BMA

Models for delivering care

Introduction

This series of briefings has been designed to help members understand the different provider models that are being considered as part of the future structure of the NHS, particularly in England.

Providers of acute, community and primary care tend to operate separately at present. But increasing emphasis on new, integrated models of care across the sectors, and greater networking within sectors, has the potential to change the provider landscape over time. Be informed.

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Integrated provider models

What models are being developed for integrated care?

The NHS vision 'the five year forward view' describes a number of new care models for the NHS in England that aim to break down the traditional divides between primary, secondary and community care, mental health and possibly social care.[1]

Multispecialty community providers

The 'multispecialty community provider' (MCP) model is based on groupings of GP practices, such as GP federations or networks. MCPs will offer a wide range of community-based care by shifting outpatient and ambulatory care out of hospital settings, and/or run local community hospitals. They may take on as partners, or employ, other health and social/care professionals, including doctors and other clinicians from secondary care. Over time MCPs may take on a delegated, capitated budget for their registered list of patients. They might also eventually become an integrated provider of out-of-hospital care. **For more information on GP federations/networks and capitated budgets, please refer to other briefings in this series, found in the 'Doctors in the NHS' section of the BMA website.**

Primary and acute care systems

The 'primary and acute care system' (PACS) model will provide NHS list-based GP and hospital services along with mental health and community care services. Either hospitals will be allowed to open or run GP practices, or a well-functioning MCP could run its main district hospital. As with MCPs, the intention is that the PACS model will reinforce out-of-hospital care and over time, may take on a delegated, capitated budget for their registered list of patients.

Urgent and emergency care networks

The 'urgent and emergency care network' model builds upon the vision set out as part of the 'urgent and emergency care review' originally published in December 2013.[2] This model will seek to improve the organisation of urgent and emergency care – including NHS 111, GP out-of-hours services, minor injuries/urgent care centres, ambulance services and A&E – making the system more efficient and easier to navigate for patients.

How are they being implemented?

The five year forward view new care models are being tested through a national programme known as 'the vanguard'. The first wave consists of 29 sites across England comprising nine PACS, 14 MCPs and six 'enhanced health in care homes' sites (another of the models proposed in the five year forward view). Being part of the vanguard gives the sites access to technical and financial support from NHS England.

However, implementation of the new models is not limited to the vanguard sites. NHS England has referred to an 'unofficial vanguard running in parallel at the same pace'[3] comprising many of the areas that were not successful in becoming part of the vanguard and other areas beyond. The tools and products developed by the vanguard will be available to everyone, in real time and support is available from the King's Fund and the Health Foundation. **For more information on the vanguard, please see the relevant section of the BMA website.**

Two further waves of the vanguard programme comprise eight urgent and emergency care network sites and 13 acute care collaboration (another of the models proposed in the five year forward view) sites. **For information on the fifth model being piloted, 'acute care collaboration' (originally the 'smaller viable hospitals' model), please see the 'secondary care models' briefing in this series, found in the 'Doctors in the NHS' section of the BMA website.**

For a list of and more information on the vanguard sites **visit the NHS England website**.

NHS England has set out four key principles that should underpin the vanguard programme: (1) clinical engagement; (2) patient involvement; (3) local ownership; and (4) national support.[4]

What are the Pros?

Encouraging and enabling different NHS providers to work together, collaboratively around the needs of patients should help deliver more joined-up services and thereby solve many of the problems faced by patients in their everyday interactions with the NHS. The proposed models represent a greater emphasis on integration in NHS policy than has been seen in recent years, which is to be welcomed.

There is a widespread assumption that shifting care from hospital to community settings will save money, although the available evidence suggests that this may not be the case. The evidence of the impact on costs in the NHS of shifting care away from acute settings is limited; in very specific contexts, it has been found to be cost-effective, but more robust and transferable evidence is required.

Multispecialty community providers

Overall the evidence available suggests that community-based care improves patient access while maintaining a level of quality that is equivalent with services offered in acute settings.[5] The evidence also suggests that managed care programmes, emphasising preventative healthcare and home treatment, as would likely be found in mature MCPs, would improve quality for patients with long term conditions.[6] In addition, patient experience is also likely to improve if more services are available in primary and community care settings.

Primary and acute care systems

A mature PACS model shares many features with an accountable care organisation (ACO), a provider model that serves an estimated 20 million people in the United States. There is robust evidence associating ACOs with delivery of equivalent or improved quality and reduced costs.[7] PACS therefore have the potential to reduce unnecessary hospital admissions and increase the number of patients seen closer to home.

Urgent and emergency care networks

Urgent and Emergency Care networks have the potential to simplify the options for patients who need unscheduled care, improve demand management and increase integration between different providers. The evidence base suggests that the existing approach in the NHS to telephone triage is leading to more emergency admissions than necessary and the approach outlined in the urgent and emergency care network model may improve this situation.[8'9]

What are the Cons?

If structural integration – where separate organisations merge to form a new organisation – becomes the main focus of these new models this will be insufficient to achieve better coordination and integration of services. Cultural, relational and behavioural change will have the most impact, but is very difficult to achieve.[10] Furthermore, the available evidence does not support any one organisational form over another in terms of performance in the NHS.[11] Too much emphasis on structural integration, and organisational form, is not guaranteed to result in more joined-up services for patients.

As the approach to the new care models in the five year forward view is very much bottom up, there is a danger that the wider local-health-economy or population-health perspective will be lost while various new models emerge. There is also the potential for confusion among patients and the public as new models emerge and before they become well established in an area.

MCPs and PACS in particular may struggle to reach their full potential given the existing regulatory and financial backdrop in the NHS in England. This includes requirements around procurement/competition and patient choice as well as the main payment and contractual mechanisms, the national tariff ('payment by results') and the NHS standard contract. In addition, another five years of flat-rate growth in NHS funding is expected over the course of this Parliament. This combined with increasing numbers of hospitals and other acute trusts being in deficit creates a very difficult environment, which may hinder (or help) the NHS from embracing significant, provider reform. **For more information on the national tariff and contracting for integrated care, please refer to other briefings in this series, found in the 'Doctors in the NHS' section of the BMA website.**

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Colocation of clinicians of different kinds is likely to be necessary but not sufficient for effective integration to be delivered.[12] Clinicians working in an MCP, while potentially benefitting from shared incentives, would still need to transcend the cultural professional barriers that may play a large role in hindering effective integration.

There is a possibility that the MCP model might prove divisive for the profession and local health economy if it is perceived to be purely 'primary care led' rather than the product of genuine cross-sector collaboration. This may be particularly acute where MCP developments have the potential to destabilise neighbouring services or providers.

Primary and Acute Care Systems

As with the MCP model, it is possible that the consolidation of services into a mature PACS could have a negative impact on the sustainability of neighbouring providers. While some disruption and destabilisation is inevitable as new integrated provider models emerge, this should be carefully planned and monitored by commissioners and providers to ensure that there are no major unintended consequences for doctors, other NHS staff and patients alike.

There is also a possibility that the PACS model might prove divisive for the profession and local health economy if it is perceived to be purely 'secondary care led' rather than the product of genuine cross-sector collaboration. This may be particularly acute where there is a threat, perceived or real, to GPs' clinical autonomy and the traditional gatekeeper role that at present is maintained through the independent contractor model of general practice.

Urgent and Emergency Care Networks

The available evidence suggests that the impact of NHS walk-in centres and nurse led minor injury units on reducing hospital admissions is limited.[13] The current progress toward developing Urgent and Emergency Care Networks is patchy, and the promised guidance from NHS England on network formation, function and objectives is urgently required to give greater definition to a complex set of relationships.

What are the implications for doctors?

At present, the scale of change that we will see across the country as a result of the five year forward view is unknown. And this will almost certainly vary from area to area, as well as depend upon the specific model or arrangements that are put in place.

With these variables in mind, the implications for doctors will range from having to adopt new ways of working with other providers/organisations, to a shift in where you see and treat your patients (ie hospital vs. community facilities), to a change in which organisation employs you. In addition, there may be more leadership and management opportunities available to doctors who are interested in taking them up.

What's the BMA policy on the new models?

The BMA has been calling for greater integration and collaboration between different parts of the health service, health and social care, as well as more integrated working across the medical profession and other clinicians for a number of years.

Following debate at the 2015 ARM (annual representative meeting) our policy on how the new care models should develop is based on five principles. There should be full consultation with the relevant stakeholders in primary and secondary care. Plans should be clinically-led. The models should ensure collaboration between the different sectors, not domination of one sector over another. Inter-organisational partnerships should be forged, rather than mergers. And the new models should focus on delivering services in an area, rather than compete with other providers outside their locality. Read the **chair of council's blog** to find out more.

Further reading/references

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11 Bramwell (2014). *Moving Services out of hospital: Joining up General Practise and community services?* London School of Hygiene and Tropical Research, University of Manchester and the Centre for Health Services Studies at the University of Kent.
12 *Ibid.*
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