Primary care-led models of integrated care:
findings from a realist synthesis

Health Policy and Politics Network 2018 Spring Event
19 April 2018
Introduction
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 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:


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
## Unintended consequences and risks: some examples

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples</th>
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| 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
"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

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<thead>
<tr>
<th>What</th>
<th>How</th>
<th>Why</th>
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<tr>
<td><strong>Workforce</strong></td>
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<td>Establish shared aims, values and a sense of belonging by ensuring staff are able to share their knowledge and experience;</td>
<td>Design training and development to reflect evolving ways of working; Provide ‘protected time’ and facilitation to enable reflective practice and quality improvement;</td>
<td>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</td>
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<td>Ensure everyone understands they have an important part to play in making the model work and has the confidence to contribute ideas and suggestions;</td>
<td>Attract and select employees whose personal values and behaviours align with your values.</td>
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<td>Ensure everyone has clear roles and responsibilities and is aware of others’ roles and responsibilities;</td>
<td>Encourage multidisciplinary connectivity through multidisciplinary learning and development.</td>
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<td>Help staff develop the skills they need to monitor and improve outcomes;</td>
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<tr>
<td><strong>Technology</strong></td>
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<td>Ensure information systems, processes and policies are in place to enable the appropriate sharing and linking of data across services and sectors;</td>
<td>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;</td>
<td>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</td>
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<td>Ensure teams always have the information and data they need, including real-time data, to make decisions in relation to individual patients and communities;</td>
<td>Provide training in the use of key information systems.</td>
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<td>Monitor data to respond to demand and maximise capacity;</td>
<td>Use advanced analytics to innovate and drive improvements in care.</td>
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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’
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https://www.journalslibrary.nihr.ac.uk/programmes/hsdr/157715/#/

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More information

Protocol:

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

Project blog:
https://mcpsynthesis.wordpress.com/