# Can a new model of integrated care improve resilience?
# An evidence synthesis of the Multispecialty Community Provider (MCP) model

The Strategy Unit.


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## Background

The NHS New Care Models programme was introduced in 2014 and fifty 'Vanguard' sites were selected across five different sub-models. One of these was a multispecialty community provider (MCP) and fourteen Vanguards were chosen to pilot these primary care led, community based integrated care models. MCPs are developing new ways of whole-system working, including greater patient, community and third sector involvement, to enable a model of delivery which builds resilience and sustainability within an environment characterised by complexity, uncertainty and volatility. *Community resilience is defined as the achievement of good outcomes for individuals and communities despite serious 'threats' to their adaptation or development; arising from both emergencies and on-going daily conditions of life.*

## Aim and Objectives

The aim of this synthesis is to provide decision makers in health and social care with an 'actionable' evidence base for the MCP model of care through:

- articulating the underlying programme theories behind the MCP model of care
- identifying sources of theoretical, empirical and practice evidence to test the programme theories
- developing the realist synthesis, to explain how the mechanisms used in different contexts contribute to outcomes and process variables

## Methods

1. Locate existing theories
   - *MCP explanations: IF this happens THEN this will happen*
2. Search for evidence
   - *Systematic search for evidence: research, practice, commentary and opinion*
3. Select articles
   - *Privileging the UK literature and look for 'what works' and for 'why it works'*
4. Extract and organise data
   - *Use a "Best fit" framework and the Quadruple Aims*

**DESIGN: Community based coordinated care is more accessible**

**DELIVERY: New forms of contracting incentivise integration and accountable care**

**PEOPLE AND COMMUNITIES: Fostering relational behaviours builds resilient communities**

5. Synthesise the evidence
   - *Look for patterns in the data*
6. Draw conclusions
   - *Bring together all the data and abstract to mid-range theories*

HEALTHCARE QUADRUPLE AIMS
Patient Experience
Staff Experience
Population Health
Cost Effective

a. **NHS England 2015**. The 10 enablers of transformation in: THE FORWARD VIEW INTO ACTION. New Care Models: support for the vanguards

b. **NHS England 2016.** MCP Framework: working document shared in confidence

c. **WHO 2016.** Framework on integrated, people-centred health services

d. **Fillingham and Weir 2014.** System leadership: Lessons and learning from AQuA's Integrated Care Discovery Communities. Figure 2: Framework AQuA's Integration System

e. **NHS England 2016.** The multispecialty community provider (MCP) emerging care model and contract framework


## Findings

| | Intervention | Mechanism |
|---|---|---|
| Design | Clear vision and case for change | Shared ownership and shared goals at micro, meso and macro levels |
| | Shared responsibility for achieving outcomes agreed in contract | Linking success or failure of individual organisations |
| | Needs assessment | Model which addresses wider determinants of health |
| Delivery | Dedicated change management team | Culture of stewardship with credibility, spread and sustainability of MCP |
| | Incremental change | Continuous learning and development |
| Management | Relationship building and collaborative behaviours | Alignment of micro, meso and macro objectives |
| | Co-produced meaningful outcomes with aligned data collection | Shared accountability with intrinsic motivation |
| | Social accounting | "Permission" to innovate |
| | Shared governance structures and standards | Focus on value rather than activity |
| People and communities | Relationships across agents viewed as a mutually reinforcing partnership | Health literacy to enable ownership of personal health |
| | Interpersonal skills training for staff | Motivation to get involved in change |
| | Social prescribing and self-care targeted at risk factors | Confidence and trust to engage in shared decision making |
| | Inclusive language (i.e. not jargon) | Mutual trust and respect |
| Workforce | Multidisciplinary working and training | Improved understanding of role within new model |
| | Clear roles and responsibilities | Credibility, legitimacy and sustainability of new roles |
| | Involvement of staff with opportunity to learn from prior experience | Staff develop adaptive skills needed for implementation and evaluation |
| | Protected time and facilitation for quality improvement | Improved team dynamics |
| | Values-based recruitment | Shared values and sense of belonging |
| Technology | Compatible information systems and patient portals | Knowledge sharing between teams, generalists/specialists |
| | Predictive and real time analytics making use of Big Data | Information readily available to support decision making |
| Leader-ship | Collaborative/system leadership approach | Teams empowered to improve and innovate |
| | Organisational development | |
| Knowledge | Data sharing agreements and protocols | Teams audit own performance and agree improvements |
| | Engagement of agents on legal and ethical implications of data sharing | Sustainability of interventions and relationships |
| | Rapid cycle evaluation | All partners held to account and weak performance addressed sooner |
| | Access to performance data, feedback and benchmarking | Reflective and adaptive 'learning' culture |

## Conclusions

Delivery of an MCP requires **resilience within and between professional and service user groups** and is dependent on notions of *trust and empowerment*, that are generated if *values and incentives for new ways of working are aligned*. Combining opportunities for training and development, resilient communities are those that have:

- shared decision making for **accountable service users** who take responsibilities for their own health
- **accountable communities** who manage demand at the most appropriate setting with high quality integrated care
- **accountable care systems** which invest and manage financial risk through agreed contracting and payment arrangements and embed learning throughout.


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