Dudley Vanguard
Conference
The journey towards our model of care

16 February 2017
MCP underlying principles

Shared Ownership
- Public accountability
- Every person registered with a GP is a member
- Mutual interest

Shared Responsibility
- Between patients and staff
- ‘Teams without walls’ taking a shared responsibility

Shared Benefits
- Achieving defined outcomes for both individuals and for communities
- Benefits are shared between stakeholders
MCP achieving maximum value

Individual
• Maximise the potential for the individual to improve their health and wellbeing

Staff
• Maximise the potential for staff to improve their effectiveness in caring for those individuals

Collective
• Maximise the potential for staff and patients to improve their effectiveness collectively in working with each other
MCP care model

Extended practice multi-disciplinary teams

Person
Social Network
Community

Shared Outcomes

Specialist and OOH population care

Extended Primary Care

Assessment & Treatment Unit

Clinical SPA (telephone triage)

OOH Community Response

Community Rehab

Multi-Disciplinary Teams
MCP outcome measures

Access and population health

- Reduce all waits
- Reduce inequality in life expectancy
- Improve prevention & risk reduction
- Improve calls, visits, diagnostics, & treatment response
- Same day (<5 yrs)
- Lifestyle factors

Continuity

- Appropriate Diagnosis and Long Term Condition Management
- Evidence-based outcomes framework

Coordination

- Care plan constructed with all relevant parties, co-produced with the individual
- Reduced avoidable admissions, DTOCs, and social isolation. Improved independent living and employment

Quality & Safety

- Minimise harm (reduce number of incident per person / per practitioner); safer prescribing; reduced ACSC admissions

Patient Benefits

- Improve patient experience / patient outcomes – as reported by them

Staff Benefits

- Improve staff efficiency, morale, patient contact time
Dudley MCP Outcomes Framework

Population Health
- Increase Healthy Life Expectancy
- Reduce Inequality in Healthy Life Expectancy
- Improve Health Related Behaviours
- Improve Prevention and Risk Reduction

Access, Continuity and Coordination
- Improve Access to Services
- Improvement in Patient Reported Outcomes
- Improvement in Patient Reported Experience
- Improve Screening, Case Finding, Monitoring and Management

Empowering People and Communities
- Improve Levels of Health Literacy
- Reduce Social Isolation
- Increase Employment for those with a Mental Health or Learning Disability
- Improve Housing and Independence for those with a Mental Health or Learning Disability

System and Staff
- Staff Recruitment, Retention and Motivation
- Safety and Quality Improvement
Possible Organisational Form

(Other organisational forms are available)

CCG

Single Contract

FT(s) &/or Private partner

MCP
Joint Venture

Sub-contractor
Sub-contractor
Sub-contractor

Integration Agreement

GP
GP
GP
GP
Asset approach to the MCP

**Culture**
- Values based
- Employer of choice
- New partnerships with public & private

**Workforce**
- Empowerment model
- Teams without walls
- Integrated planning & development

**Technology**
- Single IT system
- Disruptive technology
- Standardisation of work flow processes and communication

**Social**
- Public participation
- Voluntary Sector
- Social networks, health & wellbeing

**Information**
- Self-Improving system
- Patient reporting
- Outcome driven and evidence based

**Estate**
- Community asset
- Local ownership
- Enabler to more efficient delivery

**Leadership**
- Creates vision / belief
- Creates environment
- Focus on unblocking barriers to change

**Governance**
- Financial responsibility
- Public accountability
- Confidence in capability of system

**Population**
- Connects to public
- Aligns to public health
- Central to the design of the model of care
Evaluation of the Dudley New Care Model Programme: Findings from Year 1

Fraser Battye
Strategy Unit
This presentation is in three short parts, makes three main points and ends by asking you one big question

**Part**

1: **Introduction:**
programme and evaluation

2: **Findings:**
Programme, LTC Framework, MDTs

3: **Reflections:**
Evaluation, Dudley, next steps

**Point**

Highly complex programme, needed particular approach to evaluation

We have early findings and are starting to use them

We see strong potential for the use of evaluative evidence...so:

**Question:** how to maximise value of research / evaluation in context of an MCP?
1: Introduction: programme and evaluation
It’s useful to start with the logic of the NCM programme

- Defines problems, outlines models
- Sets models in train, with expectation of wider adoption

Suggests that evaluation must focus on learning: what is working / not, why, and what should be done next?
Vanguards are fast-moving, live experiments with defined ends, but evolving and multiple means.

Evaluation methodology prefers something a little neater and more fixed!

National direction

Augmented local services

Established local services

Ideas from elsewhere

Better population health
Improved experiences of care
Financially and clinically sustainable system
So we have set Dudley’s evaluation up to be highly applied and to operate at multiple levels.

Gives us the ability to go into detail and step back to consider strategic implications.

Workstream specific, but mixed-method involving patients, staff, surveys, etc.

Interviews with strategic stakeholders; overall system metrics

Synthesis on specific cross-cutting topics
2: Findings: Programme, LTC Framework, MDTs
Dudley’s ‘Early Findings Report’ showed just how difficult change at this scale is

• Semi-structured interviews with senior stakeholders – last summer

• Clear – and shared – rationale for change / perils of ‘Do Nothing’

• Broadly shared support for MCP as a means for change

• Varying rationales as to why this would be so, but: integrate services into single long-term contract; give to single organisation; removes perverse incentives and increases helpful ones; changes model of care; changes outcomes

• Putting this into practice: raised tensions and tested relationships...this is hard work, technically and socially

• Helped to show need to focus on primary care on way into procurement

Report available online
The LTC Framework evaluation has (literally) just reported

- Highly mixed-method (interviews / observations / surveys / data / care plan analysis (etc.)) look at Dudley’s ‘new QOF’
- Showed significant efforts of designing and piloting. CCG support also invaluable in training and rolling out
- Framework well understood in practices; implemented to different degrees: some restructured LTC care / clinics (e.g. multi-condition clinics); others no change
- Evidence of changes in skill mix
- Broad sense of increases in personalised care and improved experience – this, backed by better care planning, the area for development

Workshop this afternoon
We also found high variation in performance between practices.
The MDT evaluation is in press!

Again, highly mixed-method look at operation and impact of MDTs in primary care targeting ‘top 2%’

Benefits for staff:

- More efficient working / reduced duplication
- Improved knowledge of overall care / better communication
- Increased knowledge of social prescribing services - Integrated Plus (IP)
- Improved job satisfaction, particularly for community nursing roles

And for patients:

Better coordination of care:

“They bring everything together so all the different parts of the health [system] come together so everyone knows what my state of health is”

And gains in quality of life:

“I was isolated before, apart from the carers I didn’t see anybody…but I’ve made friends now and have the confidence to go [to the] library... and arts and crafts”
We found no effect on non-elective ACS admissions...

...but did find an effect on length of stay.
3: Reflections:
Evaluation, Dudley, next steps
Getting the ‘who and how’ of evaluation delivery right has been fundamental

High-grade NHS-based analytics…

...plus consultancy ability to do...

...plus academic rigour

As has Dudley’s open and non-defensive stance...in the face of strong contrary incentives
But we’ve got grander ambitions – and are open to your suggestions as to how we might realise them

MCPs will want / have the opportunity to move up this scale...

...which means changing the use of evaluative evidence

Self-improving systems of care

Internally demanded (evidence for improvement)

Organisations that react to problems

Externally imposed (performance management)

So, practically, how might this be further encouraged?
Questions