STP aide-mémoire: New Care Models

Gateway no. 05294

1. Introduction

New care models are at the heart of the *Forward View's* triple aim: to improve the health of populations; to improve care patients receive and their experience of it; while delivering the best value possible for taxpayers. The strongest Sustainability and Transformation Plans (STPs) will be a blueprint for how areas expect to develop and spread new care models, making the greatest possible use of technology and a reshaped workforce.

2. Success in 2020

i. **Population health models – MCPs and / or PACS – will have spread across STP areas, providing a much greater proportion of care out-of-hospital**

- Existing vanguards serve an expanded population, partnering with additional primary care and community services (MCPs) and in some cases acute hospitals (PACS).
- Strong relationships with primary care and community services led to the formation of new MCPs / PACS; taking explicit responsibility for a population's health and in time a whole population budget, based on the GP registered list.
- These models deliver much greater integration between primary and acute care; physical and mental health, and health and social care; delivering tangible and quantifiable results in for example, reducing bed-days, emergency admissions and costs per capita, while maintaining or improving the quality of reported patient experience.

ii. **Care homes will be connected to the health and care system, reducing unnecessary hospital admission**

- People who need, or are at risk of needing care delivered in a care home are actively identified; maintaining their health and independence.
- These people will be proactively managed by integrated health and care teams, and their care is jointly commissioned by the NHS and local government.

iii. **Acute Care Collaborations – hospital groups, franchises or networks – will deliver greater standardisation and better quality hospital care**

- Acute clinicians and providers in collaboration provide hospital services across STP areas; and / or across other parts of the country.
- Providers and clinical teams share assets and workforce, helping to deliver aggregate cost reductions across the STP area.
- Collaborations begin standardising how they provide services, reducing unwarranted variation in quality and cost of care.

iv. **Action on the underpinning enablers, especially technology and workforce**

- New care models harness digital technology, including fully integrated datasets, supplying real time business intelligence with predictive analytics.
- Expansion of online services and service redesign making the most of mobile technologies, wearables and apps.
- Care delivery is by multi-disciplinary teams with redesigned jobs that are more rewarding, sustainable and efficient. New roles such as health coaches, physician assistants and care navigators, pharmacists employed in community hubs or primary care, and community paramedics are widespread.

3. How are we going to get there?

Accelerate progress and expand coverage of existing vanguards

- Improve the underlying health and life chances of people and tackle inequalities. For example, the NHS working with other public services like the police or fire service, as well as voluntary groups, to maintain the independence of older people or reach marginalised groups. This way all services have a responsibility to moderate demand for high-intensity care.
- MCPs and PACS support people to manage their own health and care, by working with local authority and voluntary partners, to develop self-management resources, peer-to-peer support and carers' networks.
- Analyse and segment the population to deliver highly intense, personal and preventative care for small, changing cohorts of patients with the very highest needs and costs, e.g. frail elderly patients, marginalised populations, people in care homes. MCPs / PACS join up physical and mental health care for patients, starting with high-need groups such as people with severe and enduring mental illness and older people living with dementia.
- MCPs / PACS should integrate with a local urgent and emergency care network that joins up and streamlines 111, GP in- and out-of-hours, GP extended hours, minor injury units, walk-in centres, community pharmacies, and A&E into a coherent pathway of care. Care homes should also be wired into this system, with their own 'express' pathway.
- In the next few years, MCPS / PACS should be ready to adopt a new bundled contract and a whole population budget. To do so they will need to adopt a new organisational and legal form, with revised decision rights, capable of bearing risk.
- Acute Care Collaborations are focused on initial decisions about how to collaborate and across which services and / or back-office functions. By 2020, they need to have developed clinical standards, prompted by technology, that drive out avoidable variations in quality and cost per patient. They should also seek to share assets and workforce.
- All new care models require new working practices. This is particularly true of MCPs / PACS, which must build integrated multidisciplinary teams that co-ordinate care for high-need patients, employing new roles such as 'extensivists' (a GP or a geriatrician employed to work exclusively with frail older people who are at high-risk), care navigators, and pharmacists based in community or primary care. Primary care will need to replace the traditional one-size-fits-all "10 minute face-to-face practice consultation, followed by outpatient referral or prescription" approach with a more differentiated one, focused on the highest need groups.
- All new care models should measure their impact (prevention, quality, and efficiency, and modify or adapt working practices when they aren't working; investing in results that show impact.
- The STP process should catalyse discussions between existing vanguards and other providers, extending population coverage across the STP area and replicating learning. Identify a deliverable expansion plan, in line with national planning assumptions, that ~50-60% of the population will be served by a whole population model by 2020/21. All care home residents should benefit from enhanced services by the end of the decade.

Catalyse the next generation of vanguards

Not all parts of the STP area will be ready to move at the same pace on new care model development from 2017/18. As voluntary models, new care models depend on the enthusiasm of patients, clinicians, and other professionals who will make them a reality.

As STP leaders consider how to stimulate the next generation of vanguards, lessons from the first wave may be helpful:

- New care models only get off the ground if they are based on strong and trusting local relationships and by engaging people in the pursuit of the triple aim. A strong partnership with primary care is crucial for both MCPs and PACS (as both are founded upon list-based general practice). In many areas, models have developed from GP federations. Acute Care Collaborations are similarly built on existing clinical relationships and patient flows.
- MCPs and PACS have much in common: they are two UK-specific versions of integrated and accountable care organisations; they have the same focus on population health management and their care delivery models will look very similar. The key difference between an MCP and a PACS is the scope of services. Under the MCP model, the provider does not take on the direct running of most core acute services, although it may take on some services traditionally provided in hospitals that don't need to be; for example, diagnostics and some outpatient services. PACS embrace all core acute services, integrating them with primary and community services. PACS reflect the 'DGH footprint' of the NHS trust or Foundation Trust whereas MCPs typically operate at a minimum 30,000-50,000 population scale, and up to 150,000-300,000. The choice between these two models is fundamentally is driven by the local context and, crucially, the strength of relationships between primary and acute care providers.
- The PACS model will not be appropriate for many tertiary providers. Instead, they may become part of an at-scale acute provider; part of a hospital group or chain; or franchise their best services elsewhere. These models give a strategic choice to focus on achieving scale benefits, both quality and cost, from different forms of acute collaborations.
- Connecting care homes to the health and care system brings rapid results. It does not require new organisational forms or complex rewiring of payments and contracts. It is about new ways of working between local government, primary care and community services. We would expect each STP area to make a sustained effort to improve services offered to care home residents; preventing unnecessary hospital admissions from them.
- New care models always take several years from conception through to full maturity. They require disciplined implementation and sustained attention, including: (i) collaborative leadership and engagement; (ii) an engine room to drive change; (iii) clear governance; (iv) an explicit logic model, connecting objectives to specific actions, outputs and outcomes; (v) a compelling value proposition (vi) well-designed and defined components parts of the care model; (vii) careful sequencing and scheduling of implementation; (viii) timely monitoring and evaluation; and (ix) rapid cycles of learning and adaptation.