Shifting the Balance of Care

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Today’s presentation

- Shifting care out of hospital: Why do it?
- What does the evidence say?
- Why is it so hard?
- What are the workforce issues?
- Conclusion
- Q&A
Shifting care out of hospital: why do it?

The Triple Aim:

1. It’s cheaper

2. It improves quality of patient care

3. It improves health and wellbeing
Multiple policy interventions, little shift

- "Ease the pressure on hospitals."
- "Shift in the centre of gravity of spending."
- "Significant expansion of care in community settings."
- "Out-of-hospital care needs to become a much larger part of what the NHS does."

Year:
- 2000
- 2006
- 2013
- 2014
An unequal battle?

Community
- Social care cuts
- GPs/capita Declining
- 35% fall district nurses

Hospital
- 50% increase consultants
- Payment for activity
- Prestige/skills/ capacity
- Infrastructure
But now there’s extra imperative

Trends in hospital activity
Financial pressures

£22bn gap by 2020

Reference: Robertson et al (2017) The King’s Fund
All leading us to.....
A new model of hospital care?
A new model of primary & community care?

- Integration or collaboration
- Multi-disciplinary teams including patient-centred support for behaviour change
- Risk stratification and proactive intervention
- Detailed knowledge of the patient population and context-specific interventions
- E-rostering and workflow tech.
- Creative use of skill mix e.g. using pharmacists for medicines optimisation
- Aligned regulation and oversight
- Prof- to-prof telehealth
- Shared EHRs and real-time data
- Mobile working
- Co-location
- Shared protocols and guidelines
- Strong leadership and management capability that builds on open and collaborative culture
- Emphasis on relationships and continuity of care

Enablers
Model
What does the evidence say?
What we did

- Reviewed evidence for 27 common initiatives intended to reduce hospital utilisation
- High quality evidence (Cochrane, RCT, systematic reviews) with ‘grey’ literature where other evidence not available
- Focused on cost savings but recognised other values

Categorised initiatives into:
1. Positive evidence re reduced costs/activity
2. Mixed or emerging evidence re reduced costs/activity
3. Evidence to suggest increased costs/activity
The state of the evidence

• Limited
• Small studies
• Many are poorly-constructed
• Most are single-disease focused
• Few focus on cost
• Few consider the whole system
• Context-specific
• But, many demonstrate positive impacts in terms of patient experience or outcomes
# Redesigning elective pathways

<table>
<thead>
<tr>
<th>Relative strength of evidence of reduction in activity and whole-system costs</th>
<th>Initiative</th>
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<tbody>
<tr>
<td>Most positive evidence</td>
<td>• Improved GP access to specialist expertise</td>
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| Mixed evidence, particularly on overall cost reduction                     | • Peer review and audit of GP referrals  
|                                                                             | • Shared decision-making to support treatment choices  
|                                                                             | • Shared care models for the management of chronic disease  
|                                                                             | • Direct access to diagnostics for GPs |
| Evidence of potential to increase overall costs                            | • Consultant clinics in the community  
|                                                                             | • Specialist support from a GP with a special interest  
|                                                                             | • Referral management centres |
Redesigning elective pathways

• Significant scope in the medium to long term to redesign the elective pathway and deliver a more integrated model of elective care, with much more outpatient care delivered in primary care.

• A much more radical redesign of elective care underpinned by technology, including clinical decision support, and adoption of shared decision-making could yield savings.

• Many of the initiatives that have shown promise to date bring new expectations of GPs; nearly all require GP training and support.
Redesigning urgent and emergency care pathways

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<td>Most positive evidence</td>
<td>• Ambulance/paramedic triage to the community</td>
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<tr>
<td>Emerging positive evidence</td>
<td>• Patients experiencing GP continuity of care</td>
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<tr>
<td>Evidence of potential to increase overall costs</td>
<td>• Extending GP opening hours</td>
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<td></td>
<td>• NHS 111</td>
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<td>• Urgent care centres including minor injury units (not co-located with A&amp;E)</td>
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Redesigning urgent and emergency care pathways

- There are opportunities to redesign the urgent and emergency care pathway.
- Dependent on capacity in primary care and improved data-sharing between sectors.
- Staff need to be sufficiently trained, particularly where decisions about referrals are made.
- Influencing patients’ behaviour prior to their contact with urgent or emergency services, or to prevent further use of services (i.e. extending GP opening hours, NHS 111 and urgent care centres which are not co-located) can be difficult.
- Providing alternatives to A&E in the community runs the significant risk of supply-induced demand and inflated costs.
### Avoiding hospital admission and facilitating discharge

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<tr>
<td>Most positive evidence</td>
<td>• Condition-specific rehabilitation</td>
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<tr>
<td>Emerging positive evidence</td>
<td>• Senior assessment in A&amp;E</td>
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<td>• Rapid access clinics for urgent specialist assessment</td>
</tr>
<tr>
<td>Mixed evidence, particularly on overall cost reduction</td>
<td>• Intermediate care: rapid response services</td>
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<td>• Intermediate care: bed-based services</td>
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<td>• Hospital at Home</td>
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Avoiding admission and facilitating discharge

- Condition specific rehabilitation, most positive outcomes. Pulmonary and cardiac rehabilitation improve quality of life and reduce hospital admissions, and cost effective.

- Emerging positive evidence for rapid access clinics and senior decision-makers in A&E, further research needed, particularly economic impact.

- Evaluation of rapid response teams and the use of intermediate care beds more mixed results. Local implementation and context play a large part in their success. Clear referral criteria and good integrated working across health and social care appear to be important.

- Hospital at Home schemes successfully provide a safe alternative to hospital, but there is little evidence that they deliver net savings.

- Alternatives to hospital care may be preferable for patients and supporting independence – but may not be cheaper for the system.
## Managing “at risk” populations

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| Most positive evidence                                                     | • Additional clinical support to people in nursing and care homes  
|                                                                             | • Improved end-of-life care in the community  
|                                                                             | • Remote monitoring of people with certain long-term conditions  |
| Emerging positive evidence                                                 | • Extensivist model of care for high risk patients  |
| Mixed evidence, particularly on overall cost reduction                      | • Case management and care coordination  
|                                                                             | • Virtual ward |
Risk stratification: appealing but challenging

- Targeting high risk groups has been shown to be effective and is a central tenet of “population health”
- However, only represent 9% of emergency admissions
- This need very high impact on those at greatest risk to have overall impact on the wider system
- Much more challenging to have impact on the larger population of lower risk patients (possible explanation for low impact of care coordination

Adapted from: Roland and Abel, 2012
Support for self care

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<td>Support for self-care</td>
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<td>Emerging positive evidence</td>
<td>Social prescribing</td>
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Degree of patient “activation”

![Diabetes Self-care Behaviors chart](image-url)
Why is it so hard?
A gap between theory and practice

“Improvement initiatives are sometimes planned on the hard high ground, but are put into effect in the swampy lowlands.”

- Marshall and others, 2016, BMJ Quality & Safety
Implementation needs to take wide range of factors into account

- Context matters
- Requires rigorous framing of the problem and contextual factors that could influence feasibility and effectiveness
- Including influencing professional behaviour such as attitudes to risk

**System governance factors**
- Governance models
- Commissioner behaviour/ relationships
- Provider behaviour/ relationships
- Staff beliefs and values
- Leadership

**Hospital factors** (supply side)
- Access (rurality)
- Internal processes – admission, treatment and discharge

**Community factors**
- Primary care supply and capacity
- Community care supply and capacity
- Local authority care supply and capacity

**Patient factors** (demand side)
- Age
- Socioeconomic status
- Sex
- Health needs
- Beliefs and values

*Source: Imison and others, 2012*
Savings are difficult to realise in reality

- Some interventions identify unmet need = increase activity
- New services can fuel supply-induced demand
- Savings depend upon capacity being taken out of hospital
Monitor work

RR- Rapid Response, ESD Enhanced Step-Up

- assumes that the community based schemes are “well designed and operate efficiently – with findings on upper-end estimates of the numbers eligible for the schemes and the efficacy of the schemes”
- requires accurate targeting of schemes at patients who would otherwise be admitted.
- harder to make savings for more widely dispersed populations.
At a time when primary and community care facing significant challenges

- 1/3 GP practices have a vacancy for at least one partner
- 2016 - NHS England identified 20% GP practices as vulnerable
- 1/5 district nurse posts vacant
What does this mean for reshaping the workforce?
There are huge opportunities to reshape the workforce and enable:

- More patient focused care
- Improved health outcomes
- More rewarding roles and happier staff
- Improved collaboration and support
- Improved recruitment and retention
- Addressing workforce gaps
- Better use of resource
But to realise those opportunities you will need to:

- Build roles on a detailed understanding of patient needs and necessary skills
- Have a strong communications and change management strategy across the system
- Invest in the team, not just the role
- Support task delegation – you may need to decommission old roles if commissioning new ones
- Build sustainability through clear career pathways and evolve to make the best use of new skills
- Evaluate the impact of your workforce redesign
The ask of system leaders

- Invest in workforce redesign, even if resources are stretched
- Create a culture of support for change – focused on patient benefits
- Ensure there is strong and dedicated leadership for change
- Implement strong supporting systems and governance structures
- Develop links with key stakeholders
- Develop partnerships with HEIs
Conclusion
It’s hard work

• The NHS is undertaking the herculean task of changing its modus operandi at the same time as experiencing the leanest years in its history.

• Nobody can argue against the principle of better, more appropriate care closer to home.

• But we cannot assume that this will save money, especially in the short term.

• To succeed, we need a relentless focus on what works.

• Recognition that this requires significant change in primary, community and secondary care – for the balance to shift the model needs to change.

• Need realism about whether the funding envelope is big enough to deliver the transformation needed.
But worth it

• More patient focused care
• Improved health outcomes
• Better use of resource
• More rewarding roles and happier staff
• Improved collaboration and support
• Improved recruitment and retention
• Part of a broader strategy to address workforce gaps