System-level mechanisms and contexts for health and social care coordination through Multi-Specialty Community Providers in England: A Realist evidence synthesis

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Overview

Policy Background (NHS England)

Research Objectives

Stage 1 – elicit policy-maker assumptions

Stage 2 – realist review of evidence

Stage 3 – critical analysis – compare 1 & 2

Next Steps
Background

NHS policy – the problem

- Repeated unplanned admissions of people with multiple morbidity make disproportionately heavy use of hospital bed-days
- A substantial number of these admissions are preventable
- Reducing these admissions would substantially reduce cost and access pressures on hospital services
Background

NHS policy – the answer

• Multi-Specialty Community Providers will ‘integrate' (better-coordinate) care
• This will reduce admissions by partly replacing hospital care with non-hospital care
• This will raise the quality and reduce the cost of care

But limited detail

• How?
• For whom?
• Under which circumstances?
• In what way?
Research Objectives

1. Identify main empirical strengths and weaknesses in policy makers’ assumptions about what MCPs will do and how
   - Identify where existing evidence is weak or lacking

2. Elaborate, qualify and revise policy makers’ assumptions using evidence
   - Build contextualised understanding of system-level mechanisms in MCPs and develop new ‘logic models’ of MCPs
   - Inform policy and practice during roll-out of MCPs
What we did (are doing/will do)

Stage 1: Elicit policy assumptions

Stage 2: Realist evidence synthesis

Stage 3: Critical Analysis – compare policy assumptions with synthesised evidence

Elaborated, qualified, revised MCP logic models

Inform implementation of MCP model of care coordination/integration in England
Stage 1

Think tanks: NHS policy makers & managers, third sector managers, patients

Elicit policy assumptions

Existing MCP logic models

Key policy documents about MCPs
Stage 1

Policy-makers assumptions

• Complex
• Incompletely articulated
• Lacking in contextual information

Therefore

• Findings depend upon our interpretation of what policy makers specifically intended
• Focused review on most central assumptions
Stage 1: Most central assumptions

- **Inter-organisational network management**
  - produces 1. care coordination; 2. multi-disciplinary team working

- **Multi-disciplinary team working**
  - produces 1. organisational-level care planning; 2. preventive care

- **Culture change**
  - produces 1. multi-disciplinary team working; 2. demand management; 3. preventive care

- **Third sector involvement**
  - produces 1. demand management; 2. preventive care

- **Informational continuity of care**
  - produces 1. diversion at the patient level; 2. care planning at the patient level; care coordination is produced by informational continuity of care

- **Care planning at organisational level**
  - 1. produces patient diversion; 2. care planning at patient level; 3. demand management

- **Demand Management**
  - produces 1. patient diversion; 2. care planning at patient level; 3. preventive care, and vice-versa

- **Preventive care**
  - produces 1. patient diversion

- **Care planning at patient level**
  - 1. produces patient diversion; 2. improves patient experience

- **Patient Diversion**
  - 1. reduces costs; 2. improves patient experience
Stage 2 Realist Review: Screening

- MCP-like model of care (list)
- In last three years
- OECD countries
- Major relevance to horizontal inter-organisational linkages in primary care
Stage 2 Realist Review: extraction

- Study design
- Extract data from sources
- Evidence about initial policy maker assumptions from Stage 1
- MMAT quality appraisal score
- MCP-like model of care
Stage 2 Realist Review

PMs’ assumptions where existing evidence is weak or lacking

- Demand management produces patient diversion, care planning at the patient level, preventive care (5/5/3 sources)
- **Third sector involvement produces demand management and preventive care (3/5 sources)**
- Preventive care produces patient diversion (2 sources)

PMs’ assumptions where existing evidence is more plentiful

- Multi-disciplinary team working produces preventive care (30 sources)
- **Informational continuity of care supports care planning at the patient level (28 sources)**
- Care planning at patient level improves patient experience (26 sources)
- Multi-disciplinary team working produces organisational-level care planning (26 sources)
- Inter-organisational network management produces care coordination (26 sources)
Stage 2 Realist Review: synthesis

Synthesise extracted programme theory related to each causal assumption

Juxtapose → Consolidate

Adjudicate → Reconcile
Stage 3 Critical Analysis

Compare policy assumptions with synthesised evidence

1. Collate synthesised evidence by policy maker assumptions of causal links (NVivo)

2. Juxtapose, adjudicate, reconcile, consolidate, and write narrative summaries for each causal assumption

3. Elaborate, qualify, revise initial policy maker model of how MCPs will integrate care to produce patient diversion and reduce costs
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https://www.journalslibrary.nihr.ac.uk/programmes/hsdr/157734/#/

http://clahrc-peninsula.nihr.ac.uk/research/from-programme-theory-to-logic-models-for-multispecialty-community-providers-a-realist-evidence-synthesis
Next steps

Evaluate any future policy application of revised MCP logic models to understand how our findings informed practice.

Liaise with policy makers about the usefulness of revised MCP logic models.

Test our findings empirically through primary research (Realist evaluation) of MCPs in practice.