New models of care – what's the evidence?

Summary findings

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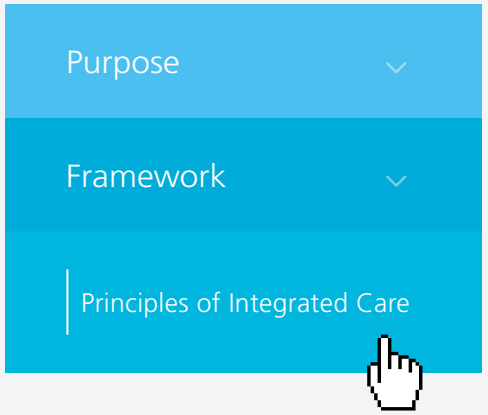


Purpose

Context

In 2015, the National Institute for Health Research called for a series of evidence reviews to inform new models of care. The NHS Five Year Forward View outlined the need for new, flexible models of service delivery tailored to local populations. There was an emphasis on integration between services and working beyond traditional organisational boundaries.

Evidence reviews were needed to understand preconditions for success, learning from other countries and related organising principles. The findings, shared here, will be useful to anyone involved in designing, delivering and evaluating integrated models of working at different levels.

The Five Evidence Reviews

01 **Hanratty et al.**
Innovation to enhance health in care homes: Rapid evidence synthesis

02 **Baxter et al.**
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

03 **Turner et al.**
An evidence synthesis of the international knowledge base for new care models to inform and mobilise knowledge for Multispecialty Community Providers (MCPs)

04 **Bunn et al.**
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

05 **Sheaff et al.**
From Programme Theory to Logic Models for Multispecialty Community Providers: A realist evidence synthesis

Making sense of the evidence

Rationale

It can be hard to find time and headspace to find and review the evidence relevant to change programmes, so we have developed this summary of the five reviews to provide a simple overview of the key messages.

Aims and objectives

The purpose of this summary is to share key messages with you which may help to inform design, implementation and evaluation of new care models, with the option to learn more by following links to the individual reviews.

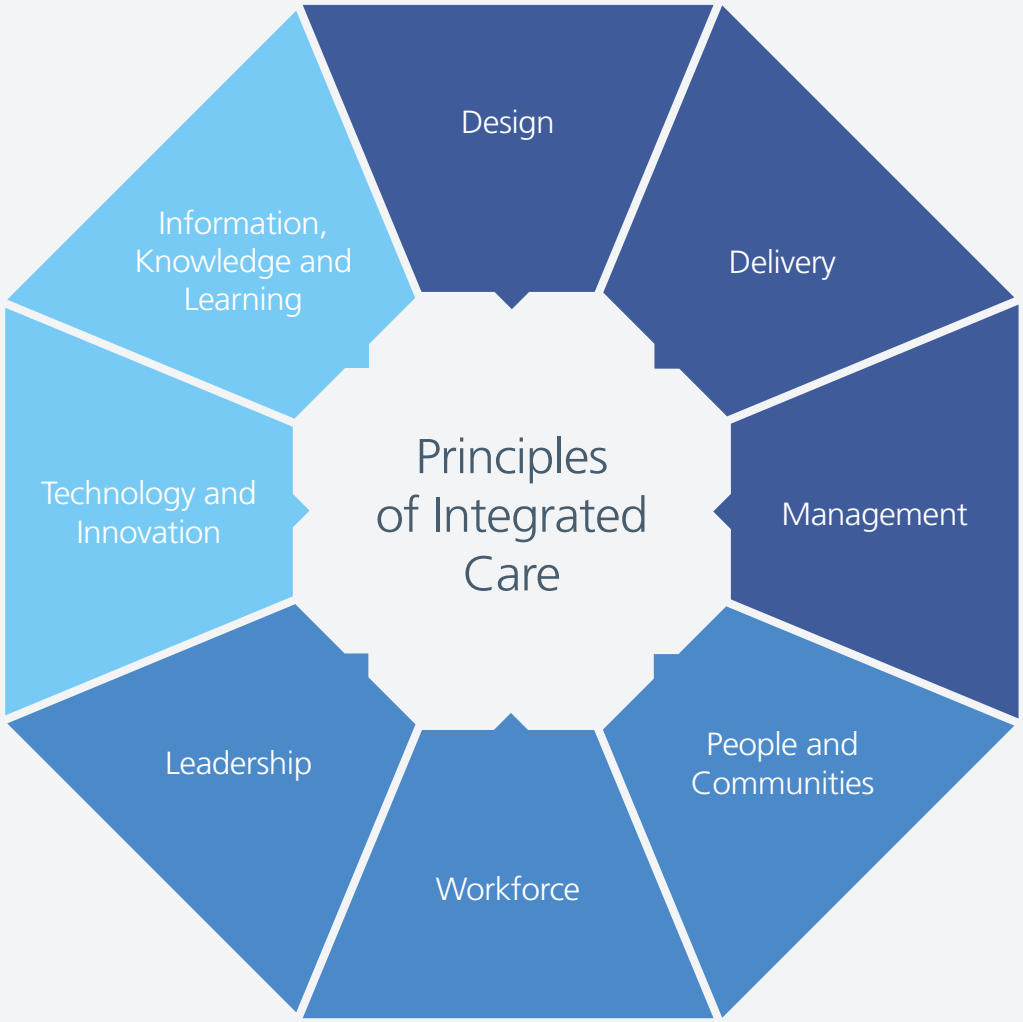
Through

We've developed a programme of activities, including workshops over Summer 2018, and this summary, working with decision makers, practitioners and public representatives to help teams to apply and act on the findings.

Framework

Principles of Integrated Care

To help make sense of the findings, we've grouped them according to a framework developed by the Strategy Unit which covers the various aspects of designing, implementing and evaluating integrated care.



Findings

Design

There are different and multiple mechanisms used to achieve integration: top down reform can be instrumental for initiating change. However, more organic integration has also shown to be successful, based on shared values or integration of clinical pathways, particularly when providers wished, but were unable, to provide all of the services required.

It is important to give new care models time to reach maturity, with commentators suggesting 5 to 7 years to see measurable effects.

Integrated care pathways, multidisciplinary teams and care co-ordinators are all common features of new care models.

The size of populations served varied with no direct evidence being found about maximum or minimum viable size.
The services offered influenced the size of population served with GP practices covering around 10,000 compared to Emergency Departments serving 70,000.

A shared vision and agreed objectives can help to create a shared identity.

Delivery

Multidisciplinary teams are a key feature of new care models. Within the multidisciplinary team is likely to be health and social care professionals but also potentially care homes, other public services or specialist services.

Multidisciplinary teams have a focus on supporting care planning, self-management and holistic care for patients with long term and/or complex needs.

It is important that patients, families and health professionals are given time, such as longer appointments, to engage in new ways of working.

There are a number of contractual forms and governance structures used by organisations participating in new care models. Many have opted for the lead provider model where one organisation takes responsibility; however, a number have also chosen to retain existing governance arrangements.

Contracting mechanisms are unlikely to deliver change without commitment to organisational development; team development is needed at all levels of the system.

Management

Ensuring that governance arrangements are in place early, and that roles and responsibilities are clarified, has been key to progressing with integration.

Shared governance structures can facilitate decision making, and coproduced outcomes and aligned data collection can help engender shared accountability.

There are some concerns around the practical challenges of contract monitoring and group accountability at a system rather than organisational level.

There is a move towards outcome-based commissioning with many MCP vanguards committing to developing new outcome frameworks. **It is unclear yet whether this will improve patient outcomes.**

Physical co-location of staff supported integration and improved mutual understanding.

People and Communities

The need to involve patients and families from development through to implementation was highlighted, as it raises awareness of the priorities of patients and families, including these in the design stage increases the sense of validity and equity of changes.

Good relationships between healthcare professionals and patients facilitate shared decision making.

Incentives such as financial reward or practical support, such as transport, or meetings timed to suit community members' needs may be required to encourage service user participation.

Trust is a key element of patient and community engagement.

Patients may require training and support in order to participate in shared care.

The resilience of patients and their communities in terms of access to social resources has been shown to be critical in empowering patients to self-care.

Greater involvement in care could create discomfort or be experienced as burdensome by some patients.

Care co-ordinator roles can support patient engagement with services.

Achieving improvement in quality, or the identification of unmet need, may lead to increased costs, particularly in the short term

Workforce

New care models often refer to new roles or responsibilities, what are these?

What training is required, and how do organisations build capacity?

Dedicated support for change management and improvement can help build capacity.

Boundary spanning roles, such as care co-ordinators, that cultivate cross-professional and cross-organisational relationships are a key mechanism to overcome organisational barriers and improve co-ordination and integration of services.

Many studies detailed changes in staff roles and responsibilities, although these were not specific, some descriptions included enhanced roles or additional responsibilities. **There were themes within the studies that creation of these new roles and new ways of working could lead to strained relationships,** particularly across disciplinary boundaries if roles and responsibilities are not clear.

Staff require training and development, in multidisciplinary settings, in order to undertake new roles and ways of working.

Training needs include communication and leadership skills – **this should be inclusive of all levels of staff, clinical and non-clinical.**

There is a need to build capability and capacity in audit, feedback and quality improvement to support system learning and facilitate sustainable change.

Recruitment and retention challenges have been a barrier to new care models.

Leadership

Leadership is considered an essential element of new care models, what attributes does the evidence suggest both system leaders and clinical leaders should demonstrate?

There needs to be organisational and leadership support for new ways of working e.g. shared decision making, developing a culture of quality improvement.

Creating a culture of openness and understanding of different roles helps to overcome barriers, **trust is vital to co-operation.**

A culture of reflection and adaptive learning can provide the conditions for innovation and improvement at all levels of the system.

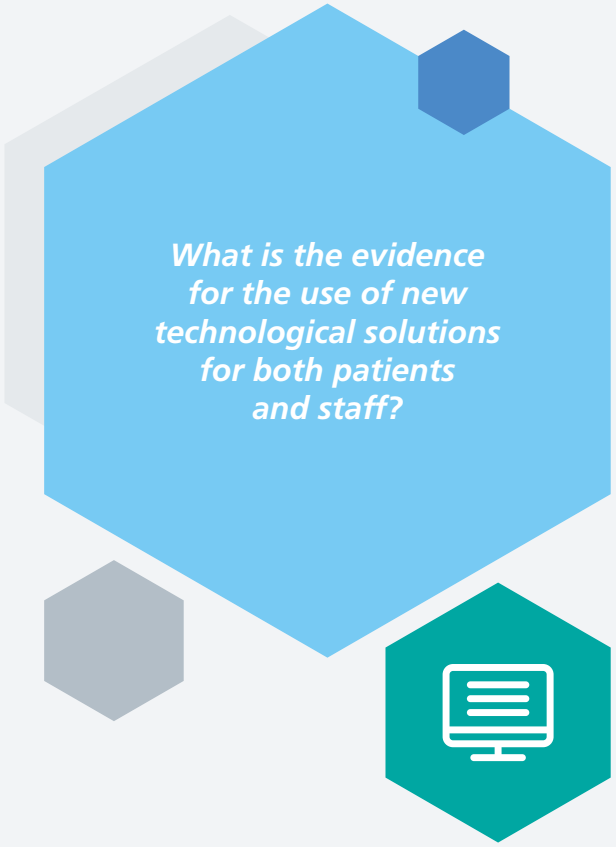
Local leaders and champions to drive forward improvement initiatives were identified as a key enabler to implementing lasting change.

Contracting mechanisms are unlikely to deliver change without commitment to organisational development, team development is needed at all levels of the system.

Historical hierarchies e.g. medical dominance can act as a barrier to integrated care.

Communication, co-ordination and leadership have been found to be features of success.

Technology and Innovation



Electronic health records are an important mechanism for managing and co-ordinating patient care and act as a key enabler for NCM.

However, **poorly designed systems or a lack of compatibility between systems are a barrier to integrated working.**

Many studies corroborated that **integrated IT systems alone would not lead to coordinated care systems.** Other mechanisms, such as reworking staff roles and a shared physical space, were also likely to be required.

There is limited evidence relating to patient use of technology.

Information, Knowledge and Learning

Lack of data was identified as a frustration in developing networks and identifying patient needs.

Identifying case mix and conducting needs analysis to target particular groups was a commonly cited use of data.

Rapid cycle evaluation and feedback loops were reported to be characteristic of organisations seeking to achieve and sustain transformational change.

Data sharing is a key component in the co-ordination and delivery of care, however it still remains a challenge between organisations.

A history of working together and understanding of roles can benefit integrated working.

Outcomes

Outcomes

Staff Experience | Patient Experience | Population health | Cost effectiveness

Staff Experience

Enhanced roles, for example in primary care, with clear understanding of responsibilities and ongoing support and training, can lead to improved staff outcomes (job satisfaction) and organisational outcomes (absenteeism and staff turnover)

Outcomes

Staff Experience | **Patient Experience** | Population health | Cost effectiveness

Patient Experience

There is some evidence to suggest that new care models can improve patient experience of care through; the use of shared decision making to develop realistic goals, care closer to home and improved access to services.

There is some suggestion that the outcomes for carers may differ from those for patients, with one study highlighting that reports of greater satisfaction from patients were not always shared by their carers.

Outcomes

Population Health

Digital technologies have the potential to enhance health and wellbeing, particularly those that promote physical activity or those that enhance mental health and wellbeing, but there is limited evidence.

There is currently inconclusive evidence around the impact of new care models on patient outcomes as few studies have assessed the long term impacts. Although some studies show positive results such as improved quality of life, improved management of long term conditions, reduced mortality and improvements in access to care.

Outcomes

Cost Effectiveness

There is inconclusive evidence around the impact of new care models on utilisation of healthcare services, with limited evidence of reduced A&E admissions and GP appointments.

It is not yet clear whether new models of care will reduce overall spending, as it is difficult to identify where the savings have been achieved between organisations.

Integrated care pathways were frequently implemented as "stand-alone" interventions with some evidence of improved process outcomes but little evidence of change in service delivery outcomes.

References

Disclaimer

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Published Papers

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