Integrated health and social care evidence reviews

What works in creating an effective Multispecialty Community Provider?

Published in May 2018

CordisBright

We have been the evaluation partner for a number of Multispecialty Community Provider Vanguard sites, which bring together different organisations in order to move specialist care out of hospitals and into the community.

Here we present the findings of our review of the literature[1] regarding best practice in the creation of MCPs and, where relevant, the provision of integrated care more generally. The review also outlines barriers to the effective establishment of MCPs.

Please get in touch with our Head of Research, Dr Stephen Boxford, for more detail or to continue the conversation.

1 Context

1.1 What is a Multispecialty Community Provider?

1.1.1 Why Multispecialty Community Providers?

The Multispecialty Community Provider (MCP) model is one of the new models of care established through NHS England's (NHSE) New Care Models programme. Fourteen MCP Vanguard sites were appointed in England from 2015 under the programme (NHSE 2016a).

MCP Vanguards are focused on moving specialist care out of hospitals and into the community (NHSE 2016a). They enable groups of GPs to combine with other community health services, health specialists, and in some cases mental health and social care services, to form an integrated out-of-hospital service of care (NHSE 2014a). MCP Vanguards aim to address care needs at a whole population level, as well as providing targeted support for those with the highest care needs, urgent care needs, and ongoing care needs (NHSE 2016a).

At their core, MCPs are about delivering integrated care services. Integrated care is an organising principle for care delivery that aims to improve patient care and experience through improved coordination (Nuffield Trust 2011). Integration is therefore the combined set of methods, processes and models that seek to bring this about. Integration can be

[1] If you would like details on the methodology used for the literature review, or a full bibliography, please get in touch with the Cordis Bright research team: info@cordisbright.co.uk

"real", i.e. organisations merge their services, or "virtual", i.e. organisations work together through networks and alliances (Ham and Curry 2011).

There is a growing body of evidence to show that integrated care pathways can prevent harm and additional costs to the system (NHSE 2014a; NHSE 2014b).

1.1.2 MCP focus

Core to the MCP approach to integrated care is the use of contracting and commissioning frameworks to support the delivery of out-of-hospital services. The integrated nature of the service model also necessitates flexible use of workforce and estates, developing shared care records and business intelligence systems, and largescale cultural change across all levels of workforce and managements in all partner organisations. This goes further than primary care trusts in the past or other forms of practice-based commissioning – it is about working in an integrated fashion to plan, finance and ultimately deliver primary care and community-based health and care services.

MCPs vary in form and focus, depending on which elements of care they seek to deliver. However, the MCP model typically focuses on four levels (NHSE 2016b):

- Whole population: prevention and population health management;
- Urgent care needs: integrated access and rapid response service;
- Ongoing care needs: enhanced primary and community care;
- Highest care needs: coordinated community based and inpatient care;

1.1.3 MCP structure

There are a range of organisational forms and contracting arrangements across MCPs, including (NHSE 2016b):

- Limited company or limited liability partnership, such as a GP super-practice or federation bringing a broader range of services into the general practice model;
- Community interest company (CIC), where providers hold a stake in a corporate joint venture which holds the MCP contract;
- Contractual alliance, where providers remain legally separate, with their own staff but are bound by an alliance agreement;
- Accountable Care Trust, created under the same existing legal framework of existing HNS foundation trusts to bring together in one legal entity the commissioning and provision of health and social care services;
- Lead provider (host) where one provider holds the MCP contracts on behalf of an alliance of providers.

2 Essential components for an effective MCP

2.1 Overview

Our review identified essential components for an effective MCP based on the NHS England framework and guidance (NHSE 2016b), as well as a wider review of best practice principles in integrated care. We first present NHSE's recommended components for an MCP, along with any relevant evidence from the wider literature. Other relevant best practice principles from the integrated care literature are summarised at the end of this section.

2.2 NHS guidance

In July 2016, NHS England published its *Multispecialty Community Provider (MCP) Emerging Care Model and Contract Framework* which details ten components involved in establishing a successful MCP, as outlined below (NHSE 2016b). Overall, the MCP components identified by NHS England are consistent with the findings of a 2010 King's Fund report on integrated care (Curry and Ham 2010), which found the ingredients for effective integrated care to include: defined populations; aligned financial incentives; effective leadership; collaborative culture; and patient engagement.

10 essential ingredients for creating a successful MCP

1. Build **collaborative leadership** around a shared local vision based on a new clinical model. Engage the local community and local GP practices individually as well as through federations and clinical commissioning groups (CCGs).

2. Create a dedicated **'engine room'** to drive and manage the local transformation programme, with adequate dedicated resources and capabilities. This is not just a programme management office and it needs your best people.

3. Establish a **transparent governance structure** so that everyone knows how decisions are made, and to ensure collective responsibility.

4. **Understand the different needs of your diverse population**, and segment into different population groups, to design your new care model.

5. Develop and maintain a clear and explicit description (a **'logic model'**) that explains how the proposed transformations in care are intended to lead to the outcomes that the MCP wants to achieve. Logic models provide a simple visual means of showing complex chains of reasoning.

6. Establish the financial case (a **'value proposition'**) for developing the MCP. Commit to a clear return on investment, so that there is a compelling and credible proposition for service change. This includes setting out how the MCP will help moderate demand, and increase provider efficiency. It has to fit with the local sustainability and transformation plans (STPs).

7. **Design and document each of the specific component parts of the care redesign**. This includes clinical and business processes and protocols, team design and job roles. Do these work with and for patients, carers and clinicians? For the most complex services, develop a clear understanding of the different costs, the expected throughputs, and the methods for selecting patients for proactive care.

8. Systematically **plan, schedule and manage the implementation of the changes** in line with the emerging design specifications, and the value proposition timetable. Achieve effective clinical and patient participation.

9. **Learn and adapt quickly**. Inevitably some changes won't work as intended. Generate timely monitoring and evaluation loops covering (a) initial implementation of change, broken down change-by-change, team-by-team; (b) the ongoing management of the services; and (c) the quantified impact on outputs and outcomes. Identify successes and rapidly address the inevitable teething problems that will occur, and failures in design or execution. Scrap the interventions that don't work.

10. **Commission and contract** for the new model, so that organisational forms and financial flows are supporting your goals rather than getting in the way.

Source: NHSE (2016), Multispecialty Community Provider Emerging Care Model and Contract Framework

We reviewed the supporting evidence for each of the ten components needed to create a successful MCP. This is outlined below.

2.2.1 Collaborative leadership

NHS England (2016b) guidance suggests that building collaborative leadership around a shared local vision based on a new clinical model is essential when establishing a successful MCP. Research into integrated care suggests that clashing cultures, such as differences between providers of medical services and long-term care services, or between physicians and other service providers, can result in failed integration efforts. To make integrated services work, staff must be able to put the interests of service users before professional cultural norms, and must be prepared to work in different ways.

The national evaluation of the Department of Health's (DoH) integrated care pilots cites professional protectionism and teams failing to work in a collaborative way as contributing factors to some integrated care pilot projects in England floundering (RAND Europe and Ernst & Young 2012). The relative success of an integrated health and social care programme in Torbay has led its evaluator to suggest that partnership working as *the* local strategy, rather than one of several strategies, is one of the key factors leading to its success (Ham 2010). A long-term commitment to partnership working is also particularly important given the length of time it can take to realise the benefits of new ways of working.

In addition to this, as part of an evaluation of the Integrated Care and Support Pioneers Programme[2], good local leadership at all levels within established and appropriate governance structures has been identified as critical in integrated care (Erens et al. 2015).

The NHS guidance regarding collaborative leadership suggests that MCPs should engage the local community and local GP practices individually as well as through federations and clinical commissioning groups (CCGs) (NHSE 2016b). This is echoed by the King's Fund, which states that integrated care projects should bring together all stages of the care pathway within a defined locality, and should include not only statutory health and social care but also third sector agencies (Curry and Ham 2010). The Fund identifies clinical and service-level integration, focused on improving care around the needs of individuals, as the most important component in integrated care (Curry and Ham 2010).

Lessons from North-West London integrated care pilot

A year-long, mixed methods evaluation of a large-scale integrated care pilot in North West London made several conclusions regarding the role of leadership in integrated care (Curry et al. 2013). These include:

- It is possible to engage a diverse range of organisations in large-scale change programmes if there is strong leadership, upfront resource and if governance and financial structures are carefully designed and agreed to at the outset.
- Any large-scale project needs to be underpinned by a strong and clear vision that is shared at all levels (and particularly amongst middle managers/clinicians who will be delivering the change). It is essential that engagement is an ongoing process.

2.2.2 Engine room

NHS guidance suggests that MCPs should create a dedicated 'engine room' in order to drive and manage the programme, including dedicated resources and capabilities and involving the MCP's best staff (NHSE 2016b).

Consultation by the King's Fund has highlighted that most commissioners of MCP and Primary and Acute Care System (PACS) Vanguards plan to transfer a number of operational activities that are currently delivered within the CCGs to the provider system (particularly activities relating to contracting and overseeing individual services) in addition to aligning and co-ordinating services (Collins 2016). Somerset was cited as an example of where commissioners intend to create a 'managed services organisation' within the PACS that will act as the 'engine room' of the accountable care organisation. This 'engine room' will provide data analytics, carry out clinical management, oversee performance of individual services, and ensure services and care models are delivered as planned.

The NHS guidance (2016b) highlights that the 'engine room' should involve the MCP's best staff. Having sufficient, consistent staff has been identified as an enabler for integration in Integrated Care and Support Pioneers (Erens et al. 2015). Further, reviews

[2] The integrated care Pioneers are a cohort of 25 local areas, supported by a range of experts to deliver change at scale and pace from 2013 onwards (Erens et al. 2015).

of literature regarding joint working between health and social care have shown that co-location of staff has been a facilitator for improvements in understanding (Rutter et al. 2004) and communication (Gibb et al. 2002). An Institute for Government report concurs that using multi-disciplinary teams can focus attention on complex issues, and that the rigorous use of data and evidence is an essential tool for drawing in resource from a range of organisations to overcome complex policy challenges (Wilson et al. 2015).

2.2.3 Transparent governance structure

The NHS England guidance suggests that MCPs need to establish clear governance structures, in order for decisions to be transparent, and to ensure collective responsibility within the model (NHSE 2016b).

Within integration, governance and management of funds are critical factors determining success. Pooled funds are a key driver of integration, but the governance structures underpinning them need to be clear. A review of literature regarding joint working between health and social care highlighted complexity of management as a barrier to joint working, particularly within multi-agency teams and integrated care services (Cameron 2016).

Further, separate management structures have been shown to create tension between professional and service management (Higgins et al. 1993), whereas strong management and appropriate professional support contributes to better outcomes for service users (see Brooks 2002; Clarkson et al. 2011). This is supported by the evaluation of the Integrated Care and Support Pioneers Programme, which found that when governance bodies were not sufficiently integrated, it was difficult to make decisions and prevent issues being recycled without resolution (Erens et al. 2015). This evaluation also identified a straightforward organisational landscape as an important factor in assisting with integrated care.

Leadership from the top – at board and, in local government, elected member level – is cited as a success factor in the majority of evaluations which have looked at how integrated care projects work (Minkman et al. 2009; RAND Europe and Ernst & Young 2012). However, there also needs to be a clear clinical vision and someone who is responsible for driving the programme, and this needs to be sustained by continuity of leadership (Ham 2010). This is sometimes achieved through organisational structures, e.g. care trusts in England, but may be achieved through the creation of a senior post, e.g. a joint director of social care and health in a locality (Ham and Oldham 2009).

However, the King's Fund (Curry and Ham 2010) and Nuffield Trust (Bardsley et al. 2013) find that devising new organisational structures is less important than collaborative behaviour. The Chief Executive of a successful integrated health and social care programme in Torbay suggested that whilst the introduction of 'general management' is necessary, this must be balanced by the effective leadership of professionals (Thistlethwaite 2011). Building upon this idea, a Health Foundation study highlighted that accountable governance needed to tread the line between being *"rigorous where it matters but encouraging toward innovation"* (Hudson 2016), that is to say on issues such as service user safety it should be firm, but allow professionals sufficient freedom to work towards agreed, intended service user outcomes.

In 2013, the National Audit of Intermediate Care used the following indicators of governance and strategy quality standards for intermediate care (Young et al. 2014) which may be applied to an MCP:

- Is there a multi-agency board?
- Has clinical governance or quality assurance been incorporated into service specifications?
- Is strategic planning undertaken jointly by health and local government?
- Has a Joint Strategic Needs Assessment that addresses the needs of relevant populations been carried out?
- Is there a local strategic plan?
- Is there a single manager co-ordinating all provision across the CCG or Local Authority area for which the services are commissioned?

The audit also suggests that frequency of clinical governance meetings is considered a proxy for good clinical governance. The audit found that most bed, home and crisis response services hold monthly clinical governance meetings, whilst re-ablement services tend to hold quarterly meetings (Young et al. 2014).

Stockport MCP Options Appraisal of Organisational Form

As part of its work towards the establishment of the MCP, the Stockport partnership considered five organisational forms, including contractual alliance; new neighbourhood led accountable care trust; a lead provider model; community interest company and; limited liability company.

Within the options appraisal, it considered which of these organisational forms would have the capacity to provide professional and clear governance which is suitable for all provider organisations and can work within the regulatory framework. It concluded that the neighbourhood led accountable care trust was the most suitable because, not only did it meet the regulatory and legislative requirements, it also would be possible to create a single organisation with clear and widely understood governance arrangements that could operate under new agreed branding, and could be developed in a sustainable way within a framework that is familiar to regulators and national bodies.

Source: Stockport Metropolitan Borough Council (2016). Multi-speciality Community Provider in Stockport: Options Appraisal of Organisational Form.

2.2.4 Understand the different needs of your diverse population

According to Leutz (1999) the 'law' of integration states that: *"you can integrate some of the services for all of the people, all of the services for some of the people, but you can't integrate all of the services for all of the people"*.

NHS England (2016b) states that before building a new care model, the MCP needs to gain a thorough understanding of its population. This understanding allows the MCP to segment its population based on needs, activity and spend, and therefore better align resources to these needs.

The King's Fund and Nuffield Trust recommend that within integrated care, commissioners need to have the ability to identify individuals in need of care and support, requiring a population-based approach involving tools to identify individuals with complex needs, and to target the proactive support and management of their needs (Goodwin et al. 2012). Analysis of case studies relating to commissioning of integrated care outlined that primary care trusts previously worked frequently with professionals and user groups to review current patterns of service use for a particular patient group, and to develop a new proposed pathway of care based on this review (Ham 2011). As a result, new patterns of care were considered to be clinically evidence based, offer a more integrated experience for users and carers, and able to create savings for investment in other areas (Ham 2011).

Reviews of research on integrated services have concluded that significant benefits can arise when integration is targeted at client groups for whom care is currently poorly co-ordinated (Curry and Ham 2010; Goodwin and Smith 2011; Ham et al. 2011; Rosen et al. 2011). The care for older people in Torbay is a good example of this (Thistlethwaite 2011). Integrated Care and Support Pioneer sites also most commonly prioritised older people with long-term conditions (LTCs), who tend to be the most intensive users of health and social care resources (Erens et al. 2015).

However, some caution is required when risk stratification approaches focus on identifying the most intensive users of health and social care. Many of these users will often have lower expenditure in subsequent years due to either being in their final year of life (when expenditure is also at its lifetime peak) or because they are suffering from acute conditions which respond to intensive treatment.

2.2.5 Logic model

Logic models that explain how the proposed transformations in care are intended to achieve outcomes are an essential part of a successful MCP (NHSE 2016b). Evidence from large-scale programmes relating to new care models has suggested that clear logic models are *"one of the active ingredients for successful change"* (NHS 2015).

Defining the ambitions and goals of integrated care, and translating these into specific and measurable objectives has also been identified as an important component in integrated care (Goodwin et al. 2012). A systematic review (Cameron et al. 2013) highlighted the importance to successful joint working of clear, realistic and achievable aims and objectives, understood and accepted by all partners including patients, families and carers. The review also notes it is critical for professionals to understand the aims and objectives of any joint initiative.

To ensure that it does explain how the proposed transformations in care are to achieve its intended outcomes, a logic model will typically consist of the following sequential elements:

Figure 1: Cordis Bright approach to building a logic model

Dimension	Description
Input	These include the different resources (e.g. financial, staff, stakeholder, equipment) that are required to deliver a service
Activities	These are the things that a service does or offers to participants
Outputs	Counting the "products" that result from running the activities
Outcomes	The immediate consequences and changes for the participants that are a result of the work of the scheme. Changes typically involve four areas of change: (1) knowledge), (2) skills, (3) attitudes and (4) behaviour
Impacts	The higher level and usually longer-term results in participant's lives, which the service may contribute towards, but which go beyond the direct or immediate change

To ensure that the MCP logic model has practical use, it is also important to consider what indicators will be required to demonstrate that outcomes have been achieved. One approach available to MCPs when deciding which indicators to measure is to apply the SMART test. This test has five criteria against which different indicators can be assessed. They are:

- **Specific:** Is the indicator clear, concise and does it capture the essence of what you are trying to measure?
- **Measurable:** Can the indicator be measured and quantified? Do you know how you are going to do this?
- **Achievable:** Is it challenging but realistic? Or is it just an unachievable aspiration?
- **Relevant:** Is this indicator important in terms of the overall outcomes you are trying to measure?
- **Timebound:** Can you say "by when" this will be achieved?

2.2.6 Value proposition

Establishing a financial case, or value proposition, is a recommended part of the process in establishing a successful MCP (NHSE 2016b). Within the value proposition the MCP should demonstrate its ability to deliver against the core aims of improving health and wellbeing, care and quality, and delivering financial efficiency. A systematic review of factors enabling the implementation of integrated health and social care argues that the financial benefits of integrating care services are still contested and should not be the sole focus in considering a value proposition; instead, a focus on benefits in terms of service

user experiences may facilitate improved engagement and adoption of integrated care (Mackie and Darvill 2016).

Careful consideration of data quality and the assumptions that form the basis of the value proposition is needed to ensure MCP projections are achievable and realistic. This applies to financial aims of the MCP as well as the health outcomes it seeks to achieve.

Value propositions for MCP vanguards may wish to consider the value of improved clinical outcomes, service user experience, service quality and safety on the one hand, as well as financial elements such as the cost of investing additional revenue, capital and non-financial resources into the Vanguard. Financial modelling may also include a counter-factual 'do nothing' model, which provides a second measure against which to judge an MCP's performance, in addition to its anticipated performance model.

2.2.7 Design and document each of the specific component parts of the care redesign

NHS guidance suggests that MCPs should design and document all components of care redesign, including clinical and business processes and protocols, team design and job roles. It is recommended that where services are more complex, a clear understanding of different costs, expected outputs and methods for selecting patients should be developed (NHSE 2016b).

The Integrated Resource Framework (IRF), developed by the Scottish Government and the NHS, helps partnerships to better understand resource use across health and social care. This enables clarity regarding costs, activity and variation across service planning and provision for different population groups, and contributes to development of integrated budgets required under proposed legislation (Ham et al. 2013).

The King's Fund highlight that the key to creating mechanisms and roles across organisations involved in supporting integration is to align systems, policies and boundaries (Gilburt 2016). Furthermore, developing new roles is often most successful when involved with building protocols alongside building relationships. When designing new components, protocols or job roles within an integrated system the King's Fund highlights that the skills required are often already present within the workforce – the challenge is ensuring these skills are shared and distributed as part of an overall integrated system of care that spans organisational boundaries. Therefore when designing new systems, it is important not only to consider what new resources the care system needs, but how existing resources can be redeployed.

2.2.8 Plan, schedule and manage the implementation of the changes

Planning, scheduling and managing the implementation of changes in the new care model in line with emerging design specifications and the value proposition timetable is a further important component of creating a successful MCP (NHSE 2016b).

Within this, the NHS also highlight that in order to be effective, MCPs should achieve clinical participation. Suter et al. (2009) note that physicians need to be effectively integrated at all levels of the system and play leadership roles in the design, implementation and operation of an integrated health system. They also point to findings from the literature which suggest that integrating physicians into care teams is not always easy, with shared decision making and inter-professional teams having been identified as key difficulties for doctors. However, they also conclude that integration of doctors at all

levels of the care pathway is a key success factor in making sure that integrated care works for the patient and that more care is delivered away from hospital settings. It is essential to have strong representation and involvement from GPs and consultants on the front line.

Patient participation is also included in this recommended component of MCPs. With regards to the improvement of care for people with long-term conditions, McShane and Mitchell (2013) have highlighted the need for patients to play an active role in their own care and support needs.

2.2.9 Learn and adapt quickly

According to NHSE, *"the success of an MCP depends on how it grows and deploys its assets"* (NHSE 2016b). Therefore, NHSE suggest that MCPs need to learn and adapt quickly, through timely monitoring and evaluation loops; and to identify successes and address failures within programmes.

Measurement is critical to the effective evaluation of any commissioning intervention; it is crucial that good measures – including strong baseline measures - are identified and reviewed from the beginning of the commissioning process. This is not only important in the context of final evaluation, but also in identifying areas for improvement and evidencing whether a change or intervention is a success.

Outcome measures are of key importance, but process and balancing measures should not be excluded. These can be very useful in determining effective change and action in the short term, especially where an intervention is particularly complex or where outcome measures can take a long time to determine. The King's Fund and Nuffield Trust have emphasised the need for regular and detailed assessment of patients', service users' and carers' experience of NHS services across the continuum of care. This would enable regular monitoring of how far integration efforts are meeting intended outcomes (Goodwin et al. 2012).

Furthermore, they suggest that this tracking should be used proactively by commissioners and providers to improve quality of care. Lack of monitoring, evaluation and audit systems has been identified as a key barrier in joint commissioning between health and social care agencies (Newman et al. 2012).

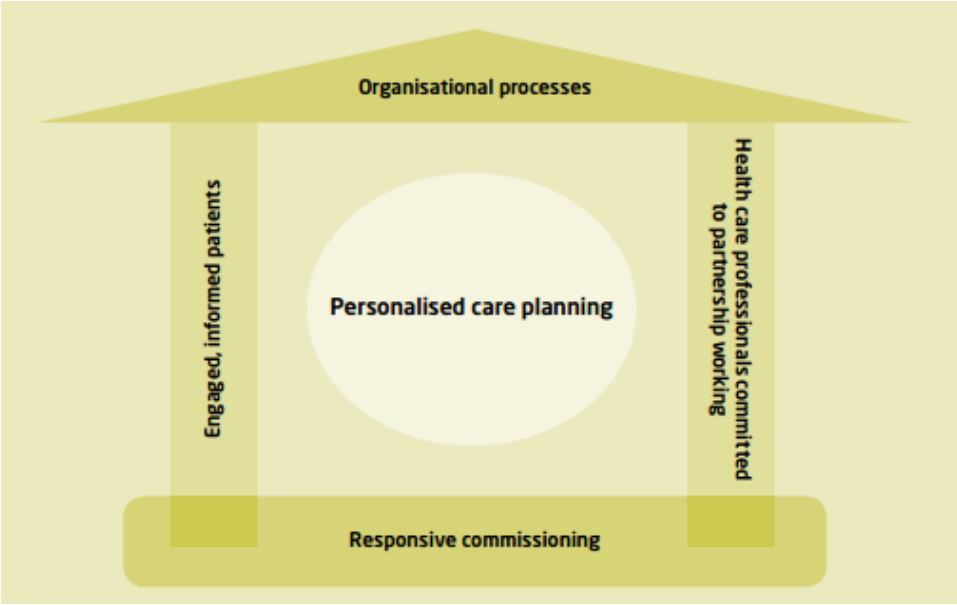
A culture of learning is also important within the organisation's workforce. For staff to become comfortable in integrated teams there needs to be a culture of learning and practical opportunities for staff to share experiences of what has and has not worked. Where this is not present, silo working tends to persist, despite structural organisational change. In particular, cross-disciplinary teams need to be brought together for training and learning (Tucker 2012).

2.2.10 Commissioning and contracting

Commissioning and contracting for the new model, particularly in order for organisational forms and financial flows to support the goals of the model, is the final component recommended by the NHS for creating a successful MCP (NHSE 2016b). The impact of effective commissioning can be reflected in the ability of integrated teams to effectively utilise pooled budgets to develop packages of care for services users.

The 'House of Care', shown in Figure 2, has been adopted as a key metaphor in NHS England's plans for improving care for people with long-term conditions and illustrates a whole-system approach to delivering services (McShane and Mitchell 2013; Coulter et al. 2013). Responsive commissioning forms the foundation of the model. Key components of responsive commissioning are reported to include: development of the market to meet current and future needs; identification of needs and mapping of resources; and ensuring sufficient time for consultations, training and IT.

Figure 2: House of Care model



Source: Coulter et al. 2013

Based on consideration of case studies of innovative models of primary care that have employed contracting methods with a performance-based element, The King's Fund has argued that the best way of commissioning MCPs specifically is to utilise population-based capitated contracts linked to the delivery of agreed outcomes (Addicott and Ham 2014). For example, in one inner city area where 36 practices had formed a network of GP federations, 60% of contract values were paid as usual, and the remaining 40% of contract value was allocated based on network performance. Therefore organisations only received full payment if all partners achieved their system-wide objectives together. This network successfully achieved a range of clinical outcomes but also facilitated the development of stronger relationships between GPs and commissioners, community services and social care (Addicott and Ham 2014).

2.3 Other good practice principles in integrated care

Research regarding integrated care and MCPs also identified a number of good practice principles that are not included in NHSE's (2016b) list of components. These are: sharing information and learning; information systems; and patient-centred models. They are outlined in more detail below.

2.3.1 Sharing information and learning

Sharing advice, support and learning between Integrated Care and Support Pioneer sites was identified by the programme evaluators as a key facilitator in integrated care (Erens et al. 2015). The same evaluation found that all the Pioneer sites that were consulted recognised information sharing across agencies and services as an *"essential building block for integrated care",* and identified that some sites had set up informal networks such as teleconferences where they could share learning (Erens et al. 2015).

This was recognised in NHSE's New Care Models support package, which emphasised the importance of sharing knowledge, with MCPs providing a key opportunity to share knowledge and learning through formal and informal channels (NHSE 2015b).

2.3.2 Information systems

The King's Fund and Nuffield Trust have highlighted the importance of sharing clinical data within integrated care, and stated that innovative approaches are needed to share data together with a commitment to developing shared clinical records (Goodwin et al. 2012). Moreover, when implementing new ways of working which have challenging financial targets attached, it is critical to be able to track progress.

Studies have found that success depends on robust information systems for rapid communication between sectors and organisations and within teams, including using a single record gathered from shared assessments (Suter et al. 2009). This is only possible with an IT system that allows data management and effective tracking of activity and outcomes.

Quality information systems also enhance communication capacity and information flow across integrated pathways. Electronic health records link users, commissioners and providers across the continuum of care and provide relevant information to these stakeholder groups. It is essential that information can be accessed from anywhere in the health and social care system, at any time, even in remote locations, to facilitate seamless communication between providers for the benefit of patients. The information system should also enable system-wide patient registration and scheduling coordination as well as management of clinical data. The ability to integrate clinical and financial information is viewed as important for monitoring cost-effectiveness and facilitating service planning (Suter et al. 2009).

However, developing and implementing integrated electronic systems is time-consuming, complex and costly. Poorly designed electronic information systems, systems that are not used by providers, lack of a clear business plan, lack of common standards, inadequate training and incentives for providers to participate, poor technology solutions and ineffective leadership all contribute to failure of information integration (Suter et al., 2009).

At a lower level of integration, the sharing of patient/service user information between health and social care services has often been hindered by a range of other barriers, such as information governance restrictions and technical problems, such as incompatible IT systems (Erens et al. 2015). The Pioneer sites attempted to devise their own solutions to information governance restrictions through share agreements between organisations, creating data 'safe havens' or sub-contracting to accredited providers (Erens et al. 2015).

2.3.3 Patient-centred models

Personalisation

The Nuffield Trust have suggested that service users are *"the organising principle of integrated care"* (Shaw et al. 2011). Therefore, the need for a shared vision encompassing the service user perspective and patient experience is essential. Organisations and interventions that fail to place the patient or service user at the centre of their integration efforts are unlikely to succeed. Failing to take into account patients' and carers' choices can, for instance, lead to major delays in the discharge of patients from acute care.

Co-production of services

The importance of involving the communities served in the design of services, as well as getting feedback from users, has also been stressed (Suter et al. 2009; Cameron et al. 2013). Service users and carers do not care about the structures and processes adopted by health and social care agencies; what they do care about is the timeliness, flexibility, responsiveness and suitability of the services they receive. In other words, they care about the impact and outcomes upon them that these services have. As such, notwithstanding the complexities of developing appropriate outcomes measures, defining outcomes that matter to service users and carers is important (Cameron et al. 2013) even where they differ from policy and practice imperatives. This is an integral part of delivering co-produced services.

Single point of access

Integrated health systems should also be easy for patients to navigate. One way of ensuring this is to provide a single point of access and a single key worker for patients, which has been shown to improve provision and patient experience (Cameron et al. 2013).

3 Barriers to effectiveness

In addition to the good practice principles described above, possible barriers to the implementation of effective integrated services through an MCP can be summarised as:

- **Time**: Integrated care requires a complex set of elements that take time to develop and embed (Curry et al. 2013). Due to this, it is essential that sufficient time is provided for structures to be put in place. Service leaders and policy makers are often keen to see change happen at scale and pace, because there is a risk that if projects do not deliver immediate financial benefits they may be deemed unsuccessful and abandoned. Research results have reported that where there is a lack of time and resources available to demonstrate change, integrated care can been seen as having failed to achieve its desired goals (Steventon et al. 2011).

- **Misaligned performance indicators and financial incentives**: Typically, financial savings through integrated care projects are realised in the acute sector, while the majority of the services provided are based in primary and social care. The evaluation of the English integrated care pilots found that reluctance to shift resources across the system was a key barrier to integration.

- **Reluctance to learn from elsewhere**: There is a considerable body of evidence of "what works" in integrated care, and independent organisations such as the Nuffield Trust, King's Fund and Health Foundation have collated much of this into accessible documents for practitioners. It is important for projects to be able to learn from what has happened elsewhere and to introduce continuous evaluation into their work to ensure that formative learning also happens.