Academy of Medical Royal Colleges

March 2018

Working together:

The New Care Models Programme and the Academy of Medical Royal Colleges

Contents:

Foreword

The new care models programme and the Academy of Medical Royal Colleges warmly commend this report to you – both for what it says and for what it represents.

It is the culmination of an interesting and fruitful process which brought together representatives from clinical professional bodies and NHS representatives; working on service change to honestly and openly discuss new and better ways to deliver care for the benefit of the population as a whole.

This report shows the range of ways the service and clinical professionals are already addressing these issues in what may be models for others, but also recognises the constraints and challenges in doing this successfully.

We hope you will find it interesting to read what we learned and discovered in this process.

What, however, is essential is moving forward and ensuring that the working together and the good ideas are not lost – particularly as the new care models programme itself formally comes to an end.

The new care models programme and the Academy have set out a clear proposal that there should be national support for a multi-specialty network which can continue to share information and good practice and link those with good ideas for improving care.

Whether this is simply about workforce issues or also wider service change being considered in Integrated Care Systems, we believe that through this process we can harness and develop the host of ideas for better population health that are currently being practised amongst clinicians in professional bodies and the service.

Louise Watson

Director NCM

Professor Carrie MacEwen

Chair, Academy of Medical Royal Colleges

Introduction:

This report brings together learning from nearly two year's work between the Academy of Medical Royal Colleges and the new care models programme at NHS England.

The new care models programme has been supporting the development of new care models in 50 vanguards across the country. The Academy of Royal Medical Colleges is the membership body for Royal Colleges and Faculties, and speaks on standards of care and medical education across the UK. Working together over the past two years, we have created a series of collaborative conversations between clinicians and professionals across specialisms, to explore issues of population health, workforce change, new roles and skills, new settings, the use of technology and personalised care.

These collaborative conversations have been powerful in developing ideas and spreading good practice. Since the new care models programme is coming to an end in March 2018, it seemed important to participants that the knowledge we gained is shared widely with clinicians and managers across the health and social care system.

This report is therefore an account of the conversations; and while it does not speak for any of the individual organisations, nor is it a set of formal recommendations – the hope is to share thinking so far and to set out a possible agenda for work into the future.

Part One – A shared commitment

Between January and September 2015, 50 vanguards were selected to take a lead on the development of new care models. This work was supported by the new care models programme at NHS England. The vanguards were intended to improve the care received by patients through the redesign and integration of health and care systems.

The Academy of Medical Royal Colleges and Royal Colleges and Faculties welcomed the NHS Five Year Forward View, and the launch of the new care models programme. Royal Colleges and Faculties have also been undertaking their own pilots to bring together clinicians and professionals from different institutions and backgrounds. It was clear to everyone concerned that there would be huge value in sharing the learning from all these initiatives.

Clinical engagement and leadership is essential for ensuring the success of new care models across the country. Future change and improvement will not be effective if it does not have a valued, well-supported and enabled workforce behind it.

After an initial meeting in 2016, the Academy, Royal Colleges and new care models programme decided to work together to explore the changes that were underway and the implications for clinical practice. Working together offered an opportunity to recognise the important role clinicians play in leading change and improvement within their local areas, and contributing to the development of new care models.

A joint statement between the AoMRC and the new care models programme

In January 2017 the Academy of Medical Royal Colleges and the New Care Models Programme issued a joint statement.

“The Academy of Medical Royal Colleges (the Academy), royal colleges and faculties have all previously expressed their support for the NHS Five Year Forward View and welcomed the launch of the new care models programme in 2015.

The Academy recognises the important role clinicians play in leading change and improvement within their local areas, and contributing to the development of new care models. This includes giving clinical input into the design and delivery of local sustainability and transformation plans, which are being designed to meet future health and care needs.

Whilst recognising that one model will not fit all care needs, clinical engagement and leadership are essential factors for ensuring the success of the new care models across the country. And also, that delivering change and improvement will not be effective if does not have a valued, well-supported and enabled workforce behind it.

The new care models programme fully recognises the vital role that clinicians perform in improving patient care and that in order for this to happen effectively, the workforce issues around capacity, capability and collaboration will need to be addressed.

The AoMRC is assured by the positive progress made on workforce issues by the new care models programme which aim to:

- Improve the health of all populations including their mental health needs and the needs of infants, children and young people throughout their life course
- Improve the individual experience of care
- Improve the experience for staff of providing care
- Reduce the per capita cost of care.

By involving staff in the conversation about workforce redesign across their organisational and professional boundaries, vanguards are identifying and addressing a number of issues which are helping to support employee development and retention.

The Academy, colleges and the new care models programme have committed to:

- Continuing to work together to promote and support workforce redesign which improves care and supports clinicians
- Sharing practical ideas between the new care models programme and the colleges and keeping the dialogue going can you
- Identifying workforce frustrations felt by clinicians and how these might be addressed by vanguards
- Identifying frustrations emerging from the new care models programme which the colleges might have a solution for
- Identifying perceived barriers to workforce change
- Holding a series of seminars over the next six months to explore specific issues.

Joint Professions' Statement

In October 2017 the Royal Colleges and Faculties followed this up with Joint Profession Statement:

Royal Colleges and professional organisations representing the range of clinicians across primary and secondary care have come together in the interests of the quality and standards of patient care and the professional skills and development of their members to:

- Affirm our joint commitment to the importance of multi-professional team working to deliver better outcomes for patients
- Identify key issues which need to be addressed to enable clinicians to work to their full
- potential and practice at the top of their licence to deliver the highest quality healthcare at a time when the NHS is under unprecedented financial and workload pressures
- Jointly commit to work together and with employers, educators and government to deliver real improvement in services to patients and the work experience of professional clinical staff.

The value of multi-professional work

Evidence consistently shows that multi-professional team working delivers better outcomes for patients and more effective and satisfying work for clinicians. Multi-professional work requires flexibility in attitude and behaviour and for professionals to value and respect the distinct contribution each professional makes. It does not, however, mean all professionals aspire to undertake an alternative professional role. Most clinicians value their professional identity and can be proud of contribution they make within their roles. As professional bodies, we are committed to ensuring that our members' professional identity and expertise acts to maximise the impact of the team in the delivery of patient centred care and not as a silo or barrier to good care and professional development. Building a 'joyful team' leads to good work and better care.

Key issues

We have identified the following key issues on which clinicians, professional bodies, employers and government must work together to support better care and better work for staff:

Recruitment and retention

Across the clinical professions there are substantial staff shortages that need to be addressed. However, the professional bodies also believe it is equally essential that greater effort is put into retaining current clinical staff in their jobs. Efforts to train or recruit new staff will not be worthwhile if the NHS is unable to retain the current workforce.

New solutions for delivering healthcare

Professional organisations recognise that new solutions are required to deliver healthcare to meet the changing needs of the population. This will need new ways of working, new roles and new behaviours and potentially changing the regulation of professionals. While these changes may be challenging and must be approached sensitively, professionals will buy into them if they see benefits to patients rather than a perceived diminution of their roles.

Professional development/career pathways

New ways of working and delivering healthcare requires employers to ensure that clinicians have the professional development they need to adapt to changing circumstances. Clinicians need to be able see there are appropriate career pathways open to them to enable them to expand their contribution to healthcare and their personal job satisfaction.

Valuing staff

Whilst still normally appreciated by patients, many healthcare staff currently feel undervalued in their work. It is crucial that clinical and other staff do feel properly valued and rewarded if they are to be as effective as they could be. This is a responsibility of Government, employers and colleagues. We have also committed to work together as professional bodies on specific initiatives around professional regulation, workforce development and patient quality of life.

Shared workshops and practice exchange

In January 2017 the Academy and New Care Models programme have organised two joint workshops, bringing together learning from the vanguards and from initiatives led by Royal Colleges, such as the Future Hospital programme and the Ophthalmologist programme.

These events were broadened out beyond the Colleges and Faculties, to include professional bodies representing other groups, including participants from local government, public health, nursing and allied professions. The workshops created space for open, honest and generous conversations between different professions. Participants have shared thinking about some of the critical workforce challenges, described through the five training themes for workforce redesign from the new care models programme:

- Leadership for population healthcare *ref: Gray M, Chana N, Kanani N (2017)*
- Team-based working
- Greater use of technology
- Working in different settings
- Personalisation

We have showcased a number of innovations in delivering care and explored our shared understanding of what makes a multi-disciplinary team effective. We have also paid attention to the development of the right workforce for the future, and to removal of obstacles to smooth the way. In doing so, we have identified a series of issues which will need to be taken forward if new models of care are to become sustainable.

Participating organisations:

Erewash Vanguard -	*Creating wellbeing - lessons from care coordination*
The Faculty of Intensive Care Medicine	*The advanced critical care practitioner*
NHS Wales -	*The benefits and challenges of collaborative multi-professional working in general practice in Wales*
Your Healthcare, Kingston -	*A different way, learning from social enterprise*
The Royal College of Ophthalmologists -	*The Way Forward Project*
The Royal College of Nursing -	*The Capital Nurse Project*
Faculty of Sexual and Reproductive Healthcare	*Community based sexual and reproductive health leadership in Greenwich*
Dartford & Gravesham and Guy's & St Thomas' vanguard	*Acute care collaborative learning*
The Royal College of Anaesthetists	*Preparing patients for surgery: Community pre-habilitation and cross-sector working*
The Royal College of Psychiatrists	*Mental health and New Models of Care: learning from th vanguards*
Fylde Coast Vanguard	*Empowering families: An MDT approach for children an families who are high users of healthcare services*
The Royal College of General Practitioners	*Integrated care for older people with frailty: innovative approaches in practice*
The Royal College of Physicians	*Future Hospital Programme: locality hubs project*

Part Two - What does an effective multi-professional team approach look like to deliver population health?

The theme of the workshop in October 2017 was the development of effective multi-disciplinary teams. To view slides click here.

Building multi-disciplinary teams - Martha Roberts

Martha drew on research by Aston Organisational Development Ltd, showing that good team working improved patient experience, the well-being of team members, as well as reducing effort rates and patient mortality. However, the research warned against reliance on what it calls 'pseudo teams', rather than truly functioning teams. In pseudo teams, satisfaction and effectiveness was actually lower than when people felt they were not in a team. While working in real teams had a positive effect, working in pseudo-teams increased staff's feeling that they wanted to quit, increased errors, stress and injury, and increased complaints of harassment and violence.

Systems Leadership - Dr Sue Goss

Sue explored some of the issues of identity and belonging, and the dilemmas faced by multi-disciplinary teams – between generic and specialty; between organisational and system loyalties; between confidence in one's own capability, and trust in the capability of others. She talked about how teams can respond positively: drawing on shared values, and using the creative tension between different perspectives to gain new insight.

Sue introduced learning from research into the actions of effective systems leaders; the art of observing patterns of working and intervening skilfully.

What are the characteristics of effective multi-disciplinary working?

From the workshop conversations, the following characteristics of effective multi-disciplinary (MDT) working were identified:

Leadership

Good leadership offered permission to take managed risks and to take the time and space to succeed. Leaders helped to move obstacles and win support for new approaches. Clinical leaders need to encourage and support colleagues into a new mind-set, one that thinks about population health, not simply the patient in front of them, welcomes multi-disciplinary working and recognises the patient as the constant in clinical practice, rather than the institution. Participants talked about the need for individuals to be pro-active and not re-active, to be solution focussed and positive. This is often easier in pilots led by enthusiastic champions.

Time and space

Participants in the workshops stressed the importance of time just to think and explore. They explained the difficulties faced by clinicians and professionals who were too busy 'just practicing' to think about new approaches - and the need for leaders to create 'time-out' to work through the dilemmas and difficulties. Participants discussed the need for investment in relationship building, and for good organisational development (OD) support. Good MDTs are not simply run through telephone calls and referral systems, but enable team members to talk together about what they are trying to achieve.

Clarity about roles and expectations

Participants stressed the importance of developing clarity about roles and expectations. This couldn't be done on paper, it was about empowering clinicians and professionals to explore and agree the boundaries between roles, learn to understand each other's skills and expertise and develop shared confidence about referrals and hand-overs.

Advanced critical care practitioners (FICM)

Work by the Faculty of Intensive Care Medicine has developed new professional roles to help to deal with more complex procedures for older and sicker patients. A national framework has been set up by the FICM, within which there are now over 200 advanced critical care practitioners. The training is carried out in a clinical apprenticeship style, completed in a critical care setting, where up to 80% of the time is spent working clinically and leads to the development of permanent staff with new qualifications and roles

Shared decision making

In a good multi-disciplinary team, decisions are made collaboratively so that clinicians didn't feel they were 'handing over' their patient, but sharing their expertise in finding the best solution. In the Foundation Healthcare Group vanguard, for example, it had proved crucial that the work was co-designed involving clinical teams from the outset.

Foundation Health Care Group

Staff have experimented with working together in different ways, building constellations of staff around the patients, through six collaborative projects - three clinical and three non-clinical. People move around the system, creating a combined front across organisations, shaping care around the patients. Using nationally agreed pathways offered a good shared basis for working together. Work has been co-designed involving clinical teams from the outset – cross-site multi-disciplinary teams bring people together in a room to work through issues. A key part of the approach has been working with patients – for example through coffee mornings to ask about how well the approach is working for them, or engaging patients in selection panels. Other key features have been the need for reliable data to support joint working, and a reliable IT infrastructure to support the work. You can read more *here.*

Shared training and education

Several presenters from vanguards spoke from experience about the value of training different professional and clinical groups together, so that each could recognise the skills and expertise that others had, and could develop shared skills and understanding.

Communities of practice

An important element in designing and implementing new care models has been the development of communities of practice, where practitioners can come together across organisational boundaries to talk about patient needs, work together to share practice, challenge each other, discuss evaluation and results, and build a culture of constant improvement. Communities of practice also offered much-needed support when progress was difficult, and could create a base for solving problems and moving obstacles.

Royal College of Physicians Future Hospital Programme: locality hubs project

The Royal College of Physicians has developed an ambitious Future Hospital Programme which champions patient involvement and leadership in service redesign and delivery. Eight projects were selected; each experimenting with different ways to embed the RCP's 11 principles of patient care [link]. Crucial to all these projects is a role for patients as full team members, and support for the patients taking part. The RCP also sponsored collaborative learning, – bringing people from all eight projects together several times a year to share learning.

Good relationships need honest conversations

In new multi-disciplinary teams, participants described the inevitable early tensions and discomfort that came from lack of understanding about each other's assessment processes, protocols, roles and expertise. Good teams actively explore these differences and are able to ask difficult questions with curiosity and respect for the wisdom and experience of others. It is important therefore that all voices are heard, and that there is an assumed equivalence between team members, so that everyone's point of view is valued.

Flexibility

Flexibility is an aspect of shared working and trust. If solutions are found together, clinicians and professionals will find it easier to adapt to them. The more they understand and trust the processes and approach of other professionals, the more likely they are to accept them.

Beginning with the patient/service user

Several presenters stressed the importance of beginning with the interest that we all have in common – the best outcome for the patient or service user. Discovering that we each have a different perspective on the best patient outcome can be intriguing and helpful. But as well as having patients interests at heart, new care models need to engage patients directly in co-producing their own care and treating them as part of the team.

Fylde Coast

We heard from a project involving multi-disciplinary teams working with the child and the family. The work has involved developing multi-disciplinary teams with strong trust, so that one team member could visit and assess on behalf of the whole team. The approach was 'asset based', building on the strengths and capabilities of the service user. Teams use the Patient Activation Measure as a tool to support patients to increase their knowledge, skill and confidence in managing their health and well-being.

Engaging with mental health, social care and the voluntary sector

Effective multi-disciplinary working means looking beyond the narrow focus of the NHS and engaging not just with social care but with services such as housing, leisure and employment as well as voluntary and community organisations. Mental health practitioners drew attention to the need to pay attention to role of schools in adolescent mental health, and the networks that often existed around vulnerable people – which might include neighbours, hairdressers, pub landlords and friends.

Tower Hamlets

Tower Hamlets Together Vanguard has developed a good model, recognising that 40-50% of the risk stratified population has mental health problems. They developed a new senior 'integrated care mental health nurse' role and included mental health staff in multi-disciplinary teams. They discovered that working at the interface of organisations requires maturity and flexibility, and the ability to cope with ambiguity and uncertainty. They are now developing competences for both the mental health workforce and for district nurses. They are building care home MDTs which include mental health clinicians and are moving towards fully integrated pathways – including, for example, consultants working with renal and gastric services.

Sharing information and data

Sharing information and data is not easy: IT systems don't communicate readily and problems related to confidentiality and information governance persist. It helped if instead of staying firmly in each organisation's 'back office', finance, IT and HR staff were able to work together to understand problems and find shared solutions.

Wellbeing Erewash Vanguard

Wellbeing Erewash vanguard, covering Eastern Derbyshire, used the SwiPE framework to consider skill level requirements to plan the future health and social care workforce based on a population of 70,000 people. The framework is based on analysis carried out by the Derbyshire strategic workforce implementation group in collaboration with HEE East Midlands, focussing initially on the frail elderly population. Analysis of the prevalence of frailty-related conditions was undertaken, and the need aligned with the skills and competencies of the current workforce required to meet the demand. By engaging clinicians throughout, risk stratification has been a dynamic, not a static process.

Part Three – Key enablers for change

In both workshops, we explored the enablers for change, including changes to clinical education, networks and communities of practice, focus on outcomes, systems leadership, engaging public health and creating the evidence base.

Clinical education

Beverley Harden spoke to the second workshop in January 2018 about the work at Health Education England (HEE) to develop the effectiveness of multi-professional teams, ensuring that patient safety is at the heart. HEE aims to create a sustainable architecture to enable this work; both through undergraduate training and continual professional development. A developmental approach involves leadership, shared attention to person-centred care, changes to clinical training, support for the workforce in undertaking new roles, and clinical OD support for new ways of working so that work can be scaled beyond the 'passionate innovators'. This means creating the right relationships between senior decision makers and professionals stepping up into new roles.

There is also a need for "intelligent commissioning" to recognise these changed roles and commission for them. To view the slides click here.

Taking clinical education forward*:*

In the current model, people train largely in hospitals, for obvious reasons to do with the concentration of clinicians and the variety of clinical experience on offer. However, this means that many clinicians don't build up experience in the settings in which they will ultimately be working. Training needs to cover a range of different settings, both at undergraduate level and once specialisms are being developed. To enable this, issues of support and supervision will need to be addressed; as well as issues faced in community settings, such as autonomy, isolation and the lack of support in decision-making.
There is agreement about the need for more clinical and post-graduate training for expanded specialist roles such as advanced care practitioners. Realistically, this will mean agreeing nationally on a limited range of new roles so that they can be trained for on a sufficient scale to offer robust support, career progression, recruitment and replacement. Future clinicians will need to be able to work effectively with patients regardless of setting, rather than expecting any particular structural or institutional arrangements.

Training should encourage thinking about population health, evidence based medicine, and a patient-centred, co-production approach to support resilience and patient self-care.

Participants discussed the desirability of setting up work-force hubs on a local system basis able to think about workforce across the patch.

Shared thinking and practice:

Spreading the learning is a constant and continual task. The workshops explored the best ways of sharing thinking and practice; good suggestions included the use of crowd-sourcing, social media and twitter. One leading physician often tweeted 'has anyone found a good way of doing…" and received many creative and helpful responses.

Networks and communities of practice:

Participants discussed the value of establishing multi-disciplinary networks in a local area, which could include local government and voluntary sector colleagues.
At a national level, the range of organisations involved in understanding changing roles needed to be widened. The CQC, other NHSE and NHSI teams and regulatory bodies could help frame a system-wide approach to innovation and risk; and to recognise the important learning from new care models about permission to experiment, and space and time to innovate

Focus on outcomes:

Clinicians and professionals are motivated by a focus on outcomes. The starting point in vanguards had been a shared exploration of local needs, leading to a focus on the most important health outcomes for the local population. Discussions about outcomes needed to encompass issues such as 'patient activation', self-care, community resilience, activity and connection, and involve local government, housing, the voluntary sector, family and friends– as well as deploying health resources.

Crucially, measurement should shift from measuring only disease-specific outcomes, to measuring well-being, active communities and a sense of belonging – all of which have been evidenced as determinants of good health. This requires public support for such a shift, and public understanding of, and agreement with, the outcomes we are trying to achieve.

Systems Leadership: How do leaders develop the strong relationships needed to lead difficult change across organisational boundaries?

System leadership is widely discussed, but there is not yet a shared understanding of what it means. We need to create a better understanding of the differences between conventional leadership and systems leadership; to build greater awareness of how systems work; and become more familiar with the tools and techniques of system change. There are also different views about the realities and boundaries of any system. Future work needed to involve trainers and regulators in building a shared understanding of systems and how to develop leadership in these settings.

Involving public health:

There is widespread recognition that everyone has a role in prevention. The shift of public health into local government offers scope to link to a wider network – housing, licensing, leisure, community services – all of which can help to address the determinants of health. In the past, public health work has often been seen primarily as identifying population needs and creating the right statistical evidence of disease prevalence. Vanguards have started to link population health data with data from hospital, community and primary care activity to understand how the system responds to population needs, and this work needs to continue. Managing public health through prevention and early intervention is not just the realm of public health professionals, but involves a wide range of professionals as well as voluntary and community groups and patients and families. It feels important to leave organisational 'hats' at the door.

Part Four – Obstacles and barriers

Despite all the good work showcased in these workshops, participants acknowledged a range of obstacles that still need to be overcome. Participants stressed the need for myth-busting – and sharing knowledge about what works. Most successful initiatives had involved breaking rules, organising the leadership to overcome obstacles or simply finding a way round them. However, as one participant said "this can't only work for the heroic and the fabulous!"

If early adopters find themselves disadvantaged financially or barriers to establishing new roles persist, the system will default to older established models. People developing new care models talked about the 'work arounds' they had created when obstacles were too hard to move, often using the additional vanguard funding to buy a way around difficulties. These 'work arounds' were not sustainable into the future.

Financial flows

There was seen to be a need to move away from payment by results and payment systems that encourage competition, towards payment systems that could accommodate greater integration and multi-agency working. Tariff systems were seen as a major obstacle.
Savings made as a result of multi-disciplinary working were not necessarily shared with partner agencies, and might not be made by the organisation which invested to make change happen. Pooled budgets are proving harder to achieve than might have been expected, and are not made easier by the approaches taken by national organisations.

Terms and conditions

In practical terms there can be difficulties rotating staff between organisations because of different working arrangements and different policies.
It was proving hard to establish attractive terms and conditions for workers who were undertaking new roles. Problems related to pensions, registration, additional payments for unsocial hours, travel allowances and mileage. These may seem trivial, but act to discourage staff from taking on new roles.

Indemnity and insurance

In several places, indemnity insurance had been encountered as an obstacle. In at least one vanguard, the additional funding had been used to provide a 'work around' to pay the additional insurance being asked for cover for new roles. However, in the January workshop, it was encouraging to hear that a solution to indemnity insurance for new clinical roles in hospitals has already been secured, and a solution for community settings is promised for April 2019.

Protectionist behaviour

Participants from Royal Colleges acknowledged that sometimes professionals indulged in protectionist behaviour. It was important to respond to anxiety about identity and encroachment of roles, encouraging flexibility through easing transfer between specialties, and identifying the shared aspects of curricula. Challenging and supporting our own clinical and professional colleagues to change may be as important as reaching out to others.

Data sharing and information

Data sharing agreements are not only difficult, but expensive. NHS Digital charges can add up for GP practices, when geographical areas are constantly changing. It encourages clinicians to delay making changes until there is a comprehensive agreement 'at the end' which never comes.

Conflicting policies
Each organisation has policies on safety, confidentiality, information governance etc. It is probably impossible to standardise all these policies, but organisations need to work together to remove contradictions and ensure that handovers are smooth and safe.

Communication and referrals
Participants highlighted the fact that sometimes tortuous referral systems are created, and it can be hard to for professionals and clinicians to talk to each other without going through complex form filling and multiple receptionists. If clinicians are going to learn to trust each other, ways need to be found to communicate freely.

Regulators
Subtle differences in regulation between different agencies could hinder multi-disciplinary working, making it harder at local level to align standards between organisations. Greater flexibility and common standards across professions would make it easier to work in this way. Regulators need to work together to understand each other and understand how their actions impact on outcomes at local level.

Social acceptance
The public need to understand the new clinical roles and feel comfortable with seeing, for example, an advanced nurse practitioner instead of the GP they expected. Receptionists and other clinicians need to be able to explain these new roles. We need to create a workforce that is understood and accepted by the public as both relevant and appropriately trained.

Part Five – Emerging issues

As participants explored the issues that affected clinicians, it was recognised that these are not all 'problems to be solved' – some are 'dilemmas to be managed'. There may be built-in tensions between two potentially desirable outcomes – and there is skill in managing that tension to ensure the right balance is maintained.

An initial set of shared principles:

- Beginning with population health
- Creating a 'whole system' approach – so that commissioners and providers work together to take responsibility for a population
- Using a robust evidence base
- Engaging with non-medical approaches to improving health
- Paying attention to prevention and early intervention to reduce the need for people to present at hospital
- Encouraging multi-disciplinary teams and shared working between primary, community and secondary care services.
- Rethinking roles and ways of working to support these shifts.

A single 'new care model' or many models?

While there is recognition that no single model will fit all care needs, the view from the workshops was that there are some shared principles which are beginning to win widespread support. So far, new models of care have developed in response to local conditions and needs. Is there a tension, going forward, between the need to standardise key elements of the approach, and the need to ensure that implementation can be shaped locally?

One important shift has been away from looking at disease types (such as diabetes) towards segmenting populations by looking at whole people – (for example at age cohorts, or people in different circumstances). This has helped to align thinking across health, local government and the voluntary sector. Do we want to agree how to do this at national level? Do we need a single model, or different models for different population groups? Given the diversity of emerging practice, does this arise from different views about the desired outcomes, or simply different views about how to reach them? Future work will need to share these conversations more widely with clinicians in non-vanguard areas.

Professional identity - an enabler, or a barrier?

Identity can be both an enabler (helping us to be confident in our roles in the system) and a barrier. Professionals will want to hold onto their professional identities, but are also able to forge new team identities based around the needs of patients. The Royal Colleges and Faculties have a crucial role in bringing different specialties together, and helping clinicians and professionals to respect the different insights and experience each bring, so that although expertise is different it is recognised as of equivalent value.

The two workshop discussions explored the tension between organisational loyalty and professional identity on the one hand and multi-agency working on the other. What was seen by professionals and clinicians as their 'home team'? Where were their loyalties strongest? Experiments with new models of care had shown that it was possible to work very closely with other professionals without losing any sense of personal skills, value and identity, but staff needed time and space to explore this.

Because of the scarcity of skilled professionals and clinicians it was desirable that everyone worked to the top of their capability, and that professionals took on extended roles whenever possible, allowing more junior staff in turn to 'move up' into roles where they, too were stretched and empowered. The colleges need to work together to agree how to recognise and badge the new skills and competences and how to articulate them.

Specialism for expertise – or generic skills to enable flexible working?

Some clinicians in the workshops were worried that new professions might 'cherry pick' the most attractive roles, and argued that professionals or clinicians in new roles needed to be available 7 days a week and not just at limited times. Others argued that it was important to guard against regressing into generic roles and losing the advantages of specialist training. For some, the way forward was 'multi-specialists' rather than generalists.

It was felt important however, not to lose touch with the desired outcomes. These included increasing flexibility and reducing the number of hand-overs between specialists in the interests of improving patient care. It was important to value generalist skills more highly, while recognising the importance of access to specialist expertise when needed.

In some areas, such as very rural areas, it wasn't possible or desirable to recruit to a large number of different specialisms, and it was important that nurses and other staff were able to play multiple roles in a system where there were far fewer clinicians available.

Colleges should promote and encourage professional and clinical work across traditional boundaries (e.g. geriatricians working in surgical services) as well as working in different settings, such as primary and community care. Colleges needed to promote trust in the expertise of other professionals and encourage close working with other professions as part of good clinical practice.

Local variation versus national schemes?

While there is real benefit in enabling local clinicians and professionals to design the roles they think are most useful, it is clearly not practicable to define roles differently in each locality. Professional groups need to be large enough to exchange practice and ideas, to ensure training and supervision and to allow a career path that makes sense across the country. It is worth, therefore, exploring and comparing the impact of these experiments, and in putting resources and effort into the best models and the most effective new roles, to ensure that the right training, registration and support resources are made available.

In none of these dilemmas will the answer be simply to move to one end of the spectrum. Optimum value will be about finding ways to judge the right balance between the two.

Part Six – The need for evidence

Participants challenged each other to demonstrate that these new care models were better at achieving outcomes than traditional models. Since a crucial dimension of new care models is attention to population health; the vanguards and other experiments needed to be able to demonstrate that outcomes improved for whole populations.

Across health and social care, we are often measuring different things: such as measuring system activity (hospital admissions or readmissions) efficacy in treatment (recovery rates, disease progression) or measures of well-being (such as loneliness, capacity to self-manage, fitness and happiness). To improve patient experience we would also need to measure things such as reductions in handovers, and confidence that clinicians listened and responded. Agreement about what needed to be measured would be helpful in agreeing what the evidence was telling us.

GIRFT and Right-Care - Simon McKenzie

NHSE and NHSI have recognised that one of the greatest opportunities for increasing efficiency in the NHS is the reduction of unwarranted variation in many clinical interventions, variation that cannot be explained by differential patient need or demand. The Rightcare programme and the Getting it Right First Time (GIFRT) methodology are driving quality and productivity improvement in over 30 clinical specialities that cost trusts over £45 billion a year. These programmes show that where there is unexplained variation, there is underuse of high value interventions, and the over-use of low value interventions, which can either waste resources or do harm. Learning about what drives these variations offers opportunities to learn about what works best that will improve individual experience, population health and reduce cost. (link to full presentation)

Programmes such as Rightcare and Get It Right First Time (GIRFT) have developed a valuable evidence base for improvements in acute care settings. It would be useful (and fascinating) to generate equivalent data about interventions in social, community and primary care. The innovations we have been exploring have been welcomed by both clinicians and patients, but the variation in cost is considerable we know there is an 'early adopter' factor in pilots and experiments, and new approaches might face additional obstacles in areas where leaders and clinicians are less committed to change. A timescale of 2-3 years may not be long enough to demonstrate sustained improvement. First attempts may not be as successful as later experiments, which can learn from what goes before. What would help us define new models of care as successful?

It would be very helpful to continue to develop a body of evidence in which we can have real confidence. Building up good data about the comparative effectiveness of new models of care and the benchmarking of experiments against each other to compare and contrast different approaches would offer considerable scope for future learning.

Part Seven – The way forward

Participants in the final event agreed that there was great value in clinicians and professions from such a range of specialities coming together at national level to explore the issues raised by new models of care. In the best possible way, these events had modelled the principles needed for effective multi-disciplinary teams. The events created a space for open and honest conversations, where difficult issues could be explored. The creative tension between different perspectives offered the best chance of a way forward.

Future working together

There are many ways that the Royal Colleges and Faculties could continue to work together. Suggestions included secondments and exchanges between the colleges, to see where there was learning that could be transferred.
At local level there was support for generating multi-professional and clinical networks to explore new models of care.
There is also the possibility of links at regional level between the Royal Colleges and Faculties and regionally organised players such as NHSE. This would offer a regional space to explore the workforce issues emerging from developments such as STPs and integrated care systems.
There was also strong support for a continuation of a national network to act as a multi-speciality reference group of senior people across all the organisations involved in promoting new models of care.

A multi-specialty network

Given the value of relationships and shared practice across specialities and professions, there was a real concern that the value of this professional exchange could be lost when the new care models programme ended. The Royal College representatives expressed a strong view that a national multi-speciality network
should continue to work, supporting future thinking about how learning from new care models might be translated into national policy, and the developmental work on ICSs and STP. Furthermore, how this learning could be used to develop practical support for teams working at sub STP and locality level, key to this will be clinical teams supporting redesign based on shared learning and underpinned by data and evidence

Such a network could:

- Offer feedback from professional and clinical bodies on developments at local level, and on the potential impact of new policies and initiatives.
- Engage with and gain hands on support from clinicians experienced in providing practical support at a provider level.
- Offer challenge and practice exchange to new models and approaches – comparing the effectiveness of practice in different localities and helping to build an understanding of what works best
- Share data and evidence – and build wider understanding of the purpose and effectiveness of new approaches
- Continue to spread learning about the ingredients for effective multi-disciplinary working
- Explore some of the difficult dilemmas, and build multi-professional solutions
- Support HEE in developing multi-specialty and professional approaches to clinical and professional education
- Engage with a range of other bodies, including regulators, national bodies and patient groups to spread awareness of multi-disciplinary working, and change expectations.

Where to go for further information:
The new care models programme have collated in the learning in the following areas:

- 3 published frameworks on population health
- Learning website
- 98 case studies of those who've helped develop the learning

The *Future NHS Collaboration platform* has continued to be a rich source of information for clinical colleagues and has case studies and a range of toolkits and frameworks.

Royal Colleges are also creating rich repositories for learning from current initiatives:

This report was created in collaboration with the NHS England new care models programme, Leadership Centre and the Office for Public Management (OPM).

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Special thanks to all those who attended the events and contributed to the learning encapsulated in this report.

Appendix One- Learning from new models of care

Through the pilot work in 50 sites on new care models, the vanguards have brought health and social care organisations together, commissioned services jointly, supported joined up clinical practice and worked in partnership with local communities and the voluntary sector.

Beginning with an understanding of the local population's needs, they have enabled clinicians and professionals to work together across organisational boundaries to rethink provision- sharing data, designing new services and creating new professional and clinical roles.

Although it is too early to judge sustained impact, the initial evaluation results are encouraging, suggesting a reduction in emergency bed days, the provision of care closer to home, and improvements in patient experience.

Our workshop in October 2017 highlighted learning from four vanguards:

Fylde Coast

By combining data on current usage of services, the vanguard at Fylde Coast found that around 55% of the healthcare budget was spent on supporting and treating just 3% of the local population, often elderly patients with multiple conditions. An extensive care service was developed to improve care and keep people well longer in the community. Neighbourhood teams worked within 10 natural geographic areas to deliver an Enhanced Primary Care Model.

We heard from a project involving multi-disciplinary teams working with the child and the family. The work has involved developing multi-disciplinary teams with strong trust, so that one team member could visit and assess on behalf of the whole team. The approach was 'asset based', building on the strengths and capabilities of the service user. Teams use the Patient Activation Measure as a tool to support patients to increase their knowledge, skill and confidence in managing their health and well-being.

A key element of the approach was to empower the family and work in the community, and programme leaders set out to win local support, knocking on doors and raising the profile of the initiative. Staff report feeling excited about what they do and say they are more effective when they work collaboratively. Patients report a greater sense of feeling empowered to manage their conditions and stay healthy. The vanguard as a whole has produced promising evidence of success: data from November 2016 shows 14% reduction in A&E attendances, 25% reduction in non-elective admissions, 21% reduction in elective admissions and 6% reduction in outpatient activity.

Wellbeing Erewash Vanguard,

Covering Eastern Derbyshire, used the SwiPE framework to consider skill level requirements to plan the future health and social care workforce based on a population of 70,000 people. The framework is based on analysis carried out by the Derbyshire strategic workforce implementation group in collaboration with HEE East Midlands, focussing initially on the frail elderly population. Analysis of the prevalence of frailty-related conditions was undertaken, and the need aligned with the skills and competencies of the current workforce required to meet the demand. By engaging clinicians throughout, risk stratification has been a dynamic, not a static process.

The focus on the link between skills and interventions enabled Erewash to create a very different workforce model – and to envisage the shift needed in workforce. Care-coordination is a key part of the response, with 12 GP practices moving to form a federation, linked to Derby Royal and Nottinghamshire University Hospital Trust. Care coordinators are employed by community care, but located in GP practices. Pharmacy, physiotherapy, and advanced nurse practitioners are all located in primary care. Results include a reduction in non-elective attendances, and greater patient satisfaction.

Foundation Health Care Group

Guys and St Thomas' NHS Foundation Trust (GSTT) and Dartford and Gravesham NHS Trust (DGT) have been in partnership through the new care models programme as an acute care collaboration vanguard (The Foundation Health Care Group) since September 2015. The partnership has aimed to integrate working across the two trusts to make best use of scarce resources, based on a strong commitment to shared vision and values. Involving the right people in leading and running the collaboration has proved very important – including a co-chairing arrangement.

Staff have experimented with working together in different ways, building constellations of staff around the patients, through six collaborative projects - three clinical and three non-clinical. People move around the system, creating a combined front across organisations, shaping care around the patients. Using nationally agreed pathways offered a good shared basis for working together. Work has been co-designed involving clinical teams from the outset – cross-site multi-disciplinary teams bring people together in a room to work through issues. A key part of the approach has been working with patients – for example through coffee mornings to ask about how well the approach is working for them, or engaging patients in selection panels. Other key features have been the need for reliable data to support joint working, and a reliable IT infrastructure to support the work. You can find out more *here.*

Your Healthcare – Kingston and Richmond

Your Healthcare is a social enterprise model, developed as a mutual, which belongs to the multi-skilled staff. Your HealthCare is an independent business providing public services run by its staff and the community. The organisation actively uses co-production as a means of delivering public services in an equal and reciprocal relationship between professionals, partners, people using services, and their families and neighbours. The organisation covers Kingston and Richmond.

Appendix Two – Learning from Medical Royal College initiatives

The Royal Colleges and Faculties have also been thinking creatively about the clinicians and the professionals of the future. They have been developing collaborative clinical leadership across specialties, creating new sources of learning and practice exchange, and exploring the potential impact of future developments in way that health services are provided. They have been offering important leadership to clinicians throughout the NHS, encouraging multi-disciplinary working, and helping to find solutions to the problems and dilemmas that must be addressed if future models are to operate at scale.

The Academy of Medical Royal Colleges has been actively bringing together clinicians to build trust and shared understanding, to agree good practice and to identify the relationship with other national bodies needed to remove obstacles to moving forward.

At the October 2017 workshop presentations were made by ten of the Royal Colleges and Faculties, or partner organisations.

The Royal College of Physicians Future Hospitals: locality hubs programme

The Royal College of Physicians has developed an ambitious Future Hospital Programme which champions patient involvement and leadership in service redesign and delivery. Eight projects were selected; each experimenting with different ways to embed the RCP's 11 principles of patient care (link). Crucial to all these projects is a role for patients as full team members, and support for the patients taking part. The RCP also sponsored collaborative learning, – bringing people from all eight projects together several times a year to share learning.

We heard from the pilot project in North West Surrey, which established a series of integrated frail and elderly hubs. The process involved record sharing, to identify over 65's with a frailty score of 4-8, and workforce mapping to establish the right MDT process. A collaborative learning structure enabled healthcare teams to successfully implement improvement projects. Data was collected and analysed using QI methodology to measure the impact of new ways of working. Results included reduced length of stay, earlier multi-professional review, more integrated care, improved patient satisfaction and greater satisfaction for staff in work that was more rewarding.

Frailty - innovative approaches in practice

The Royal College of GPs and the British Geriatric Society have been working together in North East Yorkshire to present innovative practice, developing 13 case-studies to demonstrate what theory looks like in practice. The work was led by the CCG as well as primary care; creating a strategic care co-ordinator to manage care pathways, and developing continuity of care between primary and secondary settings.

The work involved challenging a tendency to medicalise everything, involving allied health professionals in patient care. Care was at the core of the approach, highlighting the importance of improving care in motivating professionals and clinicians.

Advances in critical care practitioners (Faculty of Intensive Care Medicine)
Work by the Faculty of Intensive Care Medicine has developed new professional roles to help to deal with more complex procedures for older and sicker patients. A national framework has been set up by the FICM, within which there are now over 200 advanced critical care practitioners. The training is carried out in a clinical apprenticeship style, completed in a critical care setting, where up to 80% of the time is spent working clinically; and leads to the development of permanent staff with new qualifications and roles. The training involves a two-year full time course for people from senior nursing posts, so it is not cheap or easy, but the sponsors are convinced that this represents good value for money.

Gains have been better utilisation of the nursing workforce and an unexpected benefit has been the better retention of senior nursing staff because of greater job satisfaction. Staff vacancies have been filled, giving consultants time to deliver more teaching to staff, and reducing on-call pressures. ACCPs have begun to teach junior and mid-range medical staff on tertiary/practical expertise in new responsibilities [link]

New Models of Care: learning from the Vanguards
The Royal College Psychiatrists and the Kings Fund collaborated on a report Mental Health and New Models of Care, published in May 2017. The research concluded:
"The full opportunities to improve care through integrated approaches to mental health have not been realised". The report suggests that new models of care should aim to:

- include mental health expertise in integrated care teams
- Make mental health support a core component of enhanced models of primary care
- Strengthen the mental health component of urgent and emergency care pathways
- Make public health and well-being central to population health management.

Tower Hamlets Together vanguard has developed a good model, recognising that 40-50% of the risk stratified population has mental health problems. They developed a new senior 'integrated care mental health nurse' role and included mental health staff in multi-disciplinary teams. They discovered that working at the interface of organisations requires maturity and flexibility, and the ability to cope with ambiguity and uncertainty. They are now developing competences for both the mental health workforce and for district nurses. They are building care home MDTs which include mental health clinicians and are moving towards fully integrated pathways – including, for example, consultants working with renal and gastric services.

Academy Wales: collaborative multi-professional working in General Practice in Wales

The experience of North Wales offers valuable learning about new models of care in a highly rural environment. Challenges include poor transport links, an isolated population, problems of recruitment for all staff, and a serious shortage of doctors. The current recruitment models don't work here:

"We need people who can visit a hard to reach person and meet all their needs."

In a rural locality GPs wanted to find ways of working together to share staff and resources. A federation of 7 practices has been formed to share the risk employing staff and share workforce training. The federation aims to deliver the Welsh Government's direct4ed enhanced service for frailty by working collaboratively. Two frailty nurses and a secondee pharmacist are shared by the seven practices. The aim is to reduce hospital admissions by working to deliver better management of patients in care homes. It is early days, but the federation is also talking about delivering sexual health and diabetes services collaboratively.

The Royal College of Anaesthetists

The Royal College of Anaesthetists has been developing a programme in South Tees to improve the results of surgery. Current practice has high costs, because patients present who are not ready for surgery, and operations are either cancelled or have a higher risk of failure. The right place for risk factors to be identified is in primary care, so that the time waiting for operations can be spent helping patients to become 'operation ready'. Project leaders found that GPs were willing to work with secondary clinicians to prepare patients 'up stream'. Patient workshops on attitudes to multiple behaviour change showed that patients overwhelmingly were prepared to change behaviours when made aware of the risks – there were crucial 'teachable moments'.

The project has created an educational toolkit for GPs and primary care staff. Work is underway on an evaluation tool. There is now an interest in pre-habilitation clinics from both patients and GPs. The work points to the importance of shared decision making between the secondary care clinicians and anaesthetists, primary care doctors and patients.

Faculty of Sexual and Reproductive Healthcare

The Faculty of Sexual and Reproductive Health shared two multi-disciplinary projects – the sexual health clinic and a community gynaecology model.

The sexual health clinic was a community centred model, based on the self-empowerment of patients, with on-line access, pharmacy access and on-line diagnosis and patient prescribing. A new triage system turned out to be an important element of the process; the more experienced the triage nurse was, the better and more efficient the result. The consultant-led multi-disciplinary team included consultants, specialists, nurses, health care assistants and youth workers; building a collaborative approach to maximising skills and development. Team members spend time in every role, so they can understand connections and appreciate other roles. New doctors, for example, spend time on reception and triage. They are now working with the voluntary sector to develop an outreach service for hard to reach populations. A community gynaecology service has also been created to look after people at home, maximising income to backfill less cost effective delivery. Commissioners have moved resource from secondary care to closer to home.

The Royal College of Ophthalmologists: The Way Forward Project

The increasing demand for hospital eye services is not being met and continues to grow, so the Royal College of Ophthalmologists commissioned the Way Forward: a project to explore current methods of working, and identify best practice models - to provide some real life solutions and models of care.

The Royal College believes that ophthalmologists can act as the architects of change, collaborating with commissioning and health bodies to plan future services, and working with hospital managers, medical and non-medical healthcare colleagues to deliver better care. The work has produced valuable resources to support service improvement; and identifies different ways of working, use of IT and expanded ophthalmic teams which can form part of the solution, while stressing the need to ensure that change does not compromise patient safety or standards of care.

Key themes include improving referrals, optimising the use of consultant expertise with the backing of an effective team of medical and non-medical eye healthcare professionals, training multi-disciplinary teams, optimising flow through hospital clinics, treatment rooms and operating theatres through integrating pathways; risk stratification, shared discharge policies and shared care protocols.

ENDS.