further topics were added.  
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47 Box 2 here

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51 Written informed consent was obtained for all participants. All interviews were conducted  
52 by the same qualitative researcher (RS), audio recorded and transcribed. All transcripts were  
53 anonymised.  
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### **Data management and analysis**

A thematic analysis<sup>22</sup> was conducted, using NVivo version 11 software to manage data. The interview transcripts were read and reread to familiarise ourselves with the text. The interviewer coded every transcript line by line, and a subset (10/30) of transcripts were coded by a second researcher (BH). Emergent themes were identified in discussion with the research team, and linked together to form a final set of higher level themes. A data driven approach to the development of a coding framework was chosen, because our topic guide had been strongly influenced by the needs of the vanguard team, and we needed to ensure that any unrecognised issues of concern to the interviewees were included in the analysis. Interviews ceased once it became clear that no new themes were emerging from the data.

### **Findings**

Participants were all stakeholders in the vanguard programme. Each had an interest in, or were engaged in, the commissioning or delivery of care for older people in care homes. Findings are presented across four higher-level themes which emerged from the data: (i) understanding of the proposed changes; (ii) communication; (iii) outcomes; and (iv) trust and complexity. Verbatim quotations are presented to illustrate commonly expressed views, or unusual or contrasting perspectives.

#### *The local context*

Interviewees highlighted aspects of the local infrastructure and services that provided a favourable basis for vanguard changes. The small geographical size, single local authority and single hospital (NHS Trust) were all expected to simplify relationships and communication. General practices in the area had a history of working well together. Relationships between hospital and community services were also good. Some felt that the generous provision of care home beds in this area meant that services did not have to strive hard to support patients in their own homes.

#### ***Theme 1. Understanding of the proposed changes***

##### *A shared vision*

A majority of the interviewees shared a vision of improved care and quality of life for older people in the vanguard area. The CCG had aspirations for equitable access to care - 'the

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3 right care, delivered by the right person at the right time' and 'one bed, one outcome'.  
4 Others shared these sentiments. Support for the vanguard was described by more than one  
5 interviewee, as being 'the right thing to do', inferring a moral imperative to the work.  
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10 *The person is at the centre of it and if they need a \*\*\*\*\* wheelchair or a dietician,*  
11 *then they should get it. Not about who pays, what the financial consequences are.*  
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13 [Care home manager (8)]  
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16 Interviewees were frank in their admissions of how little they understood about the  
17 vanguard programme, and how the vision would be achieved. This was attributed by some  
18 to the CCG's desire to involve a wide range of stakeholders in service design and  
19 development, and the resulting inertia in getting started. Others blamed a lack of clarity  
20 from NHS England, which filtered down into local vanguards. This uncertainty limited  
21 external discussions about the programme.  
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28 The majority of care home managers were familiar with the headline proposals, even if they  
29 had little idea of how the vanguard would influence their work. Staff turnover was a  
30 common issue; some care homes had new managers in post, which meant that initiatives  
31 (including vanguard) were not seized upon. Care home managers talked about the pressing  
32 issues that they faced daily, particularly staffing and liaising with care providers from  
33 different sectors. This had consequences for their ability to fully engage with the vanguard.  
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#### 40 *A top-down health programme?*

41 Strategic involvement of local and national bodies was highlighted as a major strength of the  
42 vanguard. However, engagement of a broad constituency also raised questions about  
43 differing organisational agendas, and the threats that this may pose. A number of  
44 interviewees from outside the NHS expressed a perception that the vanguard was a health-  
45 dominated programme, imposed from above.  
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52 *It feels like it might be being imposed, as opposed to it coming out of the experience*  
53 *of people working in care homes.*  
54 [Third sector (1)]  
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3 This feeling of imposition was explained in terms of historic links between care homes and  
4 general practitioners, and the fact that the vanguard is building on existing work rather than  
5 starting from scratch. There were concerns that a focus on health budgets and failure to  
6 align agendas would represent a missed opportunity to capitalise on an opportunity for  
7 radical change.  
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13 *Vanguard in [Town 1] could be seen to be the catalyst for this real localised joined up*  
14 *working. But this is all just about health budgets. And it is all just about health driven*  
15 *issues. And I think that is the massive missing agenda. Because if you could get the*  
16 *Local Authority and Health to work on this, then they could be seen as an exemplar*  
17 *throughout the country.* [Local authority (3)]  
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23 The perceived imposition of the vanguard was discussed in relation to changes to  
24 commissioning and contracting, and how these would be resisted by care homes if they  
25 were not fully engaged.  
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## 32 **Theme 2. Communication**

33 Communication was one of the most frequently mentioned influences on the success of the  
34 vanguard. Interviewees were concerned with the way in which information was  
35 communicated, as well as the content. Most talked of information-sharing relating to the  
36 vanguard changes, but a significant minority also aired their views on patient or resident  
37 related communication between health services and care homes, and different parts of the  
38 health service.  
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### 45 *A shared language*

46 The absence of a shared language amongst vanguard stakeholders was noted by a number  
47 of interviewees. Discussion in meetings and the vanguard documentation was described as  
48 jargon filled, and potentially inaccessible to people from care homes and the third sector in  
49 particular. Some felt this limited their ability to engage in discussion and participate in the  
50 development of the vanguard.  
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3 *The language that's being used in some of the work planning, I think is extremely*  
4 *inaccessible. I don't think people understand. [...] It's got a very clinical CCG kind of*  
5 *look to it. [...] I just find it difficult when people jargon things up [...] because it feels*  
6 *like it's done and dusted, which it shouldn't be.* [Third sector (1)]  
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11 The vanguard programme was acknowledged to be in development, so expectations of  
12 progress were modest. However, for some, their own lack of clarity as to the expected  
13 outcomes made communication about the vanguard difficult, within their own  
14 organisations.  
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### 18 *Information sharing*

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20 Prompt and widespread diffusion of information about the vanguard was felt to be an  
21 important way of ensuring that care homes and others were engaged with the process.  
22 Information sharing was identified as a practical aspect of communication that could  
23 present a significant barrier. Many spoke of being unable to access electronic care records  
24 from other care settings. This created delays in obtaining information and duplication of  
25 effort for many healthcare professionals.  
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34 *I think there needs to be better sharing of information. Around the access to our GP*  
35 *records. For people being able to look in, to know what I've done, or what I've said,*  
36 *so that there's no duplication of information.* [General  
37 practitioner (2)]  
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42 Nurses and care home managers reported delays in receiving records, and administrative  
43 barriers to records moving with patients. A number of participants also made a connection  
44 between transfer of information and patient or resident safety.  
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### 49 **Theme 3. Evaluation of outcome measures of success**

50 Interviewees proposed a range of measures to evaluate the vanguard intervention,  
51 reflecting concerns with structural aspects of the new model of care, the process of  
52 implementation and selected outcomes. Possible evaluation measures emerged across the  
53 interviews, at different organisational levels (individual, service, organisation and whole  
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3 system) and perspectives (residents, staff, families). Where quantitative measures were  
4 proposed, someone, often the same interviewee, often suggested a complementary  
5 qualitative measure to understand or contextualise the information. Table 2 illustrates how  
6 some of the proposed measures fit together.  
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11 Table 2 here  
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15 In addition to measures that the interviewees expected to be part of any evaluation, such as  
16 the number of hospital admissions, issues such as collaboration and trust between  
17 stakeholders were suggested as critical to the development of the vanguard programme.  
18 Several interviewees emphasised the need to measure what was important, not what was  
19 easy to record.  
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25 *If we could measure collaboration, I think it would be hugely beneficial, because I*  
26 *think that not only evaluates how the programme's developing, but potentially*  
27 *collaboration is the solution to improving care and quality for patients, and value in*  
28 *the system.* [General practitioner (5)]  
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34 Many mentioned the importance of person-centred outcomes, with an older population  
35 living happier and healthier lives as a measure of success. Goals defined by care home  
36 residents, their families and carers were considered to be a priority. None of the  
37 interviewees offered a clear definition of person-centred, or reflected on how system and  
38 organisational outcomes might relate to changes for individuals. Concerns were expressed  
39 about the practical difficulties of capturing information from care homes and residents,  
40 including residents without capacity, and the difficulty of interpreting information provided  
41 by proxies, such as family members, as they may not reflect the resident's experiences.  
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#### 49 **Theme 4. Trust and complexity**

50 Interviewees expressed a desire to see the vanguard programme bring different parts of the  
51 care community together, with a common purpose. The talk of shared vision, and changes  
52 to hearts and minds, points to the expressed desire for trusting, collaborative relationships.  
53 The current reality for care homes, appeared to be some way from this goal. Relationships  
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3 between care homes and both health and local authorities were discussed in terms of  
4 mistrust and misunderstanding. This came from two key sources; the relationships that had  
5 developed over years of funding negotiations with the local authority, and the care homes'  
6 experiences of regular interactions with the health service.  
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### 10 *Relationships with external services*

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12 Some care home managers felt that colleagues in the health sector did not respect their  
13 judgement, and that care home staff were not trusted to provide a reliable report on a  
14 resident's symptoms or health care needs. This was a particular concern with hospitals and  
15 the out of hours service. Relationships with GPs were generally reported in positive terms,  
16 but one care home manager described how GPs may not always appreciate the limits of the  
17 care home's expertise in health matters.  
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25 *We've had odd times where the GPs are like, "You don't need to bother me with this.*  
26 *There's nothing really wrong with them," and you're like, "Well, I know you know*  
27 *that, but we didn't know that."* [Care home  
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29 manager (5)]  
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34 Much of the dissatisfaction expressed by care homes concerned the processes involved in  
35 the care system, predominantly the NHS. The absence of an individual to take responsibility  
36 or coordinate a resident's care journey through external services, was a concern.  
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40 The vanguard programme was seen as having the potential to address some of these  
41 concerns, improving care processes and efficiency of care pathways and enhancing trust  
42 between the sectors. Scrutiny of discharge transitions was presented as an example of how  
43 the vanguard might be able to effect change.  
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49 *I think the process of discharge from the hospital could be measured better. Has*  
50 *there been an assessment done? Is the person being discharged with their*  
51 *medication, a discharge letter or any follow-up referrals?* [Care  
52  
53 home manager (7)]  
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3 For the care home managers, funding issues were a negative influence on relationships  
4 between the local authority and care homes, and a source of mistrust. Care home managers  
5 expressed feelings of exasperation at what they perceived to be the local authority's failure  
6 to appreciate the pressures that they faced. Unfavourable comparisons were made with the  
7 funding agreements reached in neighbouring areas.  
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### 11 *Complexity*

12 The vanguard was portrayed as far-reaching, involving changes to an already complicated  
13 system of health and social care. Concerns were expressed about the unintended  
14 consequences of integration between NHS and social care services;  
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21 *My concern about [vanguard] is the NHS is a big monster at the moment that nobody*  
22 *controls. If you then amalgamated it with social services, it becomes a bigger*  
23 *monster that nobody can control.* [Care home  
24 manager (3)]  
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30 These concerns continued into the evaluation of large-scale changes, particularly attributing  
31 changes in different parts of the care pathway to patient outcomes. Some were concerned  
32 that they may be judged on outcomes over which they had little control. Measuring whole-  
33 system outcomes was difficult, and risked encouraging perverse incentives. Interviewees  
34 identified a need to ensure that changes in the care pathway were linked, in order to  
35 contribute to improvements for residents.  
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42 *It's separate components, provided by separate providers, under separate contracts.*  
43 *That can do two injurious things, one of which is a fragmented experience of care,*  
44 *but the other, and perhaps more important thing, is that it can create perverse*  
45 *incentives in the delivery of care.*  
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48 [Local authority (4)]  
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52 Navigating complex systems was a source of frustration for clinical staff, who felt that long-  
53 standing processes and systems were bureaucratic and unwieldy. Vanguard was perceived  
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3 as an opportunity to resolve some of these problems and improve clinicians' ability to  
4 provide good patient care.  
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8 *What I really hope [vanguard] will do, actually, is to get round some of the*  
9 *bureaucracy that we're currently dealing with. That vanguard will have the weight to*  
10 *make changes.* [General  
11  
12 practitioner (2)]  
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## 16 Discussion

### 17 **Summary of findings**

18 This study identified a consensus across a broad constituency that the ways in which  
19 services are provided for care home residents needed to change, and a shared belief in the  
20 benefits of closer working between health and social care. The vision of the vanguard  
21 programme was supported overall, but the programme was perceived by some as being  
22 imposed, top down, from the health service. Some aspects, such as outcomes-based  
23 commissioning were not well understood, even by staff closely linked to the work. Barriers  
24 and facilitators to change were identified around communication, outcomes, trust and  
25 complexity. Great importance was attached to the measurement of intangible but  
26 important aspects of success, such as the level of collaboration.  
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36 A number of barriers to implementing a better system were identified, and most were  
37 regarded as challenging to overcome. Engaging people in a shared venture, when they are  
38 drawn from diverse professional backgrounds and employed by organisations with differing  
39 priorities, is not straightforward. Participants shared an interest in improving the wellbeing  
40 of older people in care homes, but the daily pressures of their work limited their  
41 involvement in new initiatives. Some of the anticipated problems, such as information  
42 sharing, had potential practical solutions. Others were more abstract. Many respondents  
43 talked of the need to promote collaboration and ensure shared values, but there were few  
44 ideas of how to achieve this in practice.  
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53 Understanding how a new model of care is going to influence outcomes for care home  
54 residents is likely to increase support for change. In this study, the vanguard initiative was  
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3 seen as an opportunity to throw off some long established but unhelpful ways of working.  
4 Getting key players talking was one of the ways it was expected to effect change, along with  
5 breaking down barriers to shared information and records, reducing bureaucracy, and  
6 promoting the role of the care home in the wider system. This study identified the concerns  
7 of care home managers, including a perception that they are outsiders in the process of  
8 service development. We interviewed one third of care home managers in the vanguard  
9 area, and found great diversity in the level of awareness and understanding of the vanguard.  
10 This suggests a need to devote resources to developing relationships, as involvement of the  
11 care home sector will clearly be essential to the long term success of any changes. A  
12 programme evaluation that is meaningful to different stakeholders may be another way of  
13 fostering engagement. In this case, evaluation priorities focused on person-centred care.  
14 There was broad support for having a matrix of qualitative and quantitative outcome  
15 measures at different organisational levels, shared across different settings. This is in line  
16 with NHS England's proposed approach to local vanguard evaluation, which combined  
17 understanding what works, in what context, with agreed metrics.<sup>19</sup> Meeting resident and  
18 family expectations is an implicit goal for most services, and this was supported as a  
19 programme outcome.  
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### 32 33 34 **Strengths and limitations**

35 Our data were collected from a broad range of stakeholders, recruited from different  
36 settings. We cannot exclude the possibility that our close working with the CCG influenced  
37 the interviewees' decision to participate, or their willingness to share views and  
38 experiences. However, the critical content of the interviews suggests that this was not a  
39 major concern. The timing of our study, before the vanguard started, also presented  
40 challenges. It was inevitable that participants may not fully understand the scope or  
41 potential of the initiative. Recruitment of stakeholders working in or with the care home  
42 sector, and briefing them on the vanguard before interviews took place, allowed us to  
43 collect useful data for analysis.  
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### 52 53 **Comparison with other work**

54 Previous evaluations of integrated care have identified issues that are key to ensuring  
55 success, including effective leadership, clear communication, and a willingness to  
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57

collaborate and engage with colleagues.<sup>18</sup> Findings from the organisational relations literature<sup>20 23</sup> highlight the importance of trust, appreciating complexity, and understanding roles and responsibilities at all levels throughout the involved organisations. Our research reinforces the significance of this previous work for relation to future vanguard evaluations. Messages from the national team were reported to sometimes lack clarity and consistency, which adversely affected local understanding of the vanguard requirements. This echoes the findings of a recent review of integrated programmes, that linked poor understanding of outcomes with limited insight into how the programme will effect change.<sup>18</sup> It is also consistent with previous work that stressed the importance of defining outcomes that matter to the service users and their families.<sup>14 18</sup>

## Conclusions

Innovation in service delivery for care homes requires some alignment of organisational agendas across health and social care. This study has emphasised how much effort this requires, even in a geographical area where local authority and health organisations already work well together. The benefits of engaging the care home sector in change that they want and support are obvious, but the varied nature of the sector, current pressures and historical isolation from the NHS, make this a challenge. Evaluation of new programmes need to capture what is important to people receiving and providing care, and not to simply provide evidence of reduction in resource consumption for the funders. The less tangible benefits, such as trust and collaboration should not be overlooked, even if difficult to measure.

**Competing Interests** None declared.

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**Collaborators** The authors thank Caroline Kavanagh, Dr Shona Haining, and Dr Daniel Cowie, all of Newcastle Gateshead Clinical Commissioning Group.

**Contributors** BH and RS designed the study with CB, KB, RD, SM, & LR. RS conducted interviews. RS and BH analysed data. RS and BH drafted the article, and CB, KB, RD, SM, & LR performed critical revision of the article for important intellectual content. RS is guarantor of the paper. All authors approved the final version to be published.

**Data Sharing Statement** No additional data are available.

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**Box 1 Components of the local Care Home Vanguard programme**

- Development of enhanced care pathway
- Workforce and training workstream
- Engagement and communication strategy
- Development of an outcomes framework
- Outcomes-based contracting and payment system
- Establishment of a Provider Alliance Network
- Evaluation and monitoring

**Box 2 Interview topics**

- Understanding and perceptions of the proposed new model of care
- Barriers and facilitators to implementing change
- Anticipated consequences for residents, staff, and others
- How and why the new models might bring about change
- How the vanguard should be evaluated

**Table 1 Interviewees – Role in the local Care Home Vanguard**

Role	n
Care home manager	10
General practitioner	5
Community geriatrician	2
Older person's specialist nurse	2
GP Transformation Team	1
Third sector	1
Clinical Commissioning Group employee (leads for contracting, communications & engagement, vanguard manager, vanguard lead nurse)	4
Local authority (social worker, director of health & wellbeing, leads for vanguard and legal services)	4
NHS England vanguard team lead	1
Total:	<b>30</b>

**Table 2 Matrix of evaluation measures – selected examples proposed by interviewees in the local Care Home Vanguard study**

	Structure		Process		Outcome	
	Quantitative	Qualitative	Quantitative	Qualitative	Quantitative	Qualitative
<b>Individual</b>			How many people are involved with a resident (relational continuity)  Medication reviews completed  Does the resident have a care plan in place?	Quality of staff resident interaction  How do the care home staff feel about the support they get from NHS relating to medication?	Falls  Pressure sores  BMI  Nutrition Hydration	Resident wellbeing  Death in preferred place of care
<b>Service</b>	Staff retention	The role of skills development in staff retention	How many safeguarding alerts in a care home	How are safeguarding alerts dealt with?		
<b>System</b>			Delayed discharges	Discharge processes		



## COREQ checklist

Care home services at the vanguard: stakeholder views on the development and evaluation of novel, integrated approaches to enhancing health care in care homes.

No. Item	Guide questions/description	Reported on Page #
<b>Domain 1: Research team and reflexivity</b>		
<i>Personal Characteristics</i>		
1. Inter viewer/facilitator	Which author/s conducted the inter view or focus group?	Rachel Stocker (page 5)
2. Credentials	What were the researcher's credentials? E.g. PhD, MD	PhD (page 5)
3. Occupation	What was their occupation at the time of the study?	Research Associate (page 5)
4. Gender	Was the researcher male or female?	Female (page 5)
5. Experience and training	What experience or training did the researcher have?	PhD and experience with qualitative research studies (page 5)
<i>Relationship with participants</i>		
6. Relationship established	Was a relationship established prior to study commencement?	No (page 5)
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	Participants knew nothing personal about the interviewer other than her name.
8. Interviewer characteristics	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	None applicable
<b>Domain 2: study design</b>		
<i>Theoretical framework</i>		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	A data-driven approach using thematic analysis and constant comparison (page 5)
<i>Participant selection</i>		
10. Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball	Purposive (page 4-5)
11. Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	Email (page 5)
12. Sample size	How many participants were in the study?	30 (page 4)
13. Non-participation	How many people refused to participate or dropped out? Reasons?	None refused to participate.
<i>Setting</i>		
14. Setting of data	Where was the data collected? e.g. home,	Telephone

collection	clinic, workplace	interviews, and face to face interviews at workplaces (page 5)
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	No (page 5)
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	See Table 1 (page 16)
<i>Data collection</i>		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	An interview topic guide was developed and piloted (page 5)
18. Repeat interviews	Were repeat inter views carried out? If yes, how many?	No
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	Audio (page 5)
20. Field notes	Were field notes made during and/or after the inter view or focus group?	After interviews (page 5)
21. Duration	What was the duration of the inter views or focus group?	30-60 minutes for interviews (page 5)
22. Data saturation	Was data saturation discussed?	No
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	No
<b>Domain 3: analysis and findings</b>		
<i>Data analysis</i>		
24. Number of data coders	How many data coders coded the data?	2 (page 5)
25. Description of the coding tree	Did authors provide a description of the coding tree?	N/A
26. Derivation of themes	Were themes identified in advance or derived from the data?	Derived from the data (page 5)
27. Software	What software, if applicable, was used to manage the data?	NVivo 11 (page 5)
28. Participant checking	Did participants provide feedback on the findings?	No
<i>Reporting</i>		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	Yes and yes (page 6 onwards)
30. Data and findings consistent	Was there consistency between the data presented and the findings?	Yes
31. Clarity of major themes	Were major themes clearly presented in the findings?	Yes
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	Yes

# BMJ Open

## Care home services at the vanguard: a qualitative study exploring stakeholder views on the development and evaluation of novel, integrated approaches to enhancing health care in care homes.

Journal:	<i>BMJ Open</i>
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<b>Primary Subject Heading</b>:	Health services research
Secondary Subject Heading:	General practice / Family practice, Health policy, Geriatric medicine, Qualitative research
Keywords:	Health policy < HEALTH SERVICES ADMINISTRATION & MANAGEMENT, QUALITATIVE RESEARCH, health services for the aged, Residential Facilities, Delivery of Health Care, Integrated

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Manuscripts

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3 **Care home services at the vanguard: a qualitative study exploring stakeholder views on**  
4 **the development and evaluation of novel, integrated approaches to enhancing health care**  
5 **in care homes**  
6  
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8

9 Stocker, Rachel<sup>1</sup>; Bamford, Claire<sup>1</sup>; Brittain, Katie<sup>2</sup>; Duncan, Rachel<sup>1</sup>; Moffatt, Suzanne<sup>1</sup>;  
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22 Keywords: Health Policy; Health Services for the Aged; Qualitative Research; Residential  
23 Facilities; Delivery of Health Care, Integrated  
24  
25

26 Word count: 4480  
27  
28

29 **Abstract**  
30

31 **Objectives** To explore stakeholders' understanding of novel integrated approaches to  
32 enhancing care in care homes (a care home 'vanguard') and identify priorities for  
33 evaluation.  
34

35 **Design** A qualitative study, using semi-structured interviews with commissioners and service  
36 providers to/within care homes, and third sector organisations with thematic analysis.  
37

38 **Setting** A Clinical Commissioning Group (CCG) area in England.  
39

40 **Participants** Thirty interviewees from: care homes, the National Health Service (England)  
41 and local authority, third sector (10 care home managers, 5 general practitioners, 4 CCG  
42 employees, 4 local authority employees, 1 national (NHS England) vanguard lead, 2  
43 specialist nurses, 2 geriatricians, 1 third sector, 1 health manager).  
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3 **Results** Four higher-level themes emerged from the data: understanding of proposed  
4 changes, communication, evaluation of outcome measures of success, and trust and  
5 complexity. The vision for the new programme was shared by stakeholders, with  
6 importance attached to equitable access to high quality care. Support for the programme  
7 was described as being 'the right thing to do', inferring a moral imperative. However, the  
8 practical implications of key aspects, such as integrated working, were not clearly  
9 understood and the programme was perceived by some as being imposed, top down, from  
10 the health service. Barriers and facilitators to change were identified across themes of  
11 communication, outcomes, trust and complexity. Importance was attached to the  
12 measurement of intangible aspects of success, such as collaboration. Interviewees  
13 understood that outcome-based commissioning was one element of the new programme,  
14 but discussion of their aspirations and practices revealed values and beliefs more  
15 compatible with a system based on trust.

### 25 **Conclusions**

26 Innovation in service delivery requires organisations to adopt common priorities and share  
27 responsibility for success. The vanguard programme is working to ensure health and local  
28 authorities have this commitment, but engaging care homes that may feel isolated from the  
29 welfare system, needs sustained dialogue over the longer term. Evaluation of the  
30 programme needs to measure what is important to stakeholders, and not focus too closely  
31 on resource consumption.

### 37 **Strengths and limitations**

- 40 • This is the first study to explore aspects of an English vanguard initiative prior to  
41 implementation.
- 42 • The findings provide insights relevant to the different vanguard programmes  
43 throughout England.
- 44 • Perspectives from a wide range of stakeholders across health and social care were  
45 included.
- 46 • A limitation is that only one participant was recruited from the third sector.

## Introduction

The health and social care needs of residents in long-term care settings are increasing in complexity, as the number of older adults in the population grows.<sup>1,2</sup> In the UK, bed numbers in care homes have remained stable in recent years, and the average age of residents is 85 years.<sup>2</sup> Multiple morbidities are common; it is estimated that four out of five care home residents have a cognitive impairment whilst a similar proportion live with incontinence.<sup>3,4</sup> Despite presenting some of the most challenging problems in primary care, care home residents are believed to have poorly coordinated services, worse management of long-term conditions, and inequitable access to hospital care, compared to community dwelling older adults.<sup>5,6</sup>

Integrated working between health and social care is advocated as an appropriate, cost-effective way of improving quality of health care in care homes.<sup>7-9</sup> However, integrated care has been defined and implemented in many different ways. The National Health Service (NHS) England describe it as person-centred, coordinated, and tailored to the needs and preferences of the individual and their family.<sup>10</sup> To date, efforts to integrate care in a range of different countries and health and social care systems have produced limited evidence of improved outcomes.<sup>11</sup> A number of possible explanations have been proposed, including inadequate resources, the adoption of piecemeal rather than whole-system change<sup>5,12,13</sup>, and a failure to adequately involve service users and families.<sup>14</sup>

The UK policy response to rising demands for better quality of care, has included development of new, integrated ways of working.<sup>15</sup> Investment in 50 different 'vanguard' programmes by NHS England in 2014 has focused on integrating primary and acute care, multispecialty community providers, urgent and emergency care, and acute care collaborations. Six sites were selected to enhance health in care homes, whereby residents are offered more integrated and coordinated health care by combining health and social care services at a systemic level.<sup>16</sup> Evaluation of any new intervention is essential to provide reliable evidence to inform commissioning choices.<sup>17</sup> It is even more important in the case of the vanguard programme, as the new models aim to be replicable across England. Programmes that bring together health and social care may be particularly challenging to evaluate. Multiple stakeholders may not agree on outcomes, information collection across

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3 settings can be difficult, and appropriate sources of data may not be readily available.<sup>18</sup>  
4 Many integrated care programmes aim to reduce resource use, and changes in unplanned  
5 admissions to hospital is a commonly measured outcome.<sup>19</sup> Less tangible concepts, such as  
6 trust and collaboration between organisations have also been proposed as indicators of  
7 success.<sup>20</sup> There is a growing consensus around the need to scrutinise processes involved in  
8 any intervention, including feasibility and acceptability. Recent methodological  
9 developments, such as realist evaluation, have emphasised the importance of taking time to  
10 understand the complexities of the local context.<sup>17 21</sup>

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18 The proposed programme of change under investigation in this study consists of different  
19 work streams that encompass commissioning and service provision, care pathways,  
20 workforce and evaluation (Box 1).

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25 Box 1 here

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29 This paper reports on qualitative research aiming to inform the future evaluation of a new  
30 model of integrated care for care homes (care home vanguard) in England. At the time of the  
31 study, the vanguard programme was in the first year of development and had not officially  
32 started. In addition to identifying priorities and metrics for future evaluation, the vanguard  
33 team were developing and refining logic models to systematically consider the key  
34 components of the new care model, and preparing for a full launch of the initiative. Study  
35 objectives were to:

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42 a) Explore stakeholders' understanding, perceptions and expectations of the  
43 new programme, how it will be implemented, and how it might change care in the  
44 local context.  
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46 b) Identify the priorities for evaluation of the programme.  
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## 50 51 **Method**

52 Approval was granted by Newcastle University Faculty of Medical Sciences Research Ethics  
53 Committee.  
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## Setting

The study took place in a single Local Authority administrative area and within a single Clinical Commissioning Group (CCG). This CCG is located within a post-industrial urban location characterised by large scale socio-economic deprivation and poor health, being in the top fifth of most deprived local authorities in England with high rates of morbidity and premature mortality<sup>22</sup>, and has suffered disproportionately due to austerity-driven public sector funding cuts.

## Recruitment and sampling

Semi-structured interviews were conducted with 30 stakeholders in the local care home vanguard. Stakeholders were identified by the CCG from (i) the vanguard steering group, (ii) local services that were involved in the commissioning or delivery of care for residents of long-term care, (iii) organisations with an interest in the care and wellbeing of residents. The CCG acted as gatekeepers and sent introductory emails to potential participants, then provided the research team with relevant contact details. One of the researchers (RS) purposively sampled potential participants (n=61) using the list of contact details provided by the CCG, and contacted them directly by email or telephone to invite participation, with a covering letter and participant information sheet. Non-responders (n=14) were reminded after one week. Twenty-eight respondents agreed to participate. Interviewees who were care home managers were asked to nominate colleagues from different homes, to boost recruitment from this setting (snowball sampling); two further care home managers were recruited. No inclusion or exclusion criteria were employed. Participants' roles in the care home vanguard are detailed in Table 1.

Table 1 here

## Data collection

Interviews were conducted in March-April 2016, by telephone or in person (at the participant's workplace in a private area), and lasted 30-60 minutes. A topic guide was developed, informed by published literature on implementing new models of integrated care for the elderly, and the requirements of the research commissioners (see Box 2). The topic guide was tested with members of the research team who included qualified doctors, allied health professionals and researchers with extensive experience of qualitative research. This aimed to ensure that the topic guide was practical, suitable for use in the time



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3 available, and able to elicit the data required to answer the research questions. No further  
4 topics were added.  
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8 Box 2 here  
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11 Written informed consent was obtained for all participants. All interviews were conducted  
12 by the same qualitative researcher (RS), audio recorded and transcribed. All transcripts were  
13 anonymised.  
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### 18 **Data management and analysis**

19 A thematic analysis<sup>23</sup> was conducted, using NVivo version 11 software to manage data. The  
20 interview transcripts were read and reread to familiarise ourselves with the text. The  
21 interviewer coded every transcript line by line, and a subset (10/30) of transcripts were  
22 coded by a second researcher (BH). Emergent themes were identified in discussion with the  
23 research team, and linked together to form a final set of higher level themes. A data driven  
24 approach to the development of a coding framework was chosen, because our topic guide  
25 had been strongly influenced by the needs of the vanguard team, and we needed to ensure  
26 that any unrecognised issues of concern to the interviewees were included in the analysis.  
27 Interviews ceased once it became clear that no new themes were emerging from the data.  
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### 37 **Findings**

38 Participants were all stakeholders in the vanguard programme. Each had an interest in, or  
39 were engaged in, the commissioning or delivery of care for older people in care homes.  
40 Findings are presented across four higher-level themes which emerged from the data: (i)  
41 understanding of the proposed changes; (ii) communication; (iii) outcomes; and (iv) trust  
42 and complexity. Verbatim quotations are presented to illustrate commonly expressed views,  
43 or unusual or contrasting perspectives.  
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### 50 *The local context*

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53 Interviewees highlighted aspects of the local infrastructure and services that provided a  
54 favourable basis for vanguard changes. The small geographical size, single local authority and  
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3 single hospital (NHS Trust) were all expected to simplify relationships and communication.  
4 General practices in the area had a history of working well together. Relationships between  
5 hospital and community services were also good. Some felt that the generous provision of  
6 care home beds in this area meant that services did not have to strive hard to support  
7 patients in their own homes.  
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### 10 11 12 **Theme 1. Understanding of the proposed changes**

#### 13 *A shared vision*

14 A majority of the interviewees shared a vision of improved care and quality of life for older  
15 people in the vanguard area. The CCG had aspirations for equitable access to care - 'the  
16 right care, delivered by the right person at the right time' and 'one bed, one outcome'.  
17 Others shared these sentiments. Support for the vanguard was described by more than one  
18 interviewee, as being 'the right thing to do', inferring a moral imperative to the work.  
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26 *The person is at the centre of it and if they need a \*\*\*\*\* wheelchair or a dietician,*  
27 *then they should get it. Not about who pays, what the financial consequences are.*

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30 [Care home manager (8)]  
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33 Interviewees were frank in their admissions of how little they understood about the  
34 vanguard programme, and how the vision would be achieved. This was attributed by some  
35 to the CCG's desire to involve a wide range of stakeholders in service design and  
36 development, and the resulting inertia in getting started. Others blamed a lack of clarity  
37 from NHS England, which filtered down into local vanguards. This uncertainty limited  
38 external discussions about the programme.  
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45 The majority of care home managers were familiar with the headline proposals, even if they  
46 had little idea of how the vanguard would influence their work. Staff turnover was a  
47 common issue; some care homes had new managers in post, which meant that initiatives  
48 (including vanguard) were not seized upon. Care home managers talked about the pressing  
49 issues that they faced daily, particularly staffing and liaising with care providers from  
50 different sectors. This had consequences for their ability to fully engage with the vanguard.  
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### *A top-down health programme?*

Strategic involvement of local and national bodies was highlighted as a major strength of the vanguard. However, engagement of a broad constituency also raised questions about differing organisational agendas, and the threats that this may pose. A number of interviewees from outside the NHS expressed a perception that the vanguard was a health-dominated programme, imposed from above.

*It feels like it might be being imposed, as opposed to it coming out of the experience of people working in care homes.* [Third sector (1)]

This feeling of imposition was explained in terms of historic links between care homes and general practitioners, and the fact that the vanguard is building on existing work rather than starting from scratch. There were concerns that a focus on health budgets and failure to align agendas would represent a missed opportunity to capitalise on an opportunity for radical change.

*Vanguard in [Town 1] could be seen to be the catalyst for this real localised joined up working. But this is all just about health budgets. And it is all just about health driven issues. And I think that is the massive missing agenda. Because if you could get the Local Authority and Health to work on this, then they could be seen as an exemplar throughout the country.* [Local authority (3)]

The perceived imposition of the vanguard was discussed in relation to changes to commissioning and contracting, and how these would be resisted by care homes if they were not fully engaged.

### **Theme 2. Communication**

Communication was one of the most frequently mentioned influences on the success of the vanguard. Interviewees were concerned with the way in which information was communicated, as well as the content. Most talked of information-sharing relating to the vanguard changes, but a significant minority also aired their views on patient or resident

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3 related communication between health services and care homes, and different parts of the  
4 health service.  
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### 8 *A shared language*

9 The absence of a shared language amongst vanguard stakeholders was noted by a number  
10 of interviewees. Discussion in meetings and the vanguard documentation was described as  
11 jargon filled, and potentially inaccessible to people from care homes and the third sector in  
12 particular. Some felt this limited their ability to engage in discussion and participate in the  
13 development of the vanguard.  
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20 *The language that's being used in some of the work planning, I think is extremely*  
21 *inaccessible. I don't think people understand. [...] It's got a very clinical CCG kind of*  
22 *look to it. [...] I just find it difficult when people jargon things up [...] because it feels*  
23 *like it's done and dusted, which it shouldn't be.* [Third sector (1)]  
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28 The vanguard programme was acknowledged to be in development, so expectations of  
29 progress were modest. However, for some, their own lack of clarity as to the expected  
30 outcomes made communication about the vanguard difficult, within their own  
31 organisations.  
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### 36 *Information sharing*

37 Prompt and widespread diffusion of information about the vanguard was felt to be an  
38 important way of ensuring that care homes and others were engaged with the process.  
39 Information sharing was identified as a practical aspect of communication that could  
40 present a significant barrier. Many spoke of being unable to access electronic care records  
41 from other care settings. This created delays in obtaining information and duplication of  
42 effort for many healthcare professionals.  
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51 *I think there needs to be better sharing of information. Around the access to our GP*  
52 *records. For people being able to look in, to know what I've done, or what I've said,*  
53 *so that there's no duplication of information.* [General  
54 practitioner (2)]  
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4 Nurses and care home managers reported delays in receiving records, and administrative  
5 barriers to records moving with patients. A number of participants also made a connection  
6 between transfer of information and patient or resident safety.  
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### 10 11 **Theme 3. Evaluation of outcome measures of success**

12 Interviewees proposed a range of measures to evaluate the vanguard intervention,  
13 reflecting concerns with structural aspects of the new model of care, the process of  
14 implementation and selected outcomes. Possible evaluation measures emerged across the  
15 interviews, at different organisational levels (individual, service, organisation and whole  
16 system) and perspectives (residents, staff, families). Where quantitative measures were  
17 proposed, someone, often the same interviewee, often suggested a complementary  
18 qualitative measure to understand or contextualise the information. Table 2 illustrates how  
19 some of the proposed measures fit together.  
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28 Table 2 here  
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32 In addition to measures that the interviewees expected to be part of any evaluation, such as  
33 the number of hospital admissions, issues such as collaboration and trust between  
34 stakeholders were suggested as critical to the development of the vanguard programme.  
35 Several interviewees emphasised the need to measure what was important, not what was  
36 easy to record.  
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42 *If we could measure collaboration, I think it would be hugely beneficial, because I*  
43 *think that not only evaluates how the programme's developing, but potentially*  
44 *collaboration is the solution to improving care and quality for patients, and value in*  
45 *the system.*  
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48 [General practitioner (5)]  
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51 Many mentioned the importance of person-centred outcomes, with an older population  
52 living happier and healthier lives as a measure of success. Goals defined by care home  
53 residents, their families and carers were considered to be a priority. None of the  
54 interviewees offered a clear definition of person-centred, or reflected on how system and  
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organisational outcomes might relate to changes for individuals. Concerns were expressed about the practical difficulties of capturing information from care homes and residents, including residents without capacity, and the difficulty of interpreting information provided by proxies, such as family members, as they may not reflect the resident's experiences.

#### ***Theme 4. Trust and complexity***

Interviewees expressed a desire to see the vanguard programme bring different parts of the care community together, with a common purpose. The talk of shared vision, and changes to hearts and minds, points to the expressed desire for trusting, collaborative relationships. The current reality for care homes, appeared to be some way from this goal. Relationships between care homes and both health and local authorities were discussed in terms of mistrust and misunderstanding. This came from two key sources; the relationships that had developed over years of funding negotiations with the local authority, and the care homes' experiences of regular interactions with the health service.

#### ***Relationships with external services***

Some care home managers felt that colleagues in the health sector did not respect their judgement, and that care home staff were not trusted to provide a reliable report on a resident's symptoms or health care needs. This was a particular concern with hospitals and the out of hours service. Relationships with GPs were generally reported in positive terms, but one care home manager described how GPs may not always appreciate the limits of the care home's expertise in health matters.

*We've had odd times where the GPs are like, "You don't need to bother me with this. There's nothing really wrong with them," and you're like, "Well, I know you know that, but we didn't know that."* [Care home manager (5)]

Much of the dissatisfaction expressed by care homes concerned the processes involved in the care system, predominantly the NHS. The absence of an individual to take responsibility or coordinate a resident's care journey through external services, was a concern.

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3 The vanguard programme was seen as having the potential to address some of these  
4 concerns, improving care processes and efficiency of care pathways and enhancing trust  
5 between the sectors. Scrutiny of discharge transitions was presented as an example of how  
6 the vanguard might be able to effect change.  
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11 *I think the process of discharge from the hospital could be measured better. Has*  
12 *there been an assessment done? Is the person being discharged with their*  
13 *medication, a discharge letter or any follow-up referrals? [Care*  
14 *home manager (7)]*  
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20 For the care home managers, funding issues were a negative influence on relationships  
21 between the local authority and care homes, and a source of mistrust. Care home managers  
22 expressed feelings of exasperation at what they perceived to be the local authority's failure  
23 to appreciate the pressures that they faced. Unfavourable comparisons were made with the  
24 funding agreements reached in neighbouring areas.  
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### 30 *Complexity*

31 The vanguard was portrayed as far-reaching, involving changes to an already complicated  
32 system of health and social care. Concerns were expressed about the unintended  
33 consequences of integration between NHS and social care services;  
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38 *My concern about [vanguard] is the NHS is a big monster at the moment that nobody*  
39 *controls. If you then amalgamated it with social services, it becomes a bigger*  
40 *monster that nobody can control. [Care home*  
41 *manager (3)]*  
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47 These concerns continued into the evaluation of large-scale changes, particularly attributing  
48 changes in different parts of the care pathway to patient outcomes. Some were concerned  
49 that they may be judged on outcomes over which they had little control. Measuring whole-  
50 system outcomes was difficult, and risked encouraging perverse incentives. Interviewees  
51 identified a need to ensure that changes in the care pathway were linked, in order to  
52 contribute to improvements for residents.  
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5 *It's separate components, provided by separate providers, under separate contracts.*  
6 *That can do two injurious things, one of which is a fragmented experience of care,*  
7 *but the other, and perhaps more important thing, is that it can create perverse*  
8 *incentives in the delivery of care.*

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11 [Local authority (4)]  
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15 Navigating complex systems was a source of frustration for clinical staff, who felt that long-  
16 standing processes and systems were bureaucratic and unwieldy. Vanguard was perceived  
17 as an opportunity to resolve some of these problems and improve clinicians' ability to  
18 provide good patient care.  
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23 *What I really hope [vanguard] will do, actually, is to get round some of the*  
24 *bureaucracy that we're currently dealing with. That vanguard will have the weight to*  
25 *make changes.*

26  
27 [General  
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29 practitioner (2)]  
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## 32 Discussion

### 33 **Summary of findings**

34 This study identified a consensus across a broad constituency that the ways in which  
35 services are provided for care home residents needed to change, and a shared belief in the  
36 benefits of closer working between health and social care. The vision of the vanguard  
37 programme was supported overall, but the programme was perceived by some as being  
38 imposed, top down, from the health service. Some aspects, such as outcomes-based  
39 commissioning were not well understood, even by staff closely linked to the work. Barriers  
40 and facilitators to change were identified around communication, outcomes, trust and  
41 complexity. Great importance was attached to the measurement of intangible but  
42 important aspects of success, such as the level of collaboration.  
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53 A number of barriers to implementing a better system were identified, and most were  
54 regarded as challenging to overcome. Engaging people in a shared venture, when they are  
55 drawn from diverse professional backgrounds and employed by organisations with differing  
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3 priorities, is not straightforward. Participants shared an interest in improving the wellbeing  
4 of older people in care homes, but the daily pressures of their work limited their  
5 involvement in new initiatives. Some of the anticipated problems, such as information  
6 sharing, had potential practical solutions. Others were more abstract. Many respondents  
7 talked of the need to promote collaboration and ensure shared values, but there were few  
8 ideas of how to achieve this in practice.  
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15 Understanding how a new model of care is going to influence outcomes for care home  
16 residents is likely to increase support for change. In this study, the vanguard initiative was  
17 seen as an opportunity to throw off some long established but unhelpful ways of working.  
18 Getting key players talking was one of the ways it was expected to effect change, along with  
19 breaking down barriers to shared information and records, reducing bureaucracy, and  
20 promoting the role of the care home in the wider system. This study identified the concerns  
21 of care home managers, including a perception that they are outsiders in the process of  
22 service development. We interviewed one third of care home managers in the vanguard  
23 area, and found great diversity in the level of awareness and understanding of the vanguard.  
24 This suggests a need to devote resources to developing relationships, as involvement of the  
25 care home sector will clearly be essential to the long term success of any changes. A  
26 programme evaluation that is meaningful to different stakeholders may be another way of  
27 fostering engagement. In this case, evaluation priorities focused on person-centred care.  
28 There was broad support for having a matrix of qualitative and quantitative outcome  
29 measures at different organisational levels, shared across different settings. This is in line  
30 with NHS England's proposed approach to local vanguard evaluation, which combined  
31 understanding what works, in what context, with agreed metrics.<sup>19</sup> Meeting resident and  
32 family expectations is an implicit goal for most services, and this was supported as a  
33 programme outcome.  
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### 50 **Strengths and limitations**

51 Our data were collected from a broad range of stakeholders, recruited from different  
52 settings. We cannot exclude the possibility that our close working with the CCG influenced  
53 the interviewees' decision to participate, or their willingness to share views and  
54 experiences. However, the critical content of the interviews suggests that this was not a  
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3 major concern. The timing of our study, before the vanguard started, also presented  
4 challenges. It was inevitable that participants may not fully understand the scope or  
5 potential of the initiative. Recruitment of stakeholders working in or with the care home  
6 sector, and briefing them on the vanguard before interviews took place, allowed us to  
7 collect useful data for analysis.  
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### 11 12 13 **Comparison with other work**

14 Previous evaluations of integrated care have identified issues that are key to ensuring  
15 success, including effective leadership, clear communication, and a willingness to  
16 collaborate and engage with colleagues.<sup>18</sup> Findings from the organisational relations  
17 literature<sup>20 24</sup> highlight the importance of trust, appreciating complexity, and understanding  
18 roles and responsibilities at all levels throughout the involved organisations. Our research  
19 reinforces the significance of this previous work for relation to future vanguard evaluations.  
20 Messages from the national team were reported to sometimes lack clarity and consistency,  
21 which adversely affected local understanding of the vanguard requirements. This echoes the  
22 findings of a recent review of integrated programmes, that linked poor understanding of  
23 outcomes with limited insight into how the programme will effect change.<sup>18</sup> It is also  
24 consistent with previous work that stressed the importance of defining outcomes that  
25 matter to the service users and their families.<sup>14 18</sup>  
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### 38 **Conclusions**

39 Innovation in service delivery for care homes requires some alignment of organisational  
40 agendas across health and social care. This study has emphasised how much effort this  
41 requires, even in a geographical area where local authority and health organisations already  
42 work well together. The benefits of engaging the care home sector in change that they  
43 want and support are obvious, but the varied nature of the sector, current pressures and  
44 historical isolation from the NHS, make this a challenge. Evaluation of new programmes  
45 need to capture what is important to people receiving and providing care, and not to simply  
46 provide evidence of reduction in resource consumption for the funders. The less tangible  
47 benefits, such as trust and collaboration should not be overlooked, even if difficult to  
48 measure.  
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**Box 1 Components of the local Care Home Vanguard programme**

- Development of enhanced care pathway
- Workforce and training workstream
- Engagement and communication strategy
- Development of an outcomes framework
- Outcomes-based contracting and payment system
- Establishment of a Provider Alliance Network
- Evaluation and monitoring

**Box 2 Interview topics**

- Understanding and perceptions of the proposed new model of care
- Barriers and facilitators to implementing change
- Anticipated consequences for residents, staff, and others
- How and why the new models might bring about change
- How the vanguard should be evaluated

**Table 1 Interviewees – Role in the local Care Home Vanguard**

Role	n
Care home manager	10
General practitioner	5
Community geriatrician	2
Older person's specialist nurse	2
GP Transformation Team	1
Third sector	1
Clinical Commissioning Group employee (leads for contracting, communications & engagement, vanguard manager, vanguard lead nurse)	4
Local authority (social worker, director of health & wellbeing, leads for vanguard and legal services)	4
NHS England vanguard team lead	1
Total:	<b>30</b>

**Table 2 Matrix of evaluation measures – selected examples proposed by interviewees in the local Care Home Vanguard study**

	Structure		Process		Outcome	
	Quantitative	Qualitative	Quantitative	Qualitative	Quantitative	Qualitative
<b>Individual</b>			How many people are involved with a resident (relational continuity)  Medication reviews completed  Does the resident have a care plan in place?	Quality of staff resident interaction  How do the care home staff feel about the support they get from NHS relating to medication?	Falls  Pressure sores  BMI  Nutrition Hydration	Resident wellbeing  Death in preferred place of care
<b>Service</b>	Staff retention	The role of skills development in staff retention	How many safeguarding alerts in a care home	How are safeguarding alerts dealt with?		
<b>System</b>			Delayed discharges	Discharge processes		

## COREQ checklist

Care home services at the vanguard: stakeholder views on the development and evaluation of novel, integrated approaches to enhancing health care in care homes.

No. Item	Guide questions/description	Reported on Page #
<b>Domain 1: Research team and reflexivity</b>		
<i>Personal Characteristics</i>		
1. Inter viewer/facilitator	Which author/s conducted the inter view or focus group?	Rachel Stocker (page 5)
2. Credentials	What were the researcher's credentials? E.g. PhD, MD	PhD (page 5)
3. Occupation	What was their occupation at the time of the study?	Research Associate (page 5)
4. Gender	Was the researcher male or female?	Female (page 5)
5. Experience and training	What experience or training did the researcher have?	PhD and experience with qualitative research studies (page 5)
<i>Relationship with participants</i>		
6. Relationship established	Was a relationship established prior to study commencement?	No (page 5)
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	Participants knew nothing personal about the interviewer other than her name.
8. Interviewer characteristics	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	None applicable
<b>Domain 2: study design</b>		
<i>Theoretical framework</i>		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	A data-driven approach using thematic analysis and constant comparison (page 5)
<i>Participant selection</i>		
10. Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball	Purposive (page 4-5)
11. Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	Email (page 5)
12. Sample size	How many participants were in the study?	30 (page 4)
13. Non-participation	How many people refused to participate or dropped out? Reasons?	None refused to participate.
<i>Setting</i>		
14. Setting of data	Where was the data collected? e.g. home,	Telephone



collection	clinic, workplace	interviews, and face to face interviews at workplaces (page 5)
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	No (page 5)
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	See Table 1 (page 16)
<i>Data collection</i>		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	An interview topic guide was developed and piloted (page 5)
18. Repeat interviews	Were repeat inter views carried out? If yes, how many?	No
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	Audio (page 5)
20. Field notes	Were field notes made during and/or after the inter view or focus group?	After interviews (page 5)
21. Duration	What was the duration of the inter views or focus group?	30-60 minutes for interviews (page 5)
22. Data saturation	Was data saturation discussed?	No
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	No
<b>Domain 3: analysis and findings</b>		
<i>Data analysis</i>		
24. Number of data coders	How many data coders coded the data?	2 (page 5)
25. Description of the coding tree	Did authors provide a description of the coding tree?	N/A
26. Derivation of themes	Were themes identified in advance or derived from the data?	Derived from the data (page 5)
27. Software	What software, if applicable, was used to manage the data?	NVivo 11 (page 5)
28. Participant checking	Did participants provide feedback on the findings?	No
<i>Reporting</i>		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	Yes and yes (page 6 onwards)
30. Data and findings consistent	Was there consistency between the data presented and the findings?	Yes
31. Clarity of major themes	Were major themes clearly presented in the findings?	Yes
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	Yes