Primary care-led models of integrated care:

findings from a realist synthesis

Health Policy and Politics Network 2018 Spring Event

19 April 2018

@strategy_unit
@ScHARRSheffield

The University Of Sheffield.

NHS
Midlands and Lancashire
Commissioning Support Unit

The Strategy Unit.

Introduction

The Strategy Unit.

Background

- Fifty health care economies in England received NHS funding and support to design and deliver sustainable integrated healthcare models in 2014.

- Each of these sites, piloting one of five new models of care, are called vanguards and aim to offer better quality, experience and value for local populations.

- The fourteen Multispecialty Community Provider (MCP) vanguards were focused on delivering an **integrated care model model which is primary care led, community-based and across the local health and care system**.

- The underlying efforts to deliver a more accountable integrated model of care has precedence:

    - In England there are legacy programmes such as Integrated Care Pioneers.

    - International new care models most notably include the US Accountable Care Organisations.

Aim and Objectives

Aim

To provide decision makers in health and social care with an 'actionable' evidence base for the MCP model of care.

Objectives

(1) articulate the underlying programme theories behind the MCP model of care

(2) identify sources of theoretical, empirical and practice evidence to test the programme theories

(3) develop the realist synthesis, to explain how the *mechanisms* (resource and reasoning) used in different *contexts* could contribute to *outcomes* and (social) process variables.

(4) disseminate the findings, preparing a series of practical tools to support the 'mobilisation' of evidence.

Research questions

- What are the foremost theories of change inherent within the MCP model of care?

- What seem to be the "active ingredients" which should inform design of MCP models of care?

- What are the social and cultural conditions which influence (enabling and blocking) change within MCP models of care and how do these mechanisms operate in different contexts?

- What are the key knowledge gaps and uncertainties in relation to the design, implementation and evaluation of MCP models of care?

Methodology

'What works, for whom, in what respects, to what extent, in what contexts, and how?'

A combination of **realist synthesis** with **best fit meta-framework,** comprising:

- Articulation of a programme theory, sourced from MCP key documents e.g. logic models

- 8 areas of commonality which emerged were described (flow diagrams and narratives) and shared with stakeholders to prioritise for testing against available evidence

- 3 of the 8 areas were prioritised for a 'realist' approach

- The remaining 5 were examined as more brief evidence 'maps'.

Findings

New and expanded professional roles in a primary care led, community based, integrated care model requires:

trust between professionals

alongside

appropriate training and practical tools

to trigger

professional willingness to adopt new ways of working.

Effective embedding can result in

improved healthcare accessibility for patients

higher staff satisfaction with improved management of chronic conditions

reduction in the number of secondary care referrals

cost savings *after*

sustained implementation and stabilisation of increased demand

inclusion of training and additional community services provision

Effective accountable place-based contracting and payment systems require:

development of meaningful outcomes

with

involvement of clinicians and patients

through

sufficient time for engagement, shared learning and development

plus

shared access to robust high quality information including investment data. *This will align*

personal, professional and organisational visions, values and incentives

and build

confidence, trust, collaboration and shared decision making *for*

need-based management of financial risk and accountable investments

Mutually beneficial relationships with local communities requires:

opportunities for equal and reciprocal engagement

alongside

ongoing training, guidance, feedback and practical support

clear roles, responsibilities and expectations

to trigger

confidence to contribute to decisions/share experience and knowledge

can inform

priorities for targeted preventive and holistic care

which may encourage

**a shared sense of ownership**

for improving health behaviours and increasing social participation

Further findings

Our evidence maps further demonstrated the interdependencies between individual theory components at individual, organisational and system level:

- Professional autonomy and empowerment critical for driving cultural change associated with trust and collaboration

- Cultural change needs to be stimulated through organisational development and system leadership behaviours which promote collaborative, population-based approaches to healthcare and aligned processes which support delivery

- Shared data, in particular, offers the opportunity to improve the co-ordination and continuity of care at individual and organisational levels

- MCP-wide learning can be accomplished through training and feedback loops, built into audit and formative evaluation, to support system learning and improvement.
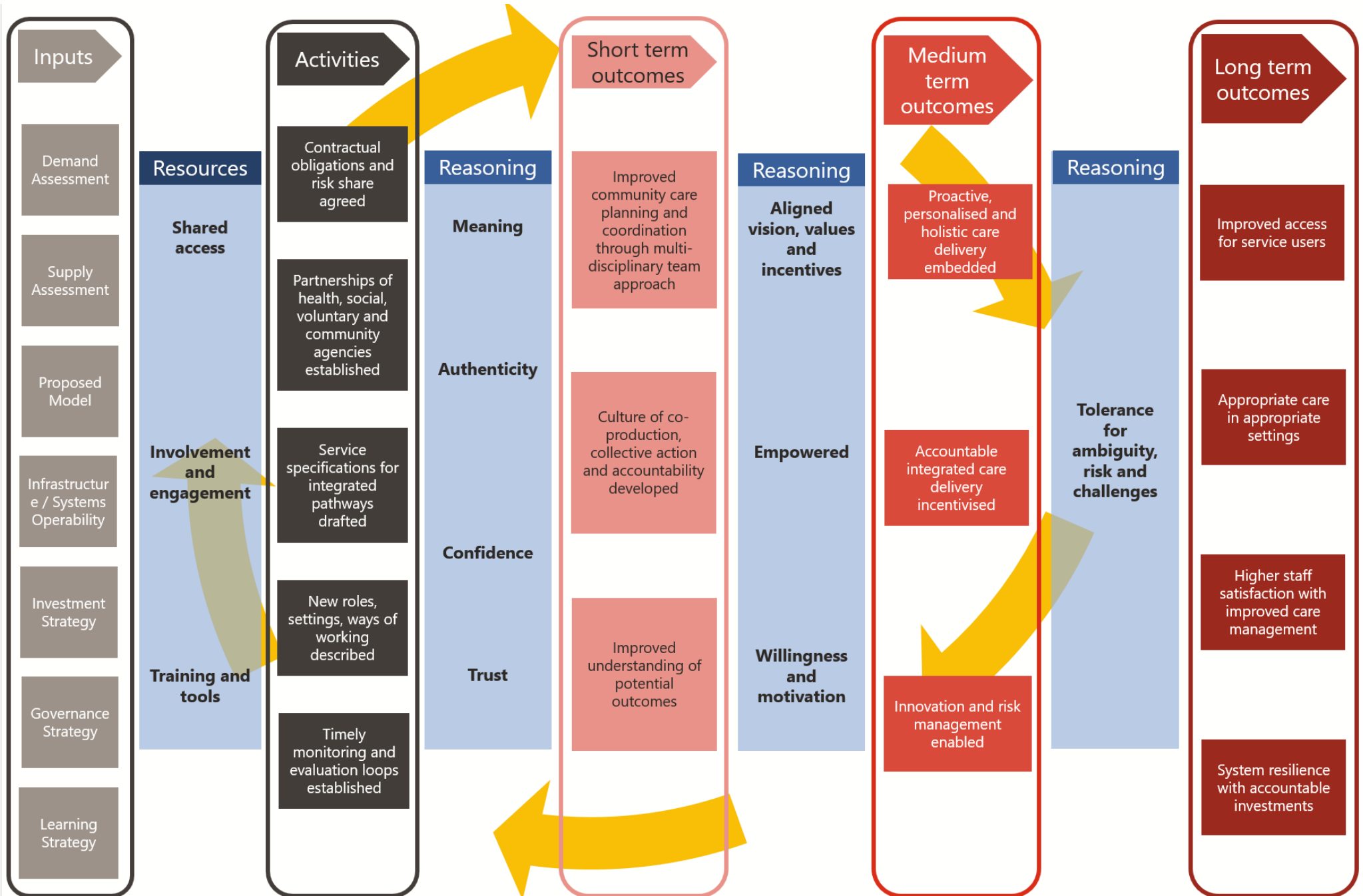
A meta-framework for understanding integrated care
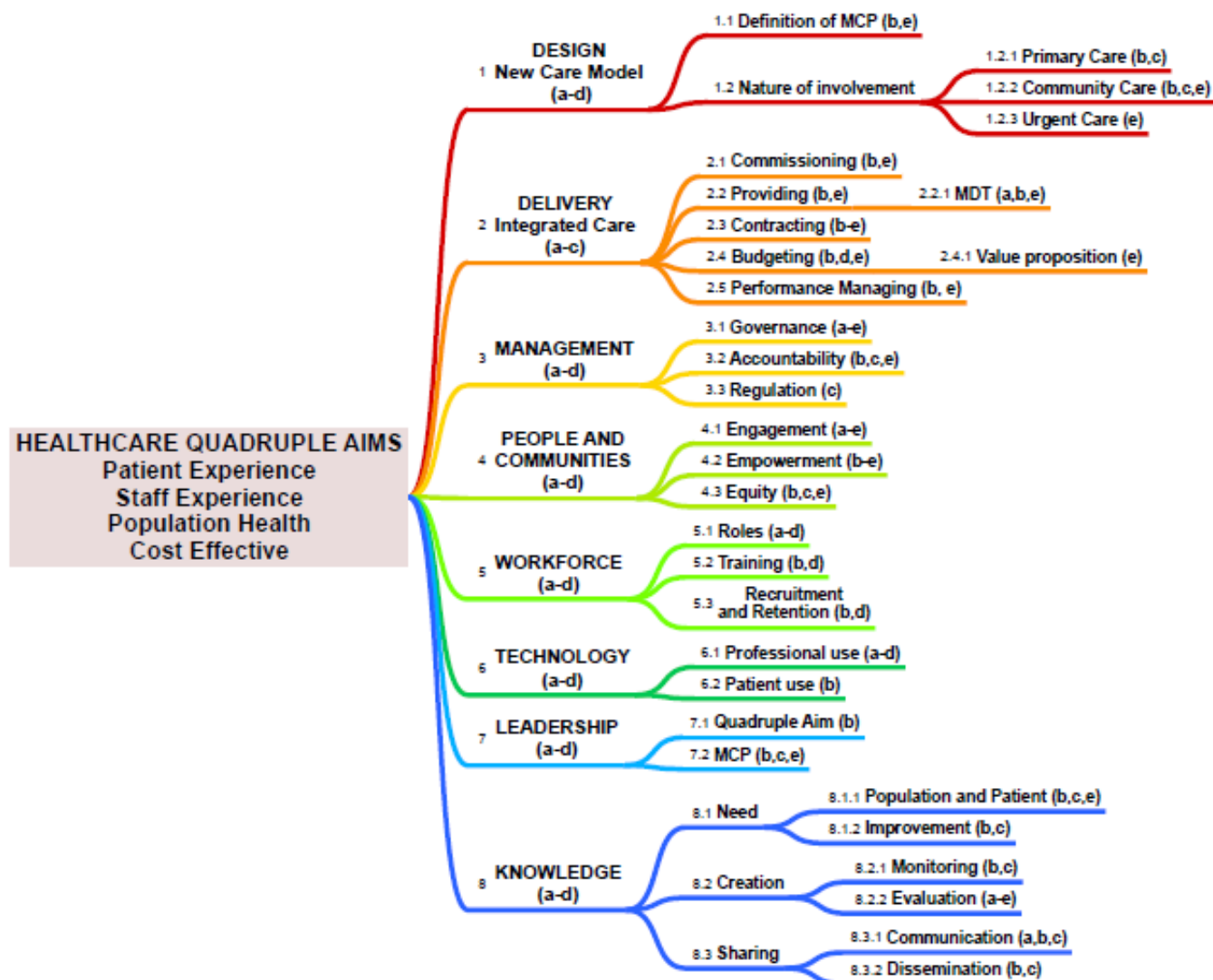
The meta best fit framework is derived from:

a. NHS England 2015. The 10 enablers of transformation in "THE FORWARD VIEW INTO ACTION. New Care Models: support for the vanguards" https://www.england.nhs.uk/wp-content/uploads/2015/12/acc-uec-support-package.pdf

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

c. WHO 2016. Framework on integrated, people-centred health services http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_39-en.pdf?ua=1

d. Fillingham and Weir 2014 System leadership: Lessons and learning from AQuA's Integrated Care Discovery Communities. Figure 2: Framework AQuA's Integration System http://www.kingsfund.org.uk/publications/system-leadership

e. NHS England 2016. The multispecialty community provider (MCP) emerging care model and contract framework https://www.england.nhs.uk/wp-content/uploads/2016/07/mcp-care-model-frmwrk.pdf

Unintended consequences and risks : some examples

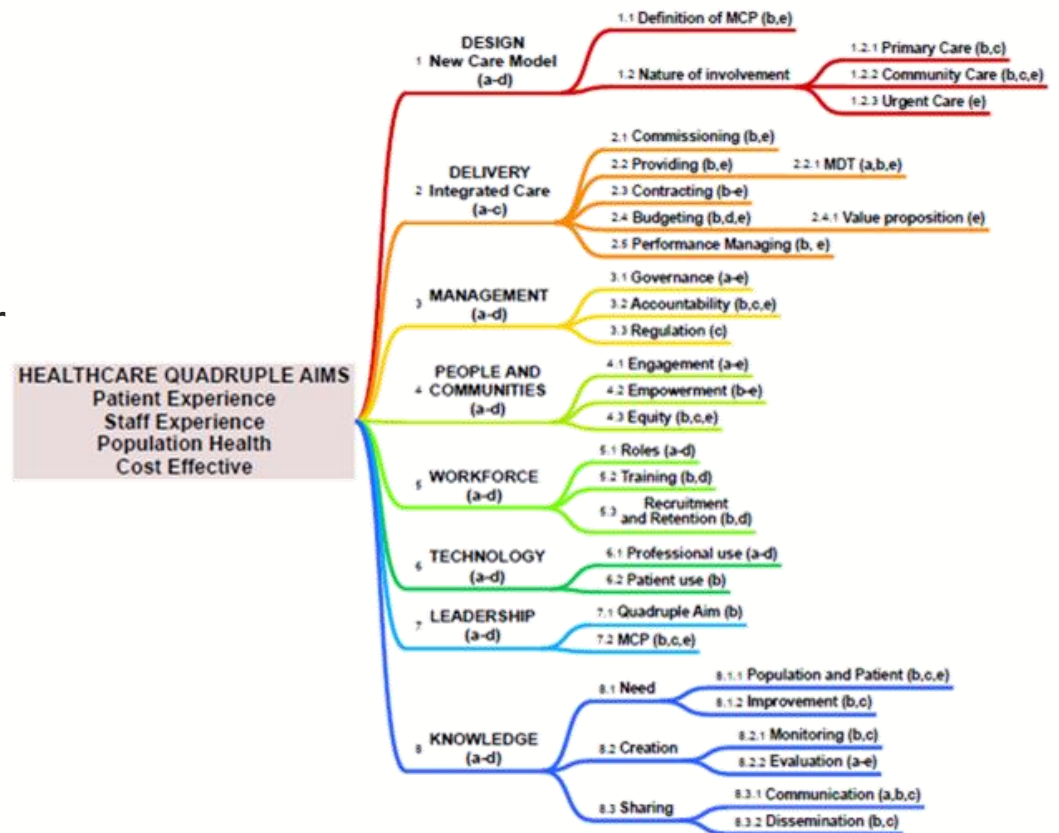|	Category	Examples
	Design	• Challenges aligning incentives and transferring risks and savings across sectors • Perverse incentives e.g. case finding stimulates demand • Tension between competition and collaboration
	Delivery	• Increased service delivery costs (e.g. supply induced demand, insufficient critical mass to deliver economies of scale) • Enhanced primary care may impact relational continuity
	Management	• Different organisational cultures/governance structures hinder agility • Managing contract failure
	People and communities	• Uneven representation could widen health inequalities • Implicit assumption that service users wish to engage in decision making • Funding cuts impact on the sustainability of third sector and community services
	Workforce	• Recruitment and retention issues • Inequalities in multidisciplinary teams can impair decision making
	Technology	• Technological advances widen the "digital divide"
	Leadership	• Organisational development can't keep pace with skills development needed • Unrealistic timeframes leading to short-term focus of monitoring and evaluation
	Knowledge	• Information asymmetry between commissioners and providers

Mobilising findings

Examples of draft materials

Inputs

- Demand Assessment
- Supply Assessment
- Proposed Model
- Infrastructure / Systems Operability
- Investment Strategy
- Governance Strategy
- Learning Strategy

Resources

- Shared access
- Involvement and engagement
- Training and tools

Activities

- Contractual obligations and risk share agreed
- Partnerships of health, social, voluntary and community agencies established
- Service specifications for integrated pathways drafted
- New roles, settings, ways of working described
- Timely monitoring and evaluation loops established

Reasoning

- Meaning
- Authenticity
- Confidence
- Trust

Short term outcomes

- Improved community care planning and coordination through multi-disciplinary team approach
- Culture of co-production, collective action and accountability developed
- Improved understanding of potential outcomes

Reasoning

- Aligned vision, values and incentives
- Empowered
- Willingness and motivation

Medium term outcomes

- Proactive, personalised and holistic care delivery embedded
- Accountable integrated care delivery incentivised
- Innovation and risk management enabled

Reasoning

- Tolerance for ambiguity, risk and challenges

Long term outcomes

- Improved access for service users
- Appropriate care in appropriate settings
- Higher staff satisfaction with improved care management
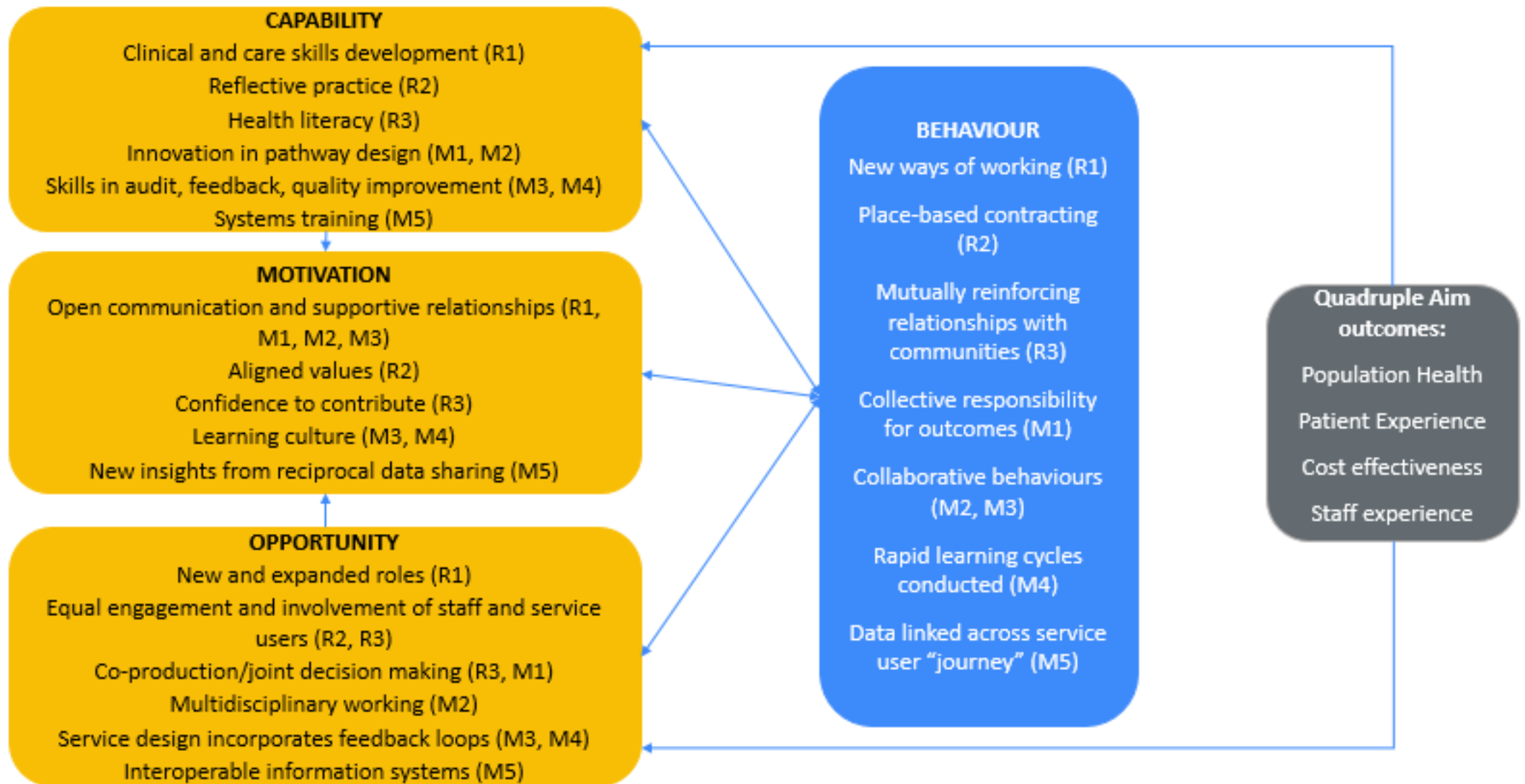- System resilience with accountable investments

15

"Active ingredients"

New models of care involve complex change. Outcomes are influenced by how individuals, services, groups and organisations connect and work together effectively and continually. Listening and responding to feedback will be vital in ensuring they learn, grow and develop; for some, the degree of flexibility and responsiveness required will mean new ways of working.

COM-B model

CAPABILITY
Clinical and care skills development (R1)
Reflective practice (R2)
Health literacy (R3)
Innovation in pathway design (M1, M2)
Skills in audit, feedback, quality improvement (M3, M4)
Systems training (M5)

MOTIVATION
Open communication and supportive relationships (R1, M1, M2, M3)
Aligned values (R2)
Confidence to contribute (R3)
Learning culture (M3, M4)
New insights from reciprocal data sharing (M5)

OPPORTUNITY
New and expanded roles (R1)
Equal engagement and involvement of staff and service users (R2, R3)
Co-production/joint decision making (R3, M1)
Multidisciplinary working (M2)
Service design incorporates feedback loops (M3, M4)
Interoperable information systems (M5)

BEHAVIOUR
New ways of working (R1)

Place-based contracting (R2)

Mutually reinforcing relationships with communities (R3)

Collective responsibility for outcomes (M1)

Collaborative behaviours (M2, M3)

Rapid learning cycles conducted (M4)

Data linked across service user "journey" (M5)

Quadruple Aim outcomes:
Population Health
Patient Experience
Cost effectiveness
Staff experience

"Active ingredients" – for example

	What	How	Why
Workforce	Establish shared aims, values and a sense of belonging by ensuring staff are able to share their knowledge and experience; Ensure everyone understands they have an important part to play in making the model work and has the confidence to contribute ideas and suggestions; Ensure everyone has clear roles and responsibilities and is aware of others' roles and responsibilities; Help staff develop the skills they need to monitor and improve outcomes;	Design training and development to reflect evolving ways of working; Provide 'protected time' and facilitation to enable reflective practice and quality improvement; Attract and select employees whose personal values and behaviours align with your values. Encourage multidisciplinary connectivity through multidisciplinary learning and development.	Capability for audit, feedback and quality improvement together with opportunities to share knowledge and experience will motivate staff to behave more collaboratively to deliver more co-ordinated care
Technology	Ensure information systems, processes and policies are in place to enable the appropriate sharing and linking of data across services and sectors; Ensure teams always have the information and data they need, including real-time data, to make decisions in relation to individual patients and communities; Monitor data to respond to demand and maximise capacity;	Offer patients easy, secure ways of accessing information and connecting to their care and to local services; Pay attention to how individual practitioners and teams will share knowledge and information; Provide training in the use of key information systems. Use advanced analytics to innovate and drive improvements in care.	Increased technical capability and the opportunity to share information will motivate staff to improve care through behaviours which promote a clearer understanding of patients' needs

Enhanced dissemination

Background

- 5 evidence syntheses on new care models were funded

Rationale

- Limited capacity to translate evidence into practice (organisational) and to manage the volume and heterogeneity of evidence (individual)

- A risk that disparate and unconnected dissemination activities might hinder rather than help

Aims and objectives

- Raise awareness of the research findings

- Inform design, implementation & evaluation of new care models

Through:

- A programme of knowledge translation & mobilisation activities

- Designed to collectively enable spread (reaching decision makers, practitioners & public representatives) and depth (helping teams to act on findings)

15/77/05 Hanratty 'Innovation to enhance health in care homes: Rapid evidence synthesis'

15/77/10 Baxter 'Understanding new models of care in local contexts: a systematic review using frameworks to examine pathways of change, applicability, and generalisability of the international research evidence'

15/77/15 Turner 'An evidence synthesis of the international knowledge base for new care models to inform and mobilise knowledge for Multispecialty Community Providers (MCPs)'

15/77/25 Bunn 'Supporting shared decision making for older people with multiple health and social care needs: a realist synthesis to inform emerging models of health and social care'

15/77/34 Sheaff/Pearson 'From Programme Theory to Logic Models for Multi-specialty Community Providers: A Realist Evidence Synthesis'

Alison Turner

alison.turner14@nhs.net

More information

Protocol:

https://systematicreviewsjournal.biomedcentral.com/articles/10.1186/s13643-016-0346-x/open-peer-review

Project page:

https://www.journalslibrary.nihr.ac.uk/programmes/hsdr/157715/#/

Project blog:

https://mcpsynthesis.wordpress.com/