# EVALUATION OF NEWCASTLE GATESHEAD ENHANCED HEALTH AND CARE IN CARE HOMES VANGUARD – CONTRACTING WORKSTREAM ENGAGEMENT

## Final Report June 2017

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**CPWS – Contract Payment Work Stream**

**Commissioners – participants who are staff working at Newcastle Gateshead Clinical Commissioning Group**

**Providers – participants who are care home providers or representatives, community based services and advocate organisations across Newcastle - Gateshead**

## 1.0 Summary

Newcastle Gateshead Clinical Commissioning Group is one of 6 national Vanguard sites for Enhanced Health in Care Homes (EHCH). It established a number of work streams to take forward its vision and objectives. This report presents an evaluation of the contracts and payments work stream (CPWS).

The evaluation aim was to explore stakeholders' perceptions of engagement and current ways of working within the work stream of the EHCH Vanguard implementation to identify what was impacting on its functioning and outcomes.

A qualitative research approach informed by realistic evaluation (Pawson & Tilley 1997) 'what works well, and for whom' was used to conduct this independent evaluation study into engagement and ways of working arrangements currently in place for the contracting Workstream. 11 semi structured interviews were conducted with members of the work stream and analysed using constant comparison. The findings from the analysis process have been mapped against a model of success factors and barriers to change in the NHS (Allcock 2015) in order to generate a summary readiness assessment for next steps.

Across the sample there are clear areas of agreement between what Providers and CCG stakeholders perceive as reasons for lack of engagement with the CPWS and what is blocking progress with contracting. There are notably few reports in the data of what is working well, with positive comments centering on the first stage of the Vanguard and what worked well. All participants say they want changes to happen; across the sample there were suggestions for changes in leadership, decisions, planning and communication within the CPWS.

While the situation is reported to have reached an impasse due to a dispute over money with no solution other than increased payments, there are positive suggestions of ways forward from all participants. Concerns were evident about current ways of working and centred on a need for more knowledge and understanding of each other and aspects of the Vanguard (e.g. each other's expectations, organisations, roles in taking things forward). This gives rise to number of interlinked barriers to working together and moving forward with engagement and contracting (Illustrated by Figure 1).

Figure 1: Stakeholders' perceptions of barriers to contracting and engagement within the EHCH Vanguard
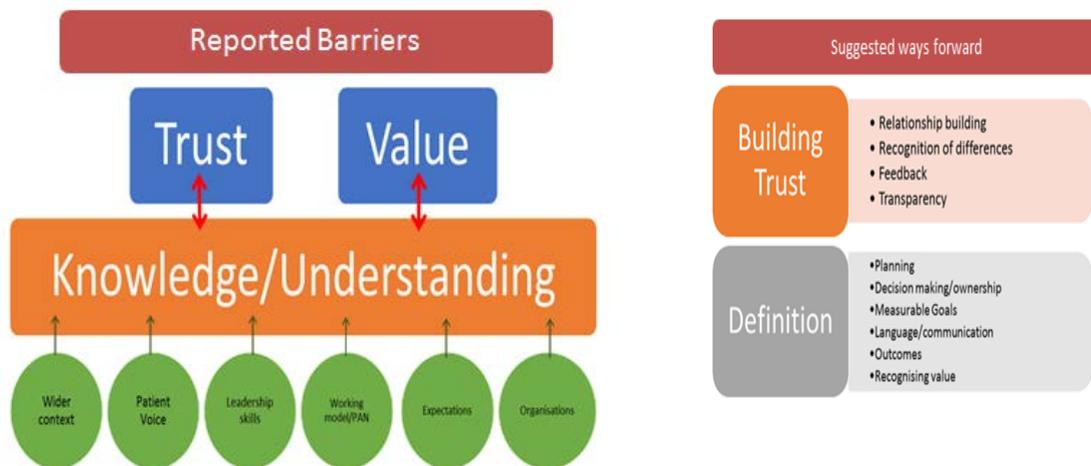


All Commissioners regarded care home Providers to be unwilling to engage with working together unless they are paid more money, and see this as a main reason for the situation reaching an impasse, describing it as a *"battle of wills" (S1).* Providers do specify too little money from the CCG as a problem but also identify a wide range of other concerns and suggest numerous ways forward. These address the way work is planned and communicated, building a trusting relationship between the CCG and Providers, and improving knowledge and understanding of the way each other works, including more transparency with regard to finances and understanding day to day functioning.

Other perceived reasons for Providers' lack of engagement with the CPWS are Commissioners' uncertainty about next steps forward and divided views about this. Providers appear to see themselves as the passive party, expecting the CCG to take the first steps to progress things, possibly because of this being the way they are used to things being done historically. There are conflicting views within the CCG about what is best in terms of decision making; whether it should be shared with Providers or whether decisions made by the CCG should be given to Providers for feedback. There are also differing views about whether to take new or tried and tested approaches in future work, both within the CCG and between CCG and Providers. Providers also highlight issues of going to meetings such as organising staff cover with a lack of resources and time.

The report is divided into three main sections. The first provides the background context and further detail on the approach taken for data collection and analysis. The second is the findings of the current situation and the third is suggestions from participants on possible solutions/the way forward. The readiness assessments are contained at the end of the latter sections.

The nature of qualitative inquiry produces information in narrative form. The findings section is presented as a series of themes (summarised in Figure 1.0), with anonymised extracts from transcripts.

## 2.0 Background

The NHS Five Year Forward View (DH 2014) set out the strategic plan for the NHS and included within it a number of challenges to the models of care required to meet changing patient and carer needs. It established 50 Vanguard sites to take the lead on 5 new models of care with a key facet being improved integration within the system of care delivery to improve outcomes, and ensuring care and treatment were delivered in the most appropriate and efficient setting. One of the models identified was the Enhanced Health in Care Homes (EHCH). Against the backdrop of the need to break down barriers in care provision, 1 in 6 people over 85 living in a long term care setting, and spending increasingly significantly with age, 6 EHCH Vanguard sites were set up nationally to challenge ways of working and improve integration and outcomes. Key outcomes include helping frail and older people to stay healthy and independent and reduce unnecessary hospital admissions, and also reviewing models of working and contracting arrangements.

The NHS set up a framework of evaluation and learning as part of the Vanguard process. Information regarding patient outcomes and the wider impact and value for money of the new models is being undertaken centrally, with each Vanguard site commissioning local evaluations of areas significant to their own setting. This evaluation is one of a series of local evaluations commissioned by the Newcastle Gateshead Clinical Commissioning Group (NGCCG) and supported by the North of England Commissioning Support Unit (NECS).

The Newcastle Gateshead EHCH Vanguard is seeking to identify what any new ways of working should look like across its providers as a result of the new care model, and plan accordingly for successful implementation of future change utilising learning from the Vanguard process. This evaluation is concerned with the learning from the implementation aspects of the Vanguard model, and specifically the Contracts and Payments work stream identified by the EHCH Vanguard for contracting and engagement.

## 3.0 Evaluation aim

The evaluation aimed to explore key stakeholders' perceptions of current ways of working as a result of the EHCH Vanguard implementation. This included perceptions of barriers and opportunities in relation to the current situation and any future change. It aimed to examine the views of both providers and commissioners in

order to provide independent, in depth information to inform commissioners of current issues regarding contracting and engagement of stakeholders and enable plans for the next steps through the creation of a readiness assessment. This would aim to facilitate future action in relation to ways of working and engagement with stakeholders to support the achievement of their vision of 'one bed, one outcome'.

Following discussion and review with the evaluation commissioners, the questions explored were 'what are the current issues in relation to engagement with each other (providers/commissioners)' and 'what would a future model of working might look like' as opposed to the initial brief on conducting development processes associated with implementing one specific model of working (Provider Alliance Network).

## 3.1 Methodology

The role of learning from practice though evaluation and in translating knowledge into practice is recognised within the EHCH Vanguard Foundation Principles of 'one bed, one outcome (Value Proposition 2015). This evaluation therefore used a qualitative approach which supports this principle. Qualitative research focuses on data gathering and analysis of people's reality or experience of a situation and how individuals' or groups are affected by an intervention.

A qualitative approach used for this study and informed by realistic evaluation (Pawson and Tilley 1997) which seeks to discover what is happening and for whom. This enables understanding to be derived from people's experience of an intervention (in this case the EHCH Vanguard CPWS) about what is making the intervention effective or ineffective and identifying what the contextual factors are. This approach to evaluation also allows for a 'lessons learnt' body of information to be generated to then determine if replication/spread can be undertaken or not. This also supports the nature of the area being evaluated, which is communication and engagement.

## 3.2 Ethics

The study was funded by the Newcastle Gateshead Clinical Commissioning Group (CCG). Ethical approval for this study was approved by the University of Sunderland Ethics Review Committee.

## 3.3 Data collection

The approach used individual interviews with members of the Workstream. 11 semi structured interviews have been conducted with stakeholders ($n = 29$) involved with the contract and commissioning work stream as identified by the funder (CCG). The distribution of respondents is illustrated in Figure 2.

Figure 2: Respondent Number by Organisation Type
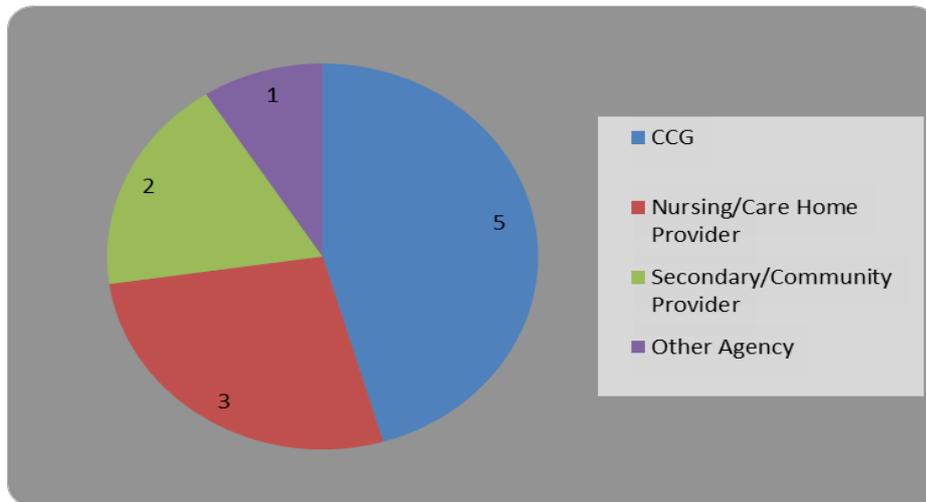


An invitation to participate letter from the University was distributed by email, with further information sent on confirmation of appointment and was reviewed within the consenting process. 9 initial responses were received with a further 2 following a second email contact from the CCG. Early topic guides were developed from project aims, available Vanguard information and literature on change. These were agreed with the project funder as part of the project initiation process. The stakeholders are best placed to inform the data collection process at the outset, so initial interviews then guided subsequent data collection. This iterative approach requires pertinent issues from the data to be identified by participants rather than being assumed beforehand by researchers.

Interviews were conducted by the researchers (IG, KG) between January 2017 and February 2017. Participants were from across commissioner, providers (secondary care and care homes) and third sector agencies. They are referred to as 'commissioners and providers' for the purposes of this report.

*Inclusion criteria* - Those directly involved in the contracts and commissioning work stream were eligible for inclusion *(n = 29).*

*Exclusion criteria* - Patients, carers and front line clinical staff.

Limitations noted include that many participants appeared to have an agenda which was relatively inflexible. They seemed to care enough about what was happening to have spent time thinking about what they wanted to say, and take part in interviews. However those in the sample report attending meetings about developing an alliance/model of working together. Therefore it is noted that this study has not been able to include the views of those who are not engaging at all with the Workstream or the evaluation process. In respect of the issue of representation, two providers (S5, S8) appeared to be have a notable degree of opinion strength within the overall sample and reported themselves as representing the views of other Care Home Providers. These participants also reported attending meetings, and so were engaged with the Provider and Commissioner group.

That said, it has been possible through the analytical process of constant comparison of responses, to identify key themes across all respondents to a level that is considered at saturation i.e. no other new/different views or themes emerging.

The brief was also only contained to this Workstream membership and the researchers contact at the development stage of the evaluation was via commissioner representatives. It is noted that some members of the group are involved in other Workstreams.

## 3.4 Data analysis

Analysis took place in a series of phases with an initial triangulation of a partial data set undertaken with IG, KG and JN (additional researcher/commissioner who is not part of the stakeholder group). This enabled a review of emergent themes and facilitated researcher reflection to inform the formulation of the readiness assessment model/tool. Data analysis was undertaken using a thematic analysis and constant comparison, where responses from earlier interviews informed later interviews, and then enabled the generation of a number of themes articulating people's experiences and views. A further period of analysis on the whole data set was undertaken and the following findings identified.

## 4.0 Findings

An overarching theme of 'knowledge/understanding' (Figure 1:p. 6) emerged from the analysis which is considered to underpin the 6 specific elements that were

identified across respondents to be impacting on successful engagement within the Workstream. These themes have subsequently been mapped to areas from the literature that are considered to be required to enable effective change, and that can act as barriers to change (Section 5).

## 4.1 Current Service Provision
### Knowledge/Understanding

The level of knowledge and understanding organisations and individuals within them have (about the development of contracts and engagement) appears to underlie and explain other key issues highlighted by participants. There is little evidence of how organisations see their positions in relation to each other, apart from in financial terms. This includes how actions and decisions taken may influence each other, how they could help and support each other and what they could learn from each other. Lacking understanding of what each other needs is specified as a barrier to progressing engagement and contracting by both Providers and Commissioners. Participants' reports indicate a need for more knowledge and understanding of each other's place, value and identity within the bigger picture of the EHCH Vanguard new care plan. Providers illustrate their perceptions of this over the financial dispute:

> So there's an issue there about what are we really doing. So I think there's no clarity, necessarily, about what the roles of the groups are, what their remit really is, and what input they can have (Provider, S4, p1)

> I'm so upset with you, that I want to divorce you, and you're saying, "Shall we go on holiday?" (Provider, S5, p6)

> [CCG] are saying continuously, well, you know, we're in special measures, we have no money, therefore what are you going to do about it? And I think you just have to accept that that's what it is. And then when we say that national living wage is increasing by 30p this year, they're… You just get shrugs of shoulders (Provider, S10, p5)

The overall impression given by organisations within the CPWS is predominantly of separateness from each other; that they are separate parts of a whole working in parallel rather than together towards achieving the aims of the EHCH Vanguard. This contrasts with participants' views that a more joined up approach is needed with

more coherence and partnership. One Provider explains (S7, below) that care providers such as care agencies, care homes district nurses are working separately causing instability with care staff who move between the two and inconsistency in the care provided in the community; these factors in turn impact on providers' perceptions of how contracts should be written.

> …everybody works too separately, and so focused on their own, kind of, mess, that they don't see everybody else. (Commissioner, S2, p1-2)

> R: …It was like a godsend. Something I've never heard before.
> I: And was that a feeling that there was some recognition of your contribution?
> R: It was actually the first time I had ever heard the term partnership.
> (Provider, S11, p12)

> I: Is there anything other than finance that's impacted on contracts and commissioning discussions?
> R: The different systems. The different systems [care providers e.g. care homes, agencies, district nursing] don't talk to each other (Provider, S7, p10)

## Expectations

While participants across the sample appear to talk about a shared, overarching goal to increase quality in care homes it seems that they may not have the same vision of what this might mean. Their responses suggest there has not been a clear, shared vision of the new care model right from the start and have not known what they wanted out of evaluation. This concern has filtered through to the CPWS resulting in a perceived lack of direction and Providers' uncertainty in the leadership from Commissioners.

> …we're talking about it being an enhanced care home Vanguard - enhanced, to me, means better. Means more. It means something that's different from what it used to be. So what enhancement is it going to be? (Provider, S6, p7)

> …it would be really useful to kind of… To get everybody's understanding of the vision. Because I think it's going to be different within the CCG, let alone bringing in the providers (Commissioner, S2, p18)

*…internally we need that clear vision and we need those clear long term aims…That's being developed. Then I kind of think that needs to… That message needs to go out to everybody else, doesn't it? (Commissioner, S2, p6)*

Providers and Commissioners struggle to give a picture of their own and each other's expectations of what the work stream model could look like. They appear to lack knowledge about what the CPWS is and why they're involved with it, again saying the timing is too soon for them to give their views of what a future model could look like.

*I think we're talking about, kind of, a provider alliance network, and I don't think we actually know what that is… I think we just terrify people when we start talking about the new care models and the provider alliance networks (Commissioner, S2, p4)*

*Maybe this work on a provider alliance network shouldn't have started until that vision was there (Commissioner, S2, p6)*

*I find the whole thing quite difficult to get my head around because we're talking about a new contracting and payments model. But I don't think we've reached the point of understanding what we're…what we want that contract and payment model to do (Commissioner, S3, p2)*

*And until we've got that [clinical] model, there's no point really in talking about how we're going to contract for that model or pay for that model, but we're going to use that to do some generic relationship building. And make sure we're taking them along with us (Commissioner, S3, p10)*

Participants' expectations about how to develop contracts are also characterised by trepidation across the sample. Their comments point towards a need for greater knowledge and understanding of each other's functioning and roles within the CPWS. Providers say they do not know what is expected of them and what services to provide, that they need some parameters and decisions made by Commissioners and without this do not know how contracts can be written. Most Commissioners echo this trepidation also saying clearer planning and definition of future work alongside relationship building needs to happen before contracting discussions.

*…if there is a transparency about the process, the timeframes, and what we're trying to achieve. But also, where do those achievements go and what do they do? (Provider, S4, p14)*

*I know that that contract cost the providers about £10,000 and still wasn't signed [in 1993]. So nobody is going to sit round a table until they are 100% serious and start paying money for legal representation until they know it's going to happen (Provider, S11, p20)*

*To engage the provider properly you've almost got to say, "Your contract is going to change – I don't know, 2018."…You need to maybe even take the Vanguard label off it. But your contract is going to change, and if you want to be part of it, you need… You need to engage. (Provider, S11, p.17)*

Most Commissioner and Provider participants talk about their expectations with regards to timing. They see the timing of discussions around contracts as too early in the development process to make decisions when there is a lack of concrete ideas on which to base decisions. They indicate they are not ready for contracts to be written, partly because they feel strong and trusting relationships need to be built up between Commissioners and Providers first, possibly supported by a third, independent party. They also suggest a plan of action with timeframe and measurable outcomes to be drawn up first, using more knowledge of what patients need and want in individual homes before decisions are made. Others feel it is too early to discuss contracts because they feel knowledge and understanding across organisations about what they do needs to be improved. It is worth noting/ recognising the reality here of the tensions within the wider context where the drive from NHS England to progress quickly is set against these Commissioners' and Providers' need for more time to build relationships and establish trust first.

*So [change is] going to be about realistic timescales as well. And one of the challenges of Vanguard has been it's been very, very fast (Commissioner, S9, p6)*

*…is this the right time to bring providers on board when we don't quite know the direction ourselves? Is this, kind of, a fool's errand? Are we just making things more complicated? (Commissioner, S2, p3)*

*I find that very frustrating that we could put our efforts into something else, instead of plugging away at one that, in my opinion, it's not the right thing at the right time. (Commissioner, S3, p9)*

Organisations appear to lack understanding of how each other operate, particularly nursing home providers understanding how Commissioners distribute their funding. This is perceived to be a barrier by participants across the sample. It was suggested by some (both Providers and Commissioners) that if Providers had knowledge of the financial structure of the CCG and also the funding available to them from NHS England they may be able to see why there is nothing left in the "pot".

## Leadership and skills

The need for strong leadership and more formal leadership style in the engagements/ contracting part of the Vanguard is identified by a number of Commissioners and Providers. Some Providers also believe the CCG do not have appropriate skills or understanding of how businesses run to make a success of the work stream. Skills such as the ability to plan to deadlines, communicate effectively, show outcomes and understand care home finance are all mentioned as lacking across the sample.

*I don't think we've got that common understanding in the small team. But that's probably because we haven't set ourselves up right.... We haven't got that right because we've been dysfunctional on lots of occasions. Which is all due to not having the clear leader in. (Commissioner, S9, p6)*

*I'm afraid I'm not impressed with [title]…Their [CCG staff's] experience or the way they do and the way they manage… because I think they're not being managed in a proper way, in an effective way, then things are being lost. (Provider, S4, p2)*

*Because when you're telling a manager who is a nurse, not responsible for finance or the mortgage or the business. She's looking from a nursing point of view. If you have a management background, what you want is how you can excel. (Provider, S5, p5)*

*…we should have proper business people dealing with… With the care homes. As opposed to nurses with degrees. And I don't mean that to sound personal (Provider, S11, p13)*

Moreover Commissioners themselves feel they do not have the skills for the roles they have been allocated within the CPWS. They also report an absence of clear goals and direction, with a "dysfunctional" team among Commissioners with a lack of unity in their vision.

*I think there's other people who would make… A better job of that engagement. I kind of think, yeah, I can do it [relationship building], if you want me to, but actually there's other people who would be able to do a better job than I can…its not what I'm qualified to do (Commissioner, S2, p.16)*

*… It's neither of our roles to do relationship building and stuff like that. And that's probably all we're doing at the moment. And, personally, I find that very difficult, because I'm not seeing an outcome (Commissioner, S3, p5)*

*We're a team of titles, not a group of people that make a team, that could be put right by the identification of a clear leader… you need to invest time in leadership strategies, developing a common culture. Having a common vision. Putting some of that communication strategy in place for your internal team. (Commissioner, S9, p4)*

Tensions are evident between Commissioners about how to make decisions and establish direction. All Commissioners interviewed, with the exception of one strongly believe that Commissioners need to make decisions on ways to move forward with contracting as a starting point to progression. They feel this would open a dialogue and give Providers something to comment on. They believe Providers do not have enough knowledge of the historical context of the Vanguard to be party to making these decisions. The impression given by Providers is that they also feel they are not informed enough to make decisions about contracts and need Commissioners to put forward the first suggestions. A conflicting view between Commissioners is that decisions should be made together to build trusting relationships. There is a sense of

frustration from Providers about this; some appear to see it as impossible to progress unless the first decisions come from Commissioners.

> *I think a lot of people are kind of... In the room today, they were kind of sitting there, going, well, why are you asking me those questions? If you're deciding. And then tell us and we'll give you comments. And we can give you feedback. But, actually, you can't just come into the room with no real set ideas and agenda for direction (Commissioner, S2, p21)*

> *And [the CCG] say, well, you're making decisions. Well, when you look at the remit, it said you make decisions. But we don't make decisions. Because we have no control over the money, we have no control of resources, we have no control of the timeframes. So we don't. So all we can ever do is comment on what it given to us. (Provider, S4, p7)*

Communication issues are reported by most Providers and some Commissioners, where there is seen to be poor communication about steps forward both between and within organisations. Both Commissioners and Providers say they need more definition and specificity in the language used in explanations of the CPWS and plans to progress. Providers report losing interest in meetings because of language being too generic or steps forward not clear, seeing meetings as time and resources wasted because they repeat the same topics without progressing. This has led to uncertainty about what this would mean in terms of contracting and how the goals would be achieved in practical terms with limited money. The lack of attendance of Providers in itself may be a barrier – if more were on board it would be worthwhile others attending.

> *We come in for a conversation on something, and the next time you come in, you're either having the same conversation - because that hasn't happened yet - or it's somebody else. And you think, well, eh? (Provider, S4, p3)*

> *I think I've been to two meetings, and there's only one other provider… unless you've got all the care providers sitting round a table, there's no point in just having two of us there (Provider, S11, p10)*

Commissioners appear to see communication problems stemming from the breakdown in the relationships between organisations. Recognising organisations' cultural differences are also evident in their comments.

> *...you need time for people to digest and understand messages. And it's... You know, when you're embedded in something and it's very clear to you. But if you're not, you need those messages given in lots of different ways…. it's going to mean something different in each organisation (Commissioner, S9, p8)*

> *I think the terminology we use in the NHS is really, really off-putting. I think the acronyms themselves are just a joke. I sit in meetings and have to think about what the acronyms are. So I think that's going to put people off as well (Commissioner, S2 p.2)*

## Patient voice

The *"patient voice" (S6)* is reportedly missing in the new care model approach to inform development of contracts. Three Providers recognise that to improve quality in care homes they would need information from the residents themselves about their experiences of living there and what they need, not only for their healthcare but for their enjoyment and fulfilment whilst living there. They describe a tension between addressing physical health needs versus patients' experience and well-being which they feel needs to be more balanced in developing services within the Vanguard. This issue is central to one Providers' interview (S6) and mentioned by one Commissioner.

> *CCG-wise, they've always got… They were always number crunching. You know, they always… It's always about what's the data telling me? Well, what the data is telling you is it's not telling you anything about the experience of your service users. It's telling you that you've got so many bed days. It's telling you all the hard stuff, but it's not telling you all the soft stuff (Provider, S6, p11)*

> *I still think there are some things we can do differently…. if you think 50% of the people are having.. their lives saved… And the other 50% of the people are linked to an ageing population. The challenge is the workforce doesn't know how to look after the ageing population (Commissioner, S9, p14)*

This lack of knowledge about how to look after an aging population well, as opposed to looking after their clinical needs comes through in many of the interviews. There are differences between Commissioner and Provider narratives, where Commissioners talk very little about the day to day running of nursing homes and where Providers give examples of tensions between clinicians, nursing home staff, patients and how the care home system as a whole operates. Here, what is left unsaid by Commissioners is perhaps telling of a lack of knowledge and understanding of detail about everyday care home functioning and cost ramifications. Providers also say the day to day running of care homes is not fully understood "bottom first" (S6) and there was a real sense of frustration about this.

> *Anybody who runs a business would go to the bottom first and say, actually, guys, what could you do? You know, what is your capacity? You know, is it going to meet our needs for the next five years? Ten years? And then you build from there. (Provider, S6, p13)*

### Wider context

Cultural barriers are reported by two thirds of the sample (both Commissioner and Providers) where there are difficulties bridging the different approaches held by organisations to the delivery of care home services, e.g. in ways of working, systems and financial structures. They highlight an issue of *"marrying different mindsets" (S11)* and a need for a different approach to contracting and delivering care in care homes where the patients' wellbeing is placed at the centre of services rather than only addressing their physical health needs. Examples of situations are given such as when political versus cultural or independent care homes versus NHS government funded organisations come into play. There is a hope that the unifying goal of improving quality for older people is a shared motivator.

Differences in organisational cultures which are not necessarily realised by others in the CPWS are also reported. All Commissioners suggest external pressures from NHS England, to achieve goals that do not take regional differences into account together with an atmosphere that they are not achieving enough.

> *…we're verily tightly monitored by NHS England. So we almost need to be seen to be doing it. And I personally find that incredibly frustrating that we can't just hold our hands up and say, "Yeah, we said we would do it. But,*

*actually, we've checked it out, we've tested it, we've talked to some people and it's not right." So I think part of it is… Is that. It's in our plans, and there's a push for us to do it – whether it's the right thing or not (Commissioner, S3, p8)*

Commissioners and Providers feel there is little account taken for local versus regional issues where it is *"not a regional approach" (S5),* where expectations are based around successful models from elsewhere in the country rather than needs of the local area. There is also an uncertainty about whether the Vanguard vision to try new approaches is the right one set against the current NHS climate. Some participants give a sense of feeling overwhelmed trying to understand how changes will happen within a system that is so embedded and complex.

*Is the NHS just so big that it's hard for somebody to go back and make changes? I think it is, isn't it? (Provider, S11, p18)*

*My understanding of Vanguards is a time-limited piece of work, with quite a bit of money thrown at it. Just to see whether or not they can realise some changes. I'm not confident that's the right approach. And because there's a changing landscape at the moment, certainly that model doesn't necessarily fit (Provider, S7, p1)*

*But the conversations with NHS England…it's all about… Almost a feeling that we're doing something wrong that we're not in that space, rather than an acknowledgement that it's just not the right time (S3, p9)*

A few Commissioners and Providers indicate a need to challenge the juxtaposition of independent and public sector mindsets working together within the Vanguard. A small number of Providers and Commissioners tentatively challenge the historical, *"risk averse" (S1)* approach to spending money adopted by the public sector and the CCG, advocating a need to try new ways of doing things *"without punishment" (S10).* Difference of opinion between Commissioners on this appears to be slowing progression, where two Commissioners suggest the CCG could take more risks in trying new things and others feel it is better to stick to tried and tested methods.

*You know, they're [Commissioners are] a bit like, "What's it going to mean? How is it going to be different? We've got cost pressures as it is."…so therefore they revert back to, well, I'm going to do what I've always done. (Commissioner, S1 p7)*

*What I think would be good is to…have some of these quick and dirty things that focus on a very discreet part of the care chain, to have a go. And they [Providers] need to be funded by somebody, and there needs to be no punishment for trying. Because otherwise it'll just be the same-old, same-old. (Provider, S10, p12)*

*If it doesn't work, that's fine. But we're not going to beat you over the head on your quality assessment framework as a result. And we're not going to withdraw the business. And that doesn't quite sit easily with the public-sector ethos. When you're dealing with the independent sector where it's very much money for results. But I think we've got to try it. And I think part of the positive side of the CCG setting up the commissioner and provider group is to get to that point. (Provider, S8, p2)*

Exploring ways of unifying organisations in the approach taken to engagement and contracting within this wider context seems necessary, possibly by starting with the patients' needs and perspectives in mind *"from the bottom up" (S6)* and acknowledging the aging population and adapting services to fit this need.

*[There is an] absolute need to look at the resources out there and the current landscape. Patients living longer, patients requiring more care closer to home, there's been no investment in that. So, from a commissioning perspective, somebody needs to commission care in the community (Provider, S7, p9)*

## Trust

The lack of understanding within the Vanguard of each other's' organisations and financial structures appears to have generated an atmosphere of mistrust. This is evident between organisations where there is a need for more commitment, certainty and clarity around what care homes are paid and organisations' financial systems.

Also, due to historical differences there is a lack of trust that history may repeat itself where things have not happened, and of Commissioners' motives to save money by way of the amount they are paying care homes. For Providers being unclear about their role and the intended outcomes of their involvement also appears to be a contributing factor.

> *The providers are coming and saying they need more money in their fees. And I genuinely, hand on heart, don't know if that's true or not. Do they make a teeny-tiny bit of profit and they're absolutely, you know, just one thing away from going under? (Commissioner, S3, p13)*

> *We've never, ever really worked in partnership with any of these people. They don't take us seriously. It's like if they can give you £5, even if they had £10, they would still just give you £5 because it's about getting... I suppose, you know, they are commissioners of public money and it is about getting the best deal. (Provider, S11, p18)*

Some Providers express a profound mistrust of the Commissioners' rationale for not being able to pay them more. One care home owner (S5) perceives the CCG (their terminology) to be *"enriching themselves"* at the expense of providers yet does not explain reasons behind this view. This participant reports that care home providers to have *"deep anger and resentment"* because of feeling that they were being paid too little when the money was there to be spent, and that they had been *"made a fool of"* not just over money but because they had been taken advantage of. These feelings of mistrust are also expressed by other Providers in varying degrees of strength.

> *…in terms of trust you've got three parties involved. You've got the provider, you've got social care, who are in financial problems, and you've got clinical commissioning groups who are financially strapped… I suspect the providers are probably thinking it's them that's going to have to carry that additional cost (Provider, S7, p5)*

Apprehension is expressed by a small number of Providers about *"biting off the hand that feeds them" (S3, S4)* of raising discussion about finances in meetings and potentially jeopardising contracts. They do not want to risk funding by speaking up

about any dissatisfaction they may have, and fear being honest as they do not want to risk this affecting the amount of money they get. This fear about being open and honest in their views and comments with Commissioners illustrates further the lack of trust between organisations.

> *And the care homes have concerns about how much they're willing to say in public because it might bite them. You know, how...? If they say, oh, we agree with these issues, then they might find they get pulled up by the council for not delivering, or by CQC for not delivering. So there is a danger in being open and honest about not being that good. (Provider, S4, p15)*

> *You get many people who are procurement people, rather than commissioning people…. And you can't afford to offend them or to do anything, because either your business will suffer dramatically (Provider, S10, p.5)*

Perceived lack of commitment from Commissioners is another issue suggested by Providers, fuelling the feeling of mistrust. They report needing to trust that contracts are really going to happen, given historical delays and non-events.

> *I think the big thing we need with commissioners is commitment. Because if they're expecting us to change the model and to invest… well, that's a bit like, sort of, getting engaged. Unless you think that you're going to get married, you're probably not going to be completely committed at the point you need to. (Provider, S10, p15)*

> *I know that that contract[1] cost the providers about £10,000 and still wasn't signed [in 1993]. So nobody is going to sit round a table until they are 100% serious and start paying money for legal representation until they know it's going to happen (Provider, S11, p20)*

> *I think, from talking to [other Providers] informally, they would rather take that, a lower level of return, over a longer period (Provider, S8, p11)*

It seems overall that the breakdown in the relationship between Commissioners and Providers is due to a lack of trust stemming from their dispute over pay. Some

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[1] Local Authority contract – pre CCG

Providers are highly sceptical of Commissioners' motives in not paying them enough. At best, there is optimism that this could be repaired with a number of ways forward (including improving management skills, small incentives, longer term commitment, planning, transparency). At worst, the situation is likened to a marriage breakdown but with one party ignoring the situation.

> *…you're heading for a divorce and the husband is asking you to go for a holiday. A romantic one too…. Come on, not going to happen. You need to be friends. You need to be colleagues, partners. With a lot of trust with each other. That trust will be developed. And it's not just money that's an issue. It's the conduct of the CCG (S5, p16).*

### Value

Financial concerns and a lack of money for care homes is in the background of all interviews, both for Commissioners and Providers. The dispute over pay has reportedly been part of a circular discussion over a long time and may be seen as a given rather than a concern to be addressed in interviews: providers know that it is unlikely they will be paid a significant amount more money and Commissioners cannot see a way of paying them more. However, Providers being paid too little does not explain all of the barriers identified by participants to progress in contracting and engagements. Their narratives suggest wider beliefs underpinning perceptions of their own value as stakeholders in the CPWS, their role within it and the work they do.

Both Commissioners and Providers mention the need to recognise value of work being done by care homes and by staff there as outputs rather than in monetary terms (S2, p19)

> *…we can't give them [Providers] more money. And the improvements aren't going to happen straightaway. And I think to overcome that, I don't even know where we would start (Commissioner, S2, p1)*

> *I kind of don't think finance is the way to go….Is it, kind of, the changes to…? The care? The care delivery? That could incentivise them, if they could see that? But these are... They're so ___ [00:54:42] build as well. They're really slow builders (Commissioner, S2, p19)*

Providers appear to place importance on the value of their work despite their strong message that they have too little money to provide quality care. Underlying this message however is a feeling that they are undervalued, because as well as being about having too little money this is also to do with the value of their work being recognised and their own progress being visible to them. It is also to do with feeling that the time they spend on the CPWS is valuable and not wasted.

> *And there seems to be lots of meetings or discussions, but not a lot of hard outcomes from it. So that's why we started to challenge them and say, well, what's the value of us being here? (Provider, S4, p1)*

> *If we can't make an impact, there's no point doing it, even if we should be doing it. But if we can't make an impact, there's no point. (S4, p12)*

> *You've got to give something to care home managers and owners that is actually of benefit to them by doing it... I suppose it's that age-old question – if you're in normal business, you say, "Well, what's in it for me?" (S6, p4)*

> *So to some extent [engagement is] about being joined up, and what's the value of what you're doing? …Which is why, I think, at times, they're losing interest… We all have limited resources. You know, everybody has limited resources. Is it worth us continuing to always turn up? (Provider, S4, p6)*

> *And the incentive is about better outcomes for patients. And if you're getting better outcomes for patients, are you making financial savings anyway? (Provider, S8, p5)*

Seeing value from providing enhanced quality is articulated by one Provider (S9), who gives a sense of pride for being part of a group that stands out for its enhanced quality. This is a positive view that suggests a reason for Providers' engagement with change and ways forward. Other providers report being unable to see their own progress and impact of their work within the Vanguard because goals are not planned in ways that progress can be documented and recorded. It seems that building on what makes these Providers high quality may be one way of reinforcing their sense of value from being part of the CPWS. Weighing up the value of taking

part in the CPWS against the cost of taking part (in terms of cover) remains a challenge for Providers.

> *…our involvement has been, if I'm honest, pretty limited because… When you're a provider and you're right up against it – which a lot of people are at the moment, I can't see that this delivers against the other challenges that I have to deal with on a day-to-day basis (Provider, S10, p2)*

Providers see themselves as having little autonomy – where they are passive in decision making and reliant on the Commissioners to make decisions and give direction. They feel the Commissioners are not doing this which seemingly gives rise to little ownership over what they are doing. One Provider questions whether Providers need to feel ownership to feel valued. One Commissioner also recognises that care home staff are undervalued, and suggests recognising and listening to them as experts as a starting point for progress.

> *So where is the ownership of the outcome? The Vanguard group don't own any outcomes, really… how many of the care homes are actually involved and feel that they are party to what's going to come out, so that they can actually do it? (Provider, S4, p.11)*

> *I think the staff that work in care homes aren't valued by the wider NHS. And I think that's apparent in everything we've done so far... They're experts in looking after that patient. If you listen to them, they might be able to tell you something really important… Maybe that's the way to go... Maybe it's looking at that, rather than money (Commissioner, S2, p.19)*

Similarly, the value Commissioners place on their own roles in the CPWS appear to be eroded by perceptions of failure. Half of the Commissioner Participants report being unable to build relationships between organisations to facilitate progress due to lack of appropriate skills. Another reports that efforts to engage Providers have been unsuccessful, partly due to a lack of a two way trust. In this way most Commissioner Participants give an impression of feeling unable and/or unequipped to do what is required of them for the CPWS. These experiences indicate Commissioners to lack some confidence in moving forward with the engagement and

contracting and to perceive their current work as having low value in this work stream.

> *…I feel like I'm taking from them. I'm not… There's nothing I can give in return [for Providers' time/involvement]. So, you know, yes – it's relationship building and trust building, but there has to be a two-way thing as well. And at the minute I'm not giving them anything back (Commissioner, S3, p14)*

> *…we kind of thought it would be a lot smoother. And people would want to get involved, because we're trying to make things better. And it just hasn't happened… that balancing act doesn't work – what do you want us to do? Where do we go from here? (Commissioner, S2, p16)*

## 4.2 Suggested changes
### Introduction

Positive perceptions of ways forward are evident in all interviews to varying degrees, where suggested solutions are varied and do not centre on paying care homes more money alone. Suggested solutions address complex and interlinked barriers to engagement and contracting specified by participants, regarding a lack of knowledge and understanding, trust and value.

A need for change is evident in all participants' narratives, where Providers appear to be keen for patients to be at the centre of decisions made and for more commitment and stability from the CCG. Commissioners appear to be divided in their views of how contracting should be developed, where some appear eager to hear how Providers want contracts to be written and others are in agreement with Providers that it is too soon to be addressing contracts when relationship barriers need to be tackled first e.g. planning and relationship building.

Provider (S8) makes the most positive comments in the sample about the future and the goals of the Vanguard to bring people together; other Commissioners and Providers give positive comments about the ethos of the Vanguard and the leadership and planning in the first phase (S5, S6, S8, S9). These comments illustrate a sense of hope and momentum among Providers which is becoming lost

within the complexity of the situation and among the many other problems they identify.

> *I think the fact that the care home Vanguard has…taken that whole-systems approach, and brought people together, has been really positive. I think we're in the evaluation stage at the moment (Provider, S8, p1)*

> *So I think the clinical engagement has gone very, very well. I think that the structure of the Vanguard programme has been good in the way that it's focused on engagement and clinical payment and contracting...With the information that we had when that was established for that six workstream approach, I think that... That was very, very good (Commissioner, S9, p1)*

> *I think that in the planning phase, we're stronger than the delivery phase. So the planning phase had much... Had clear leadership, had clear direction (Commissioner, S9, p7)*


### Definition

A number of ways to increase definition in ways forward to improve engagement and progress contracting are suggested by Commissioners and Providers.

#### *Goals and planning*

Most Providers want goals to be set out and planned clearly by the Commissioners for their feedback. They suggest smaller, more specific steps forward with measurable, achievable outcomes. They think this should be done with the production of a step by step plan of action with deadlines that are formalised and agreed with Commissioners.

> *…to keep your interest and drive, you know you've got to do things by certain dates. And wishing that you've got a degree of flexibility (Provider, S4, p6)*

Most Commissioners suggest that there should be a greater definition of goals; starting with what each person wants to achieve within their role in the CWPS first and then discussed and agreed.

*…internally we need that clear vision and we need those clear long term aims…That's being developed. Then I kind of think that needs to… That message needs to go out to everybody else, doesn't it? (Commissioner, S2, p6)*

### Decisions

The majority of participants want first steps and plans decided by Commissioners with an opportunity to agree this together. This would allow for clarity on what needs to be done and what is realistic from Providers' points of view.

### Planning

Many Providers believe that to plan quality services information from care home residents is needed.

One Provider suggests care homes are recognised individually by Commissioners and NHS England where services are put in place according to the needs of residents, where some homes specialise.

It is felt by most Commissioners and many Providers that the timing is too early to develop contracts – they need to build relationships and ideas about what they want first.

The message that there should be different contracts for different care needs is communicated clearly by a small number of Providers (S5, S8, S11).

### Language

Clearer messages are suggested given in different ways that account for the differences in organisational cultures within the Vanguard. This raises the question of whether the language used in meetings, correspondence and shared documentation accessible to everyone in CPWS?

The need for concrete ideas to be communicated is reported (S2, S3, S4) giving parameters, structure and clarity about what everyone in the CPWS needs to do.

### Impact of work

Many Providers and some Commissioners place importance on seeing the benefit of what they are doing and the impact of their work. This includes seeing outcomes even if this will take a long time to generate, which they feel would give them a sense

of value and achievement. It is suggested they would be motivated by knowing the impact of their work, which would make financial savings in the long term.

> *....if people aren't seeing that, and not seeing those changes and seeing what we've actually achieved… Excuse me. I think we're missing a trick… And that might help us almost get past this… The fees, the stumbling block. Because it's, look, we're still in a dispute about fees – however, these things are still happening (Commissioner, S3, p7)*

> *I don't really know the outputs from the pathways of care work. I think they are developing some outputs. And I think the Newcastle voice is in there now. So… But I don't know what the ultimate aim of this Vanguard programme was in terms of how you're going to know you've achieved success. (Provider, S7, p12)*

### Finance

Providers clearly say money needs to be recognised as a problem and understood by Commissioners before services are commissioned. However, there are differing views of how this should be decided on, including jointly looking at feasibility of services, longer term contracts, to service users' views being at the centre.

> *We're fighting constantly with the local authorities and the CCGs to have the true cost of care recognised. We've got national living wage, which will increase shortly by another 30p. So, you know, we're looking at that being a make or break (Provider, S10, p3)*

> *And it's not just, simply black and white - oh, I'll give you X number of pounds. And you will deliver these outcomes. It's actually sitting down with a commissioner and saying what's feasible. (Provider, S6, p10)*

A small number of Providers see a small financial incentive amount as an acceptable way forward that would make a difference to their engagement, and suggest longer term contracts and greater commitment from Commissioners as a potential way forward.

> *I think, real problems in the care market at the moment, including for the Vanguard, is about instability and volatility of the market (Provider, S8, p8)*

One Commissioner suggests working the contract around the budget they have got, but with a patient centred focus, echoing some Providers' views. Another Commissioner acknowledges that pay is low for Providers making geographical comparisons.

> *I know geographically it's hard doing comparisons …But when you look at what we're paying in the North East compared to what they're paying in Nottingham and East and North Herts and Wakefield and…we are amongst the lowest payers. (Commissioner, S2, p12)*

> *And a model of care shouldn't be designed on how much it costs - it should be designed on what's right for the patient. And then we work out if it's affordable afterwards. Or how we make it affordable (Commissioner, S3, p12)*

### Building Trust

#### *Commitment*

If there is to be change, Providers say they want concrete assurance from Commissioners that the contract will happen, and that there will be long term stability for them.

> *I think it's about this stability of income, and moving away from payment by results and moving away from short-term contracts (Provider, S8 p11)*

#### *Relationships*

A number of Providers and Commissioners suggest building relationships as a first step forward. They see it as necessary before any discussions can be had about planning, finances or contracts.

> *The core thing is the development of the relationships…it's [the contract] got to be right and everyone has got to have an equal opportunity to speak and to*

*see, and we're nowhere near that level of relationship. (Commissioner, S2, p.9)*

Sharing knowledge of each other's' functionality, the way they operate on a day to day basis is suggested as a way to improve relationships and understanding between organisations.

*Recognition of different organisational cultures value of work*

The need to approach next steps from a different perspective is raised by Commissioners and Providers. They suggest this from the bottom up, centring on the user, the individual and their well-being rather than basing decisions on meeting physical health needs in line with statistics rather than experience (without knowing what makes it better for people). They specify a need to change in the way things are done, and support from Commissioners to try new things. One suggestion for making this happen was to bring in independent bodies to facilitate this and building relationships first.

> *I: And you're talking really about quite a massive difference in the way services... The approach to the way services are set up, really. That change in mind set.*
> *R: It has to be a change in mind set(Provider, s6, p7)*
>
> *I think there's definitely an appetite for something new, and MCP would be... Look to be the most logical thing.…you could do all of the work of an MCP, but not formally applying to be in the next stage. But I think that type of world and that type of model is naturally where this work could go (Commissioner, S9, p4)*
>
> *I think it needs to be somebody independent starting to develop those relationships. Or you do what other areas have done when they've got, like, an integrated programme board… I think, nationally, that's been shown to work. And I know every area is different, and every area has a unique relationship. (Commissioner, S2, p9)*

Providers also see it as important for Commissioners to understand better the services needed to keep people out of hospital and in their own home, for the patients' wellbeing and also to save money.

> *It's the fact that you can't get the support you need…. I mean, you sometimes have people assaulting other residents and running round like a wild person. You can't get anybody... You couldn't get anything done (Provider, S11, p9)*

> *I think the main thing is to focus on outcomes, rather than the bricks and mortar. Because we…we just cannot provide bricks and mortar at the prices that they want (Provider, S10, P10)*

## 5.0 Discussion & Readiness Assessment

The evaluation aim was to explore stakeholders' perceptions of engagement and current ways of working within the work stream of the EHCH Vanguard implementation to identify what was impacting on its functioning and outcomes.

In carrying this work out we focused on engagement issues to obtain information on learning from this to share locally and within the wider system. Whilst the report commissioners were aware that there were issues pertaining to engagement and taking forward any changes in contracting, they considered that an independent view would further assist in understanding more about what these were. This process of independent evaluation aimed to aid both the national learning associated with implementing the Vanguard Programme as well as inform next steps in the change process in relation to ways of local working and future engagement approaches.

This evaluation has, through exploration of what was working well and for whom in respect of engagement, identified a series of key issues articulated by respondents that affected CPWS functioning and outcomes. The findings from the study are predominately reflective of issues frequently identified in the literature about change. As requested within the evaluation outcomes, we have undertaken a mapping of the findings in the form of a Readiness Assessment, a business tool to enable strategic and operational change processes. The study finding themes were mapped against

the change model themes and using a RAG (Red, Amber, and Green) a picture of 'readiness' was derived and contained in Tables 1 & 2. This allows a visual summary of the findings for discussion, prioritisation and potential for future measurement of progression.

This Readiness Assessment has been devised using a transformational change model (Allcock et al 2015). There are numerous frameworks and models of in the literature for effective transformational change and management.  The model selected to frame this readiness assessment is one that is derived from a study which not only used a wide range of leadership and management literature and research findings, but also informed through interviews with a range of people who have recently had to lead or been involved in rapid and transformational change in health and social care (providers and commissioners). This model was also selected because:

- It uses reasonably clear language (which was an issue identified in this work)
- It provides a focus on what is needed for success, and common barriers to change, giving a structure to a plan which can be shared and monitored, again something suggested by participants in the ways forward aspect of the study findings.
- It resonates with the elements of the findings

Vanguards are about enabling change and improvement in care and delivery at pace. Leading and managing change is a complex area and whilst there is unlikely to be a 'quick fix' to this scenario, the use of the readiness assessment framework derived from this change model aims to support shared discussions and understanding about priorities and the way forward as opposed to a looking back/debating the current issues approach.

The change model by Allcock et al (2015) essentially has two key elements, which are four barriers to change and seven measures of success. These have been used to frame the readiness status and are listed in each table. The red, amber and green criteria are defined through the extent to which each factor appeared within the data and the resultant themes. The RAG, whilst by its nature is subjective, has been drawn from the available evidence and is intended to be a guide for shared review and action planning.

**Table 1: Readiness Assessment: Barriers to change**

| Barrier to change factor | Readiness |
|---|---|
| Having the motivation to change | Partly evident |
| Headspace to make change happen | Partly evident |
| Recognition of the need to change | Evident |
| Capability: having the right skills | Significant gap/requires attention |

| Readiness Assessment RAG |
|---|
| Significant gap/requires attention |
| Partly evident |
| Evident |

When looking at the evidence from the study (Figure: p5) and reading the findings there may initially appear to be dissatisfaction and to some degree a sense of failure expressed by the respondents in the success of the CPWS. The mapping process against the change barriers has however demonstrated that there are a number of areas of positivity in relation to willingness to change factors. A key finding from the study that becomes evident in the readiness assessment process is the strength of recognition of the need to change. There is strong evidence of a desire to change, though some differing views on how this should be achieved.

The issue of capability is viewed as a gap by all, and an area that should be considered for prioritising in any agreed action plan. The leadership theme highlights issues that respondents felt required addressing. There are some areas for attention in relation to supporting people to have time and thinking 'space' to be able to both process and practically engage in the activities associated with the Workstream.

**Readiness Assessment: Success factors for change**

Success factors for change are less developed within the CPWS. There is either absence or little evidence of the factors and conditions considered being essential to successful change and transformation. More specifically, while there were some contract and transactional points identified, the key messages are on the whole concerned with relationships and leadership aspects of engagement.

Table 2 has mapped the evidence by the themes within the findings section.

Table 2: Readiness Assessment: Success Factors For Change.

| Change Success Factor | Readiness |
|---|---|
| Committed and respected leadership engaging the staff | Knowledge & Understanding, Leadership & skills, Expectations, Trust |
| Culture hospitable and supportive of change | Knowledge & Understanding, Leadership & skills, Value, Trust, Patient voice, Wider context |
| Data and analytics that measure and communicate impact | Patient voice, Leadership & skills, Trust |
| Capabilities and skills to identify and solve problems | Leadership & skills, Patient voice, Expectations |
| Resources and support to do the work of change | Patient voice, Trust, Value |
| An enabling environment which supports and drives change | Knowledge & Understanding, Leadership & skills, Value, Trust, Expectations, Wider context |
| Management practices that ensure execution and implementation | Leadership & Skills, Expectations, Patient voice |

| Readiness Assessment RAG |
|---|
| Significant concerns/issues raised |
| Some factors in place required for change |
| Many factors in place for change |

The seven success factors from the Allcock model can be summarised as either related to relationships or infrastructure/practical enablers, and that there is a need to address both aspects of these in enabling transformational change.

The evaluation has identified a desire for greater involvement in taking forward change in ways of working by the participants, but from a basis of wanting a clearer vision, and a desire to do this in partnership but with some initial direction/structure to comment on as opposed to joint generation of plans/ideas from scratch. This, combined with a reported lack of skills and capability across both providers and commissioners for the new ways of working (Vanguard/New Models of Care), gives the RAG picture of action being required to address these leadership/relationship factors.

The relationship context of the CPWG needs to be taken into consideration when reviewing this assessment of the evidence and the resultant RAG. The starting point for the Vanguard activity is from an existing relationship with CPWG members which appears to be largely transactional and passive in nature, with some specific unresolved contractual issues. This reinforces need for clarity both evident within the

findings and also in the factors required for successful change. What is the Workstream is trying to achieve? Is it about transformation of the Care Home service with providers and commissioners or a task-based transactional group about the specific content of the contracts? If it is about transformational, would require a different relationship and contributions by members to that currently in place. This issue is articulated within the evidence in differing views on timing i.e. whether it was feasible to make the contract and commissioning changes whilst other parallel activity such as the clinical pathway work is still in its infancy.

The factors pertaining to infrastructure require attention. The change model advocates the effective use of informatics to both inform decision making about priorities and monitor performance. The model acknowledges this can be problematic in relation to obtaining useful and reliable data, but that it is important in enabling decisions and debate. The issue of resources and support is noted in the assessment as 'significant concerns'. This is derived from findings around the ability to release and support people to be physically able to engage on a practical level thus creating the headroom to look at things differently and be part of the change process. Another practical solution included the need to consider creating incentives or capacity within contracts to allow new initiatives to be trialled. Challenges were identified here linked to the issue of local/geographical factors in terms of population. The reality that there is a disproportionate number of residents attracting lower income levels than perhaps exists in other part of the country, and thus there being little or no capacity to resource new initiatives.

## 6.0 Recommendations/Learning points

This evaluation has highlighted the need to proactively address capacity building and capability for change both at the individual level and the system level. This report has also illustrated the need to be cognisant of local variation in expectations, relationships and historical ways of working, and their potential impact in the ambition to achieve transformational change and to build this into future transformational activity planning.

**Local recommendations**

Further discussion with the commissioning team should be undertaken in respect of the RAG findings and attention be given to both **what** needs to be done and **how**. This should explore areas of undertaking a facilitated post evaluation sharing of key themes to enable validation and ownership of readiness assessment would be in keeping with both the feedback and the change model. Using data provided by this process could result in a jointly agreed action plan with stakeholders including addressing roles, responsibilities and ownership for achieving agreed outcomes.

**National learning**

A number of learning points are identified in respect of wider sharing. The issue of local context should not be underestimated and there is a need to be cognisant of existing relationships and local population issues/demands when embarking on a planned change process. Nationally, consideration could be given to the use of a collaborative self-assessment process at the outset of introducing new models of care or commissioning arrangements. This would enable identification of roles and expectations in current contractual relationships and what this looks like (transaction, transformational) and facilitate transparency and ownership for any proposed changes to ways of working.

Resources/support for analysis regarding geographical/demographic income variation and validity/viability of funding models should be explored with a view to provide more effective support local variation and transition to changes in care delivery.

Finally, there needs to be consideration to provision of organisational development and workforce development support for stakeholders involved in moving from transactional based responsibilities/roles to transformational roles and responsibilities.

## 7. 0 Conclusion

The Five Year Forward View (DH 2014:16) refers to delivering integrated care around the person as being about able to 'manage systems – networks of care - not just organisations'. This is further reinforced in the recent publication of Next Steps on the Five Year Forward View (DH 2017) in the need for leadership capability and capacity to work in new ways, but also for 'Evolution not big bang' (2017:29). This

study has also highlighted the importance of being cognisant of the importance of this but also ensuring proactive assessment of capacity, system maturity taking into account local context and the basis of existing working relationships. As we increasingly work across health and care boundaries ensuring that attention is paid to understanding and having greater insight into differing perspectives and the impact of language is also essential for enabling engagement and change.

This type of transformational change expected within the Vanguard approach is achieved through people and relationships. There is a need to invest in these areas and identify workforce development needs as an integral part to the transformational process at outset if we are to support people to succeed in achieving this ambitious vision for new models of care and ways of working.

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