Shifting the balance of care

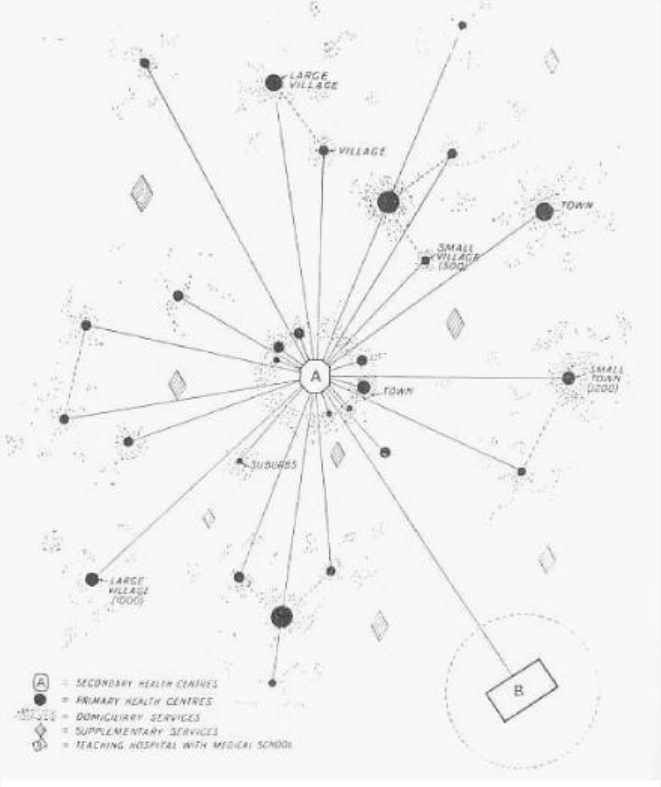
Great expectations

nuffieldtrust

A long term ambition

“The general availability of medical services can only be effected by new and extended organisation, distributed according to the needs of the community. This organisation is needed on grounds of efficiency and cost, and is necessary alike in the interest of the public and of the medical profession.”

Interim Report on the Future Provision of Medical and Allied Services (Dawson **1920**)



Five main areas

1. Changes in the elective care pathway.
2. Changes in the urgent and emergency care pathway.
3. Time-limited initiatives aimed at avoiding admission or facilitating discharge from hospital.
4. Managing ‘at risk’ populations including end-of-life care and support for people in nursing homes.
5. Support for patients to care for themselves and access community resources.

Evidence suggests some initiatives may reduce activity and save money

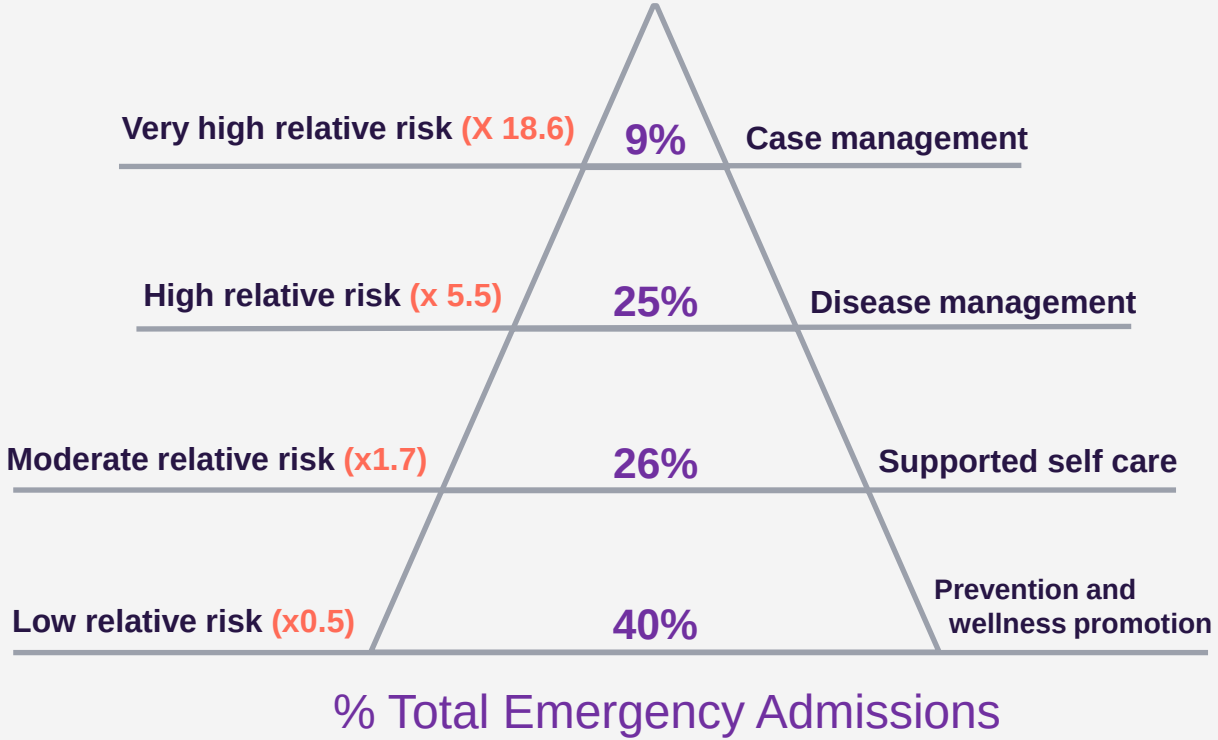
Most Positive	Emerging positive
Remote monitoring of people with certain LTCs	Patients experiencing GP continuity of care
Improved end-of-life care in the community	Extensivist model of care for high risk patients
Condition specific rehabilitation	Social prescribing
Targeted support for self care	Senior assessment in A&E
Additional clinical support to people in nursing and care homes (including staff)	Rapid access clinics for urgent specialist assessment
Improved GP access to specialist expertise	
Ambulance/paramedic triage to the community	

Many initiatives may not save or may cost money

Mixed - re £ + activity	May cost ££
Case management and care coordination	Extending GP opening hours
Intermediate care: rapid response services	Specialist support from a GP with a special interest
Intermediate care: bed-based services	Consultant clinics in the community
Hospital at Home	NHS 111
Shared care models for the management of chronic disease	Urgent care centres including minor injury units (not co-located with A&E)
Virtual ward	Referral management centres
Shared decision making to support treatment choices	
Direct access to diagnostics for GPs	

Risk stratification: challenges

- Regression to mean
- Requires holistic view of patient
- Patient's capacity to engage
- Need very high impact on those at greatest risk to have impact overall
- Impact dissipated when applied to larger lower risk groups



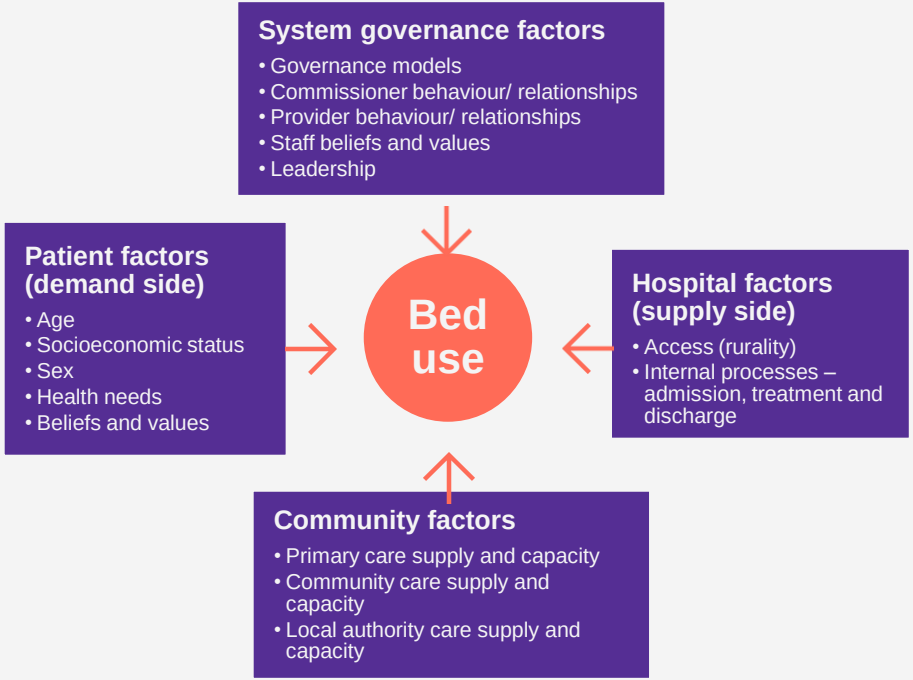
Adapted from: *Roland and Abel, 2012*

The 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



Imison and others, 2012

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

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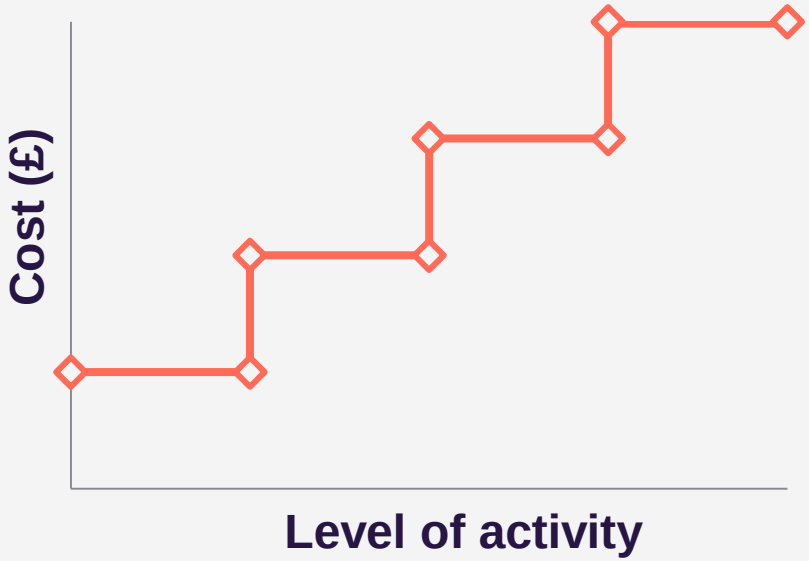
Case management and care coordination	Extending GP opening hours
Intermediate care: rapid response services	Specialist support from a GP with a special interest
Intermediate care: bed-based services	Consultant clinics in the community
Hospital at Home	NHS 111 – telephone triage by external agency
Shared care models for the management of chronic disease	Urgent care centres including minor injury units (not co-located with A&E)
Virtual ward	Referral management
Shared decision making to support treatment choices	
Direct access to diagnostics for GPs	

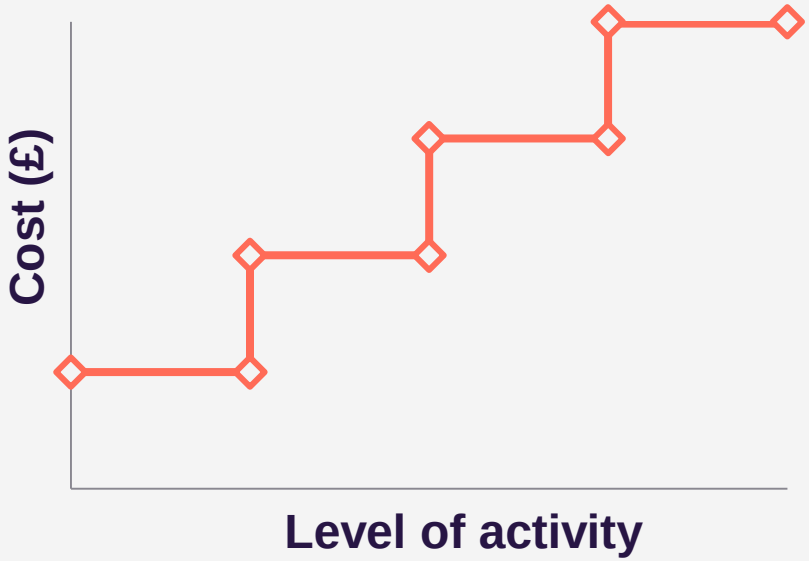
Why is it so hard to release savings from shifting care?

- “Lumpy” hospital costs - Price ≠ Cost
- Variable:
  - Nursing costs
  - Food & consumables
- Semi-variable
  - Energy
  - Support with minimum staffing levels
- Fixed
  - Buildings
  - Facilities management
  - Basic support services



Why is it so hard to release savings from shifting care?

- Lower unit costs in community do not mean lower costs overall.
- Care coordination can cost more than it saves
  - Additional services - supply-induced demand
  - Targeting overuse can expose underuse
  - Traditional primary care may actually be rather good
  - Accuracy of predictive models



Payer vs system impact

Cost to payer of hospital week	£1400
Cost for a care home	£800
Saving to payer	£600

But if 80% are fixed total cost to the system rise to £1720

If the payer can ignore the impact on the provider there is still a risk. Assume each patient week allows 2 new admissions:

Cost to payer = 2* £1500 + £1720

Average cost has fallen, but total cost has risen.

Will economic benefits only be visible when we have whole system change?

- A more radical approach needed?
- Initiatives have been too small and underpowered?
- Unsupported by wider system incentives
- More time

Conclusion

- 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 unless there is a parallel focus on provider cost reduction
- To succeed, we need a relentless focus on what works
- Crucially, to admit when the funding envelope simply isn’t big enough to deliver the transformation needed.

Framing ideas for service change

Hunches, anecdotes or incomplete diagnosis

Measuring activity not demand

Mistaking activity for value

Understanding the importance of context

Identifying the active ingredient when copying

Being clear about what we mean e.g. integration

Losing sight of the patient

What matters to me?

“The redesign a diabetes pathway is a totally different proposition from understanding what help people with diabetes need in their lives, then designing in response to that”

Standardisation – sometimes misunderstood.

The rule is “*design in response to variety” not “standardise and streamline to control it”*

Setting objectives

Too many

Too vague

Avoiding difficult issues

Framing:

- To appeal to external funders
- In ways that alarm staff
- Failing to respond to patient needs

Project design

Projects are often highly complex

Gaps in the logic model between intervention and outcome

Project design

Very ambitious timescales

Lots of examples of the planning fallacy

Leadership & governance

Give the project to someone who is already too busy

Absent senior leaders

Anxious finance directors

The problem of defection in multi-organisation collaboration

Losing sight of the patient

Death by assurance

Technical issues

Boring but important

Financial flows

Information governance

Legal and regulatory issues cannot be wished away

Some of these are not really the barriers they are claimed to be

Relationships

The importance of relationships and behaviours are underestimated

History and previous failures to deliver

Institutional focus (more likely where the emphasis is on resource shifts)

Defection and other bad behaviour

Avoiding difficult issues is common

Health centric thinking

Evaluation

Too early or underpowered

Changing objectives over time

Choosing measures wisely

Over claiming savings

Understanding the system dynamics effects

Pilots can mislead

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