

FUTURE MODELS OF CARE

**WHAT MAKES A GOOD
MULTISPECIALTY
COMMUNITY PROVIDER?**

June 2015



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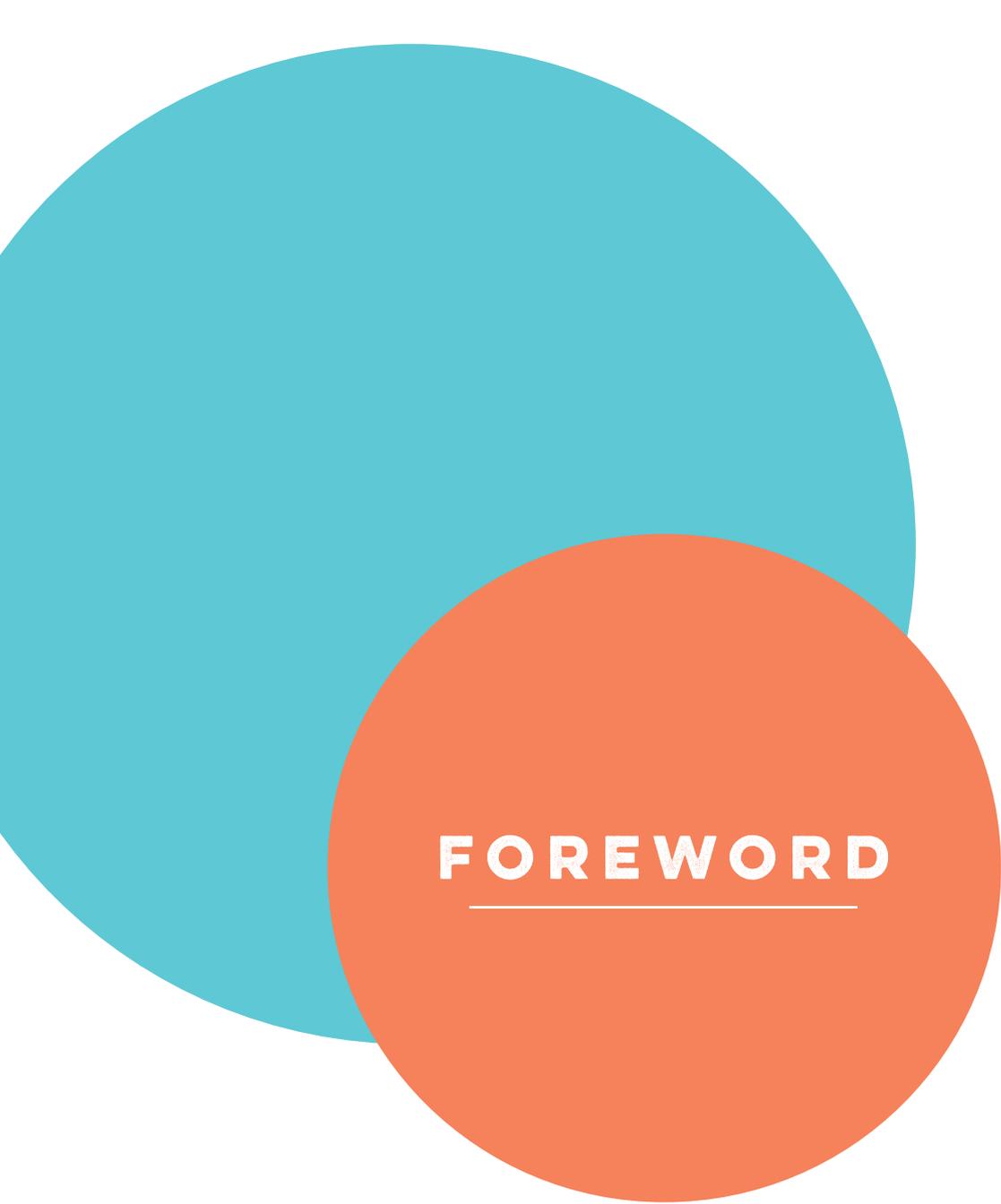
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FOREWORD

The aim of this report is to provide the London health economy with a resource that can be used to help inform, question and support the development and commissioning of Multispecialty Community Providers (MCPs), one of the models of care outlined in the Five Year Forward View (NHS England 2014).

We contend that the London Primary Care Transformation Board (NHS England 2015) and key reports from The King's Fund (Ham and Murray 2015, Robertson et al 2015) and Nuffield Trust (Dayan et al 2015) have helped to shape a vision for the future of health and care services that can be used in such a regard, yet there is a gap in knowledge - a community services and service user perspective. This report aims to address this gap taking inspiration from the work that has gone before but bringing the voice of the frontline and service users directly to the fore to inform planning and decision-making.



BACKGROUND — AND — OBJECTIVES

The Five Year Forward View (NHS England 2014) sets out an ambition for the NHS, with a focus upon the favoured models of care to be implemented across health services. Each of the models outlined will, to a greater or lesser degree, impact the way community services are both commissioned and provided.

This project was commissioned to explore how the MCP model might work in London. It has been delivered in partnership with the London Region of NHS England, the Office of London CCGs and a Design Group¹ comprised of leaders from a variety of health and care organisations.

The need for this project emerged from a consensus of opinion between our Design Group and the Office of London CCGs on the need to:

- i. further explore the MCP vision and outline guiding features for providers and commissioners regarding how MCPs can be delivered in practice, and
- ii. widen the conversation from a GP practice and GP federation centric view of MCPs, to include a broader view from all community services, as they too will significantly influence this model's future.

Our objective was therefore to identify and describe features of what good MCPs should look like, and then to present these features to London's key health stakeholders to help question, inform and support the development and commissioning of future MCPs.

¹For information on members of the Design Group please visit <http://www.transformldn.org/public/whos-involved/>

METHOD

We deployed a hybrid research methodology, drawing upon grounded theoretical approaches and desk based methods, all enabled by a focused crowdsourcing process to increase scale, stakeholder representation, and increase reliability.

The research was completed in two broad steps:

1. **Understanding excellent community based services:**
to build a view, broadly, on what excellent community based services look like, and the impact that such services can have on the health of the population of London.
2. **Building guiding features for MCPs:**
to build upon the insights generated in step 1, using the views of diverse stakeholder groups, to tease out the likely foundations and features of MCPs, specifically, and the role of community services within them.

We delivered these two steps by creating and analysing six qualitative data sets, achieved through 4 engagements, and 2 sessions of desk research:

Engagement 1, a professional & public cross-section:

Health and care staff and service users, shared their views on what excellent community services would look like and the impact that they could have on the health of London, via a series of online workshops² and focus groups.

Engagement 2, GP managers:

We collected feedback and insights on the community services agenda at a GP federation workshop that was facilitated by the Office of London CCGs.

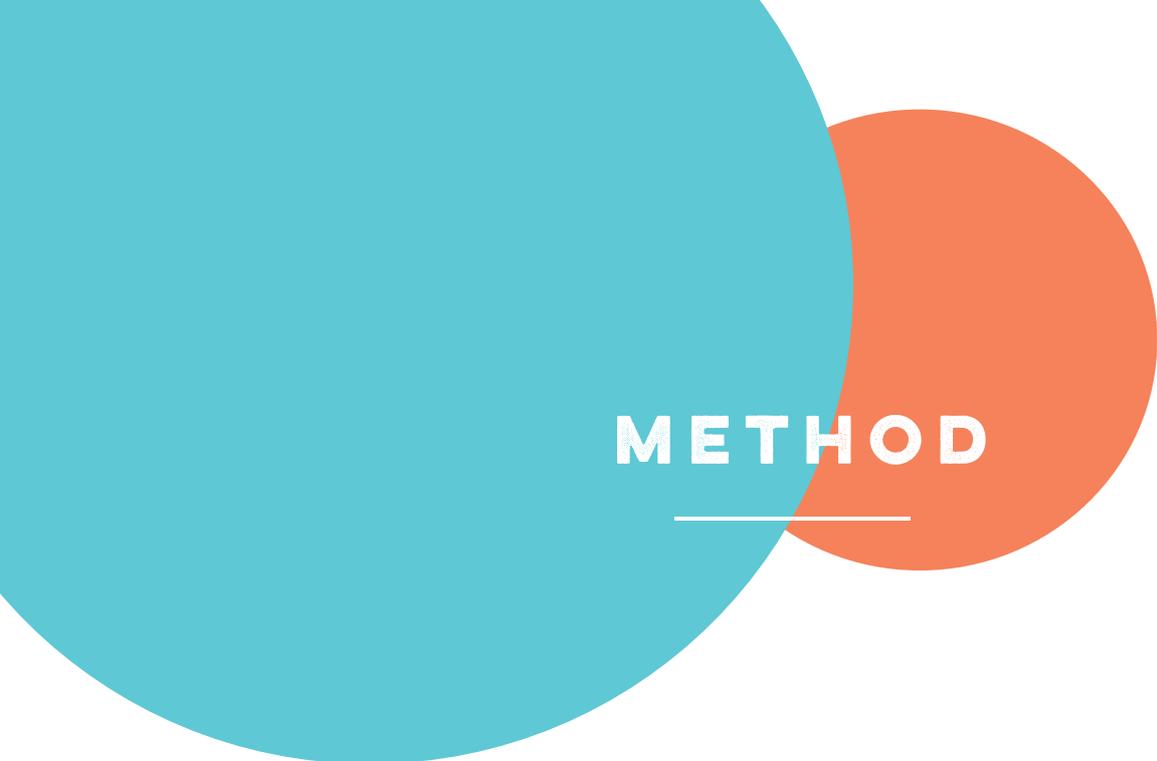
Engagement 3, system leaders:

We conducted in-depth interviews with people identified by London's Chief Nurse as system leaders in the area of community services transformation.

Engagement 4, a professional & public cross-section:

We deployed an online workshop to engage a cross-section of health and care professionals to discuss the implications of future models of care for community services transformation.

²A form of crowdsourcing pioneered by the change agency Clever Together.



METHOD

Desk research 1, vanguard applicants:

We analysed every London Vanguard Application, relating to the MCP model, with additional emphasis on the winning bid.

Desk research 2, thought leaders in the literature:

We completed a light-touch review of the literature in this area, reviewing 3 key papers (Ham and Murray 2015, NHS England 2014, Robertson et al 2014).

Collectively over the six datasets, 12,649 data points were captured and 1,220+ people were directly involved, including service users and a broad cross-section of clinical and non-clinical staff.

Having built the six datasets we probed the data using inductive analytical approaches to reveal common meta-themes. Then through a process of triangulation we interrogated the datasets clustered by these meta-themes, to reveal common sub-themes across the datasets.

We then used these sub-themes to reveal:

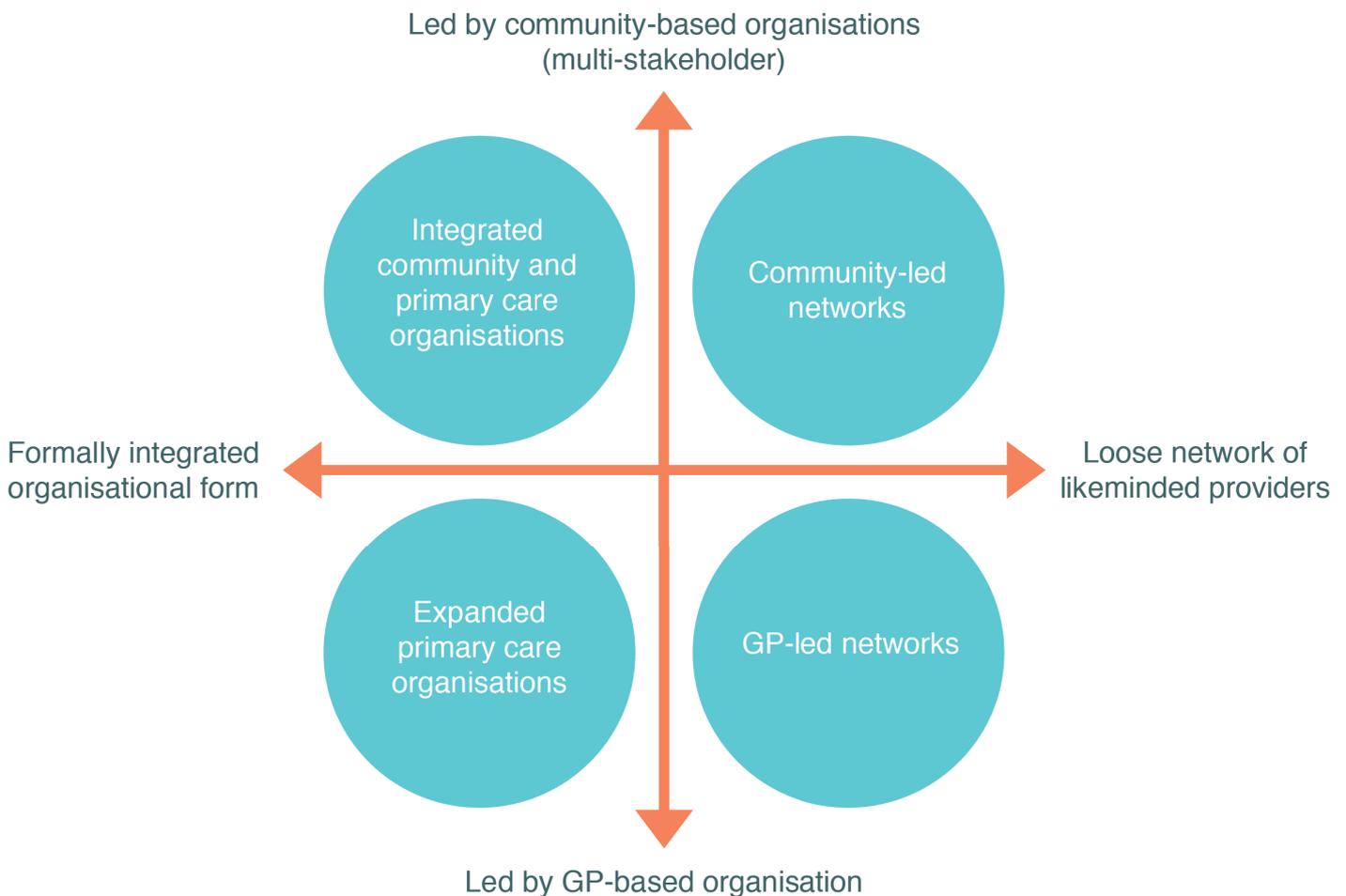
- i. A framework for excellent community services, which revealed four meta-themes around the design and delivery of excellent community services:
 - Care is about me,
 - Make London healthier and happier,
 - Working as one team, and
 - Happy staff with the right skills.
- ii. High-level insights regarding the broad vision of MCPs, and
- iii. Common sub-themes – the likely guiding features for the development and commissioning of future MCPs.

RESULTS

HIGH-LEVEL INSIGHTS

Form vs Function?

One of the key high-level conclusions regarding MCPs that our data reveals, is that there is no one generic form that MCPs should take, however, there is a great deal of alignment on the function of MCPs. Four preferences regarding their form were identified (see below):



RESULTS

There is, however, a great deal of alignment between those who provide health care services on the function of this new care model, which is good news, as the data reveals that service users do not care which form they deal with, as long as their MCP conforms to the framework that has emerged in our work regarding excellent community based care.

This form vs function insight leads us to conclude that there is no right way to construct the MCP model:

- i. the design and implementation of this model should be driven by local needs and resources,
- ii. professionals need to acknowledge that the conversation to date about MCPs has been too narrowly focused on a predominantly GP-led model,
- iii. leaders seeking to provide and/or commission these new models of care must engage in meaningful conversation regarding the full spectrum of methods of implementation.

Will pure MCPs really exist?

Another key insight was that the boundaries of services can be (and often ought to be according to service users) so blurred that the distinction between the new care models proposed in the Five Year Forward View (NHS England 2014) is likely to be a false one. Whilst we will see the rise of 'pure' MCPs, in greater likelihood many of the organisations and health economies across London will seek to develop hybrid models.

Will underinvestment hold MCPs back?

There is a general acknowledgement within the data that underinvestment in community services in the last 5-10 years, has had a knock on impact on demand in secondary and primary care. MCPs are being seen as a viable way to deliver the promise of transformed community services, yet there is also a natural cynicism in professional quarters about whether past underinvestment will hold back the development of this model.

Are we ready for the necessary cultural shift?

Again, there is agreement that the cultural shift needed around delegation of responsibility for service leadership and service delivery will be difficult to manage.

How will MCPs be funded?

The general assumption is that MCPs will be funded through capitated contracts. There is little talk of more innovative approaches, such as payment by results, which may eventually be favoured by local Health and Wellbeing Boards.

25 GUIDING FEATURES FOR THE DEVELOPMENT AND COMMISSIONING OF FUTURE MCPS

A

CARE IS ABOUT ME

Me and my fellow Londoners are at the heart of care. Everything is planned and delivered around our needs

1

CO-PRODUCTION AND PERSONALISATION

All MCPs should work to ensure that organisational outcomes are based upon people's personal objectives. This will involve co-production with the community that use services to make sure they are designed and delivered around what people really want and need. As part of this MCPs should work towards allowing money to follow the needs of people, this can be achieved by shared resources and investment, across health and care partnerships.

2

SIMPLIFIED ACCESS

MCPs should become the single point of access for people creating a hub for the services available in a particular area; this will help to simplify accessing healthcare. There will need to be strong communication with patients around what is available and which services to use for different situations/problems.

3

CARE PLANNING IN PARTNERSHIP

All parts of MCPs should revolve around robust care planning, initially focusing efforts on those with the most complex needs. Care plans should be created together with service users and a known care team; they need to support self-management and joint decision making. The involvement of families, carers and other members of a person's network in this process will be crucial as it will enable them to offer support, helping people to achieve their goals.

4

HOLISTIC APPROACH

MCPs are ideally placed to offer a more holistic approach to healthcare, to achieve this they will need to integrate physical and mental health services and place more emphasis on the wider determinants of wellbeing.

5

TIMELY AND CONVENIENT SERVICES

MCPs need to be able to offer more timely and convenient services for people by offering expert care close to the communities in which people live and work. This should be enhanced by the use of technology to make access easier (this includes making full use of telehealth and telemedicine). Offering the right care at the right time in the right place will help to shorten the service user's journey. Working with out of hours services will also be a priority for creating a more seamless service.

B

MAKE LONDON HEALTHIER AND HAPPIER

Londoners lead healthier and happier lives, with less time spent in hospitals

6 PREVENTION

MCPs, with their concentration around practice lists, have a crucial role to play in prevention and early intervention; this will enable services to be targeted at those who need them most – risk stratification and population segmentation, will be useful tools for active case finding. MCPs should support the prevention agenda at the earliest intervention – with visits to new mothers and improved education in schools.

7 SHARED OUTCOMES

The different organisations and professions within the MCP will need to agree shared outcomes. These outcomes must be meaningful to people and look at mental and physical health equally as well as the wider determinants of health and wellbeing. To help deliver this there will need to be pooled budgets and resources, risk sharing and joint responsibility for delivering the agreed outcomes. The different organisations working in partnership within the MCP will need to be incentivised to deliver these outcomes in the same way.

8 INVESTMENT AND RESOURCES

To achieve results MCPs, in some areas, will need investment in resourcing and infrastructure in the community, allowing for the delivery of more specialised services in community settings. For this to be successfully realised MCPs should operate around contracts with realistic timeframes allowing time for the outcomes of investment to be realised and progress to be sustainable.

9 SPECIALIST CARE IN THE COMMUNITY

A key feature of the MCP model is the provision of specialist care in the community. MCPs need to coordinate specialist input into delivery and coordination of out of hospital care, this will help to shift care from acute to community and primary care settings, thereby reducing hospital admissions and improving early discharge.

10 GETTING INVOLVED WITH RESEARCH

MCPs should become more involved with research, the use of data and analytics can identify key areas for intervention/improvement. MCPs have the potential to become pioneers in the area of population health management

C

WORKING AS ONE TEAM

Everyone involved in my care, regardless of which organisation they are part of, works as one team.

11

ORGANISATIONAL STRUCTURE

There needs to be acknowledgment that there is no one size fits all approach to creating an MCP – the structure and configuration of the model will come down to local capability and need. There needs to be a focus on putting people at the centre rather than debate over various organisational structures. Clarity needs to be provided for staff and work needs to be done to make sure this is not perceived as another top down reorganisation.

12

INTEGRATING SERVICES

MCPs present an opportunity to combine primary care services with wider community based services, preventative care, mental health, social care, other local authority workers, learning disability services, care home provision, urgent care, pharmacy services and voluntary / private sector services. MCPs will need to place additional focus on when patients transition between services e.g. when moving from children's to adult services. MCPs also need to build links to other services in their area, such as those provided by acute trusts and those provided at a county or borough level. There is a real opportunity here for everyone to gain clarity over the other services available in their area and beyond, providing a more seamless service.

13

AGREEMENT ON PARTNERSHIP WORKING

For MCPs to succeed there will need to be shared understanding on how partnership working will operate – this will be achieved by robust partnership agreements or MOUs between all those involved. This will involve all providers sitting together and agreeing common goals and ways of working. There is a particular need to get GPs on board with the MCP model, and work will need to be done to both reconcile the different business mind-sets of GPs and community services and develop and build successful working relationships.

14

WORKING WITH THE WIDER COMMUNITY

MCPs should work much more closely with voluntary sector, community organisations and other areas of civil society e.g housing. They need to be part of supporting a community wide vision for a healthier future. By looking at the assets available within the community MCPs are able to empower people and involve local communities, signposting people towards services that are able to support their broader health and wellbeing.

15**SUPPORTING COLLABORATION & COMMUNICATION**

MCPs need to support closer collaboration and communication between different organisations. This will be achieved by working with primary, secondary and community services to create shared interoperable IT systems, allowing for a more seamless transfer of information between acute services, the community and other providers. This system should also enable people to access their own records and plans. Collaborative working will need to be further supported by co-locating teams and providing joint training – this will help to build relationships between different professions and organisations and also support skill and knowledge sharing.

16**WORKING WITH ACUTE CARE**

MCPs need to ensure that care provided in the community is integrated with that provided in specialist settings by simplifying organisational boundaries and creating standard care pathways across organisations. There will also need to be closer working with acute specialists to assist with the development of planned care community interventions for specific groups eg. MSK, gynaecology, dementia etc.

17**JOINT COMMISSIONING**

Joint commissioning arrangements will help to support collaborative working MCPs need to work with CCGs and NHS England to develop contracts and funding mechanisms that support collaboration, examples being, alliance contracts and integrated budgets with shared outcomes and risks.

D**HAPPY STAFF WITH THE RIGHT SKILLS**

The people who care for me, and their leaders are inspired, motivated and skilled

18**STAFF ENGAGEMENT**

MCPs must consult with staff of all professions on the future direction of their organisation/partnership, this will alleviate the sense of uncertainty, by taking everyone on a journey and embedding the importance of staff engagement from the outset. This process should start with the co-creation of the vision, values and plans of the MCP organisation or partnership.

19**UNDERSTANDING EVERYONE'S ROLE**

To encourage successful integrated working MCPs should provide joint training (encompassing both physical and mental health), with shadowing of other professions and roles. This will improve everyone's understanding of the other roles and capabilities within the community workforce.

20

TRAINING AND DEVELOPMENT

MCPs need to prioritise training and ongoing support and development for all staff, including care staff and healthcare assistants, with protected time available for development. Skills development should be based both around professional development and the needs of service users. This will ensure we have competent staff who are able to focus on the people's real needs and deliver care with compassion – values based recruitment is an approach that can support this.

21

GOVERNANCE STRUCTURE

There will need to be shared agreement between different organisations on governance structures with devolved governance being a possible option in some instances. The governance arrangements of MCPs should also ensure that all staff groups are represented, with the leadership/board reflecting the diversity of the community based workforce.

22

RECOGNISING THE SKILLS AVAILABLE

MCPs need to better utilise and develop the skills of staff already working in the community, for example the prescribing rights of AHPs and others, using the skills and talents they have to best effect. MCPs must recognise the importance of the role of generalists in the community, as well as the role of AHPs, maximising their skills and supporting staff to work at the limits of their practice, by taking on a broader range of tasks/treatments.

23

LEADERSHIP

Leadership of MCPs should not be based on job role but who is best to lead – leaders need to live the values of their organisation and give their staff the confidence and freedom to do their jobs effectively. They need to have a vision and work to address organisational and team divides, facilitating the sharing of skills and knowledge across teams and organisations. There will need to be investment in training and support to ensure the availability of the right leadership skills in the community.

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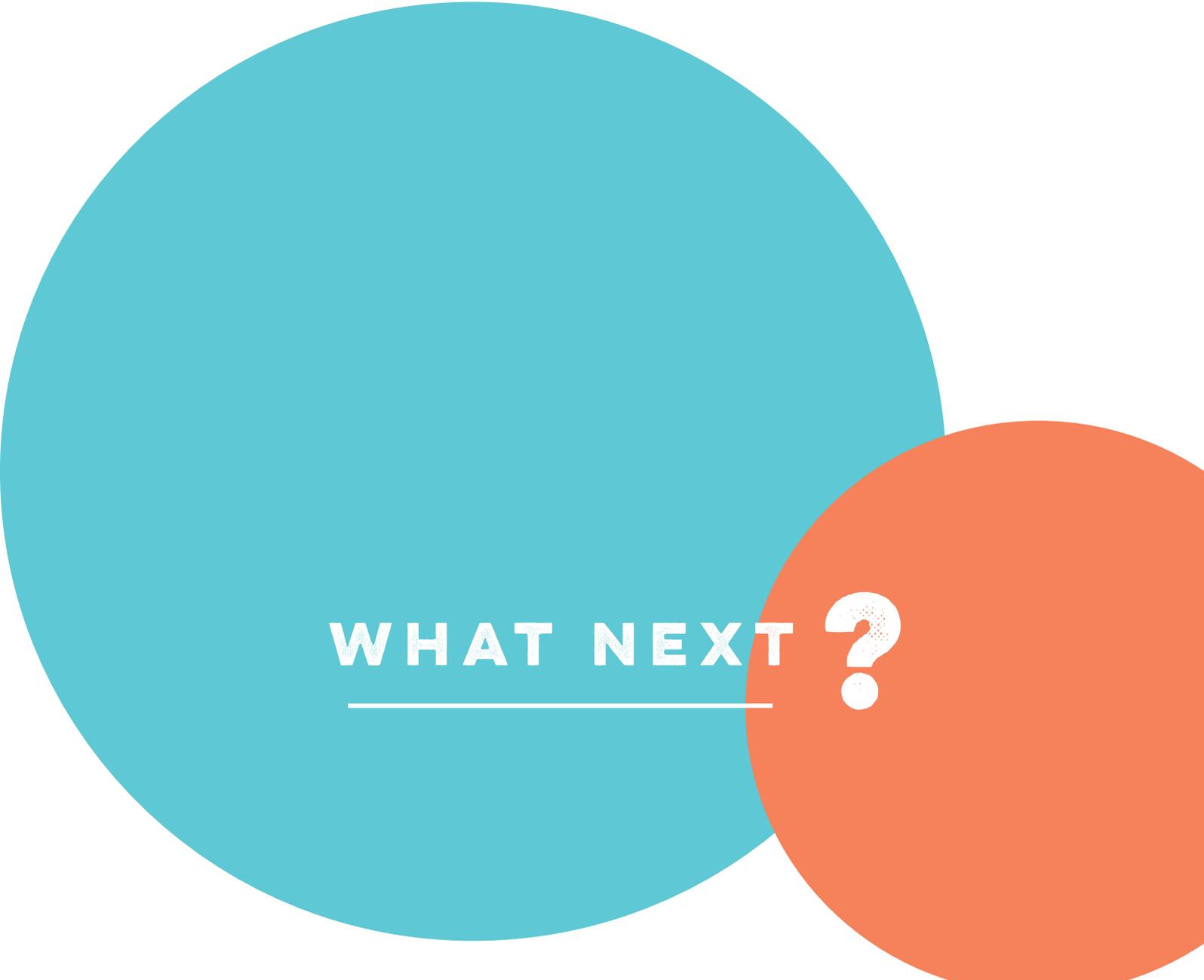
SHARING KNOWLEDGE AND RAISING THE PROFILE OF THE COMMUNITY

MCPs need to take a key role in developing and sharing best practice in community healthcare. There is a real opportunity for the model to raise the profile of community based services – by sharing knowledge and learning through both formal and informal channels. This will also help to attract talented staff.

25

PLANNING FOR THE FUTURE

MCPs need to work with other organisations to plan for future workforce needs – ensuring there are enough people with the right skills for integrated working, ultimately allowing staff to spend more time with patients. MCPs will need to work with other agencies to plan for the loss of senior staff, create an analysis of skills required for the future and work closely with educational providers to achieve this, by hosting more community based training placements.



WHAT NEXT?

We suggest that next step for our sector is to take this report together with the conclusions reached by others, and to work collaboratively to build a shared consensus across primary and community on the future shape of MCPs.

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