SOME REFERENCES and EVIDENCE BASE ON COMMUNITY-BASED CARE and INTEGRATED CARE and IMPACT ON ACUTE PATHWAY INCLUDING ADMISSION AVOIDANCE and INTEGRATED CARE / OUT OF HOSPITAL CARE

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1: Are the Department of Health & NHS England making evidence-based strategy?

Greg Dropkin on Warrington, St Helens, West Cheshire and Liverpool – ACOs & MCPs
http://www.labournet.net/other/1703/stpaco2.html
Evidence?
The NHS is supposed to deliver evidence-based medicine, clinicians are educated on that basis, and new treatments are only licensed after passing rigorous trials and cost-benefit analysis. What's the point to medical school or nurse training if evidence is tossed overboard?

The St Helens plan purports to list evidence for each of their plans. None of it is referenced. For example: "Stand alone telephonic case management has been estimated to reduce admissions by 5%." Says who? The Nuffield Trust (pp85-6) says there is mixed evidence on case management. Research at the University of Manchester published in 2015 is entitled "Effectiveness of Case Management for 'At Risk' Patients in Primary Care: A Systematic Review and Meta-Analysis". From the abstract (https://www.ncbi.nlm.nih.gov/pubmed/26186598):
This was the first meta-analytic review which examined the effects of case management on a wide range of outcomes and considered also the effects of key moderators. Current results do not support case management as an effective model, especially concerning reduction of secondary care use or total costs.
St Helens says: "Social prescribing has saved Newcastle West CCG an estimated £2 - £7 million". This is actually the Ways to Wellness programme (http://www.newcastlegatesheadccg.nhs.uk/nhs-in-newcastle-commits-1-65m-to-improve-long-term-health-conditions/) which started in 2015 and runs for 7 years. It hasn't been evaluated yet. Nuffield (p95) describes it as a "large scale trial". The actual savings it will achieve are, at this stage, only projected.

Warrington says “Evidence shows that proactive planning using risk stratification is a key tool to improving outcomes”. Again, no reference for that. The Nuffield review (pp87-9) found risk stratification tools still struggle to identify ‘at risk’ individuals at the point before they deteriorate. A virtual ward is a model of home-based multidisciplinary care based on the idea of a hospital ward. Intended to avoid emergency admission or readmission, patients are typically identified using a risk stratification tool. As Nuffield reported, an evaluation of three NHS virtual wards targeting patients at risk of admission found no reduction in emergency hospital admissions in the six months after admission to the ward, but it did find a decrease in elective admissions and outpatient attendances. There was no reduction in overall hospital costs.

2: Overview on proposition that there are alternatives that can replace hospital care

NHS For Sale: Myths, Lies & Deception. Jacky Davis, John Lister, David Wrigley. 2015. pp 44-47- Are alternatives any cheaper? Do they even work? [references in book] http://keepournhspublic.com/

Monitor. Moving healthcare closer to home: a summary
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/459400/moving_healthcare_closer_to_home_summary.pdf

It is difficult to cut costs across a local health economy in the short run
Although schemes can help hospitals avoid future capital spending, it is difficult for local health economies to save costs in the short run through community-based schemes. Three of the four schemes we modelled did not break even within five years. This is because:

- Schemes can take up to three years to set up, recruit and become sufficiently credible to attract referrals. So providers and commissioners should not expect immediate impacts.
- Even when schemes are cheaper per patient, it may be difficult for the local health economy to realise any savings. A local scheme (or schemes) will only lead to health economy-wide savings if it consistently diverts enough patients from local acute hospitals to allow them to close bed bays or wards. The cost saving is then only realised if providers and commissioners have the will to close down capacity that is freed up. In the context of rising demand for acute care, commissioners and providers will need to be entirely confident that community-based schemes can safely absorb expected extra demand before they will feel justified in closing acute capacity. However, community-based schemes will help commissioners and providers to avoid or delay future capital spending whether acute capacity is closed or not.

3: Is there evidence for community based care reducing hospital admissions safely?

Developing accountable care systems: Lessons from Canterbury, New Zealand. **Anna Charles. Kings Fund. August 2017**

https://www.kingsfund.org.uk/sites/default/files/2017-08/Developing_ACSs_final_digital_0.pdf

Here is evidence suggesting significant positive outcomes, such as reducing the need for hospital care by supporting more (particularly older) people in their homes and communities in the context of a public health service and under conditions referred to in the introduction (see below). However, in its plans for accountable care systems, NHSE fails to take into account the absence in England of several *important features essential to the success of the Canterbury model.* These include *the maintenance of acute bed numbers alongside increased investment in community-based services, and sustained investment in staff to*

give them the skills and confidence to innovate. Significantly, as well as investment, *the Canterbury transformation has taken more than a decade* while still not eradicating a substantial underlying deficit. This highlights the challenge of the tight timescales and limited funding attached to current plans for the transformation of NHS services.

Introduction from this Kings Fund report:

One of the biggest challenges currently facing the NHS is how to slow increasing demand for acute hospital care. In New Zealand, the transformation of the Canterbury health system provides an example of how this has been done, and indicates that expanding hospital capacity is not inevitable if investment is made in alternative models of provision and community-based services. • Three key approaches were central to delivering the transformation in Canterbury: the development of a clear, unifying vision behind the 'one system, one budget' message; sustained investment in giving staff skills to support them to innovate and giving them permission to do so; and developing new models of integrated working and new forms of contracting to support this. The changes in Canterbury have been the result of collaborative working, relying on system leadership, and strong relationships and staff engagement across the health and care system. • The overall transformation has not been the result of one 'big bang' change, but an aggregation of many simultaneous changes to the way in which care is organised and delivered. A number of new programmes and delivery models were developed as part of the transformation. Common themes running through these were integrating care across organisational and service boundaries; increasing investment in community-based services; and strengthening primary care. The networked organisation of general practice has been key to many of the developments. • As a result of the transformations, the health system is supporting more people in their homes and communities and has moderated demand for hospital care, particularly among older people. Compared with the rest of New Zealand, Canterbury has lower acute medical admission rates; lower acute readmission rates; shorter average length of stay; lower emergency department attendances; higher spending on community-based services; and lower spending on emergency hospital care. • Although the Canterbury system has moderated demand for acute care, it has not cut beds or taken resources from hospitals in absolute terms, and its finances remain challenging. This casts doubt over expectations that new models of care will enable disinvestment in acute hospitals in the NHS. A more realistic goal would be to bend the demand curve, slowing – but not reversing – growth. • The changes in Canterbury required investment – for example, in implementing new technologies, training staff and developing new models of provision – and took several years. [ten years – TOS] These are also prerequisites for transformation in the NHS.

Shifting the balance of care: Great expectations. **Nuffield Trust.** 1 March 2017
https://www.nuffieldtrust.org.uk/research/shifting-the-balance-of-care-great-expectations

1. Demographic and other drivers create an imperative to shift the balance of care from hospital to community. The NHS plans to undertake this transition while demand rises and it experiences the longest period of funding constraint in its history.
2. NHS national policy-makers plan that moving care out of hospital will deliver the 'triple aim' of improving population health and the quality of patient care, while reducing costs. This [long-time] goal for health policy in England is a key element of many STPs currently being developed.
3. Some STPs are targeting up to 30% reductions in some areas of hospital activity, including outpatient care, A&E attendances and emergency inpatient care over the next four years. Yet this is being planned in the face of steady growth in all areas of hospital activity – for example a doubling of elective care over the last 30 years
4. Drawing on a review of the STPs and an in-depth literature review of 27 initiatives to move care out of hospital, we look at what their impact has been, particularly on cost, and what has contributed to their success or otherwise.

5. Many of the initiatives outlined in this report have the potential to improve patient outcomes and experience. Some were able to demonstrate overall cost savings, but others deliver no net savings and some may increase overall costs.
6. Where schemes have been most successful, they have: targeted particular patient populations (such as those in nursing homes or the end of life); improved access to specialist expertise in the community; provided active support to patients including continuity of care; appropriately supported and trained staff; and addressed a gap in services rather than duplicating existing work.
7. Analysis suggests that the falls in hospital activity projected in many STPs will be extremely difficult to realise. A significant shift in care will require additional supporting facilities in the community, appropriate workforce and strong analytical capacity. These are frequently lacking and rely heavily on additional investment, which is not available.
8. NHS bodies frequently overstate the economic benefits of initiatives intended to shift the balance of care. … They may use prices to calculate savings rather than actual costs and can therefore wrongly assume that overhead or fixed costs can be fully taken out. Similarly, many underestimate the potential that community based schemes may have for revealing unmet need and fuelling underlying demand.
9. The implementation challenges involved in shifting care out of hospital are considerable and even initiatives with great potential can fail. This is often because those responsible for planning and implementing them do not take into account the wide range of system, organisational and individual factors that impact upon their feasibility and effectiveness. Many schemes rely on models to identify 'at risk' groups that are often deficient and fail to adequately identify patients genuinely at risk of increased hospitalisation.
10. Many initiatives place additional responsibilities upon primary and community care, at a time when they are struggling with rising vacancies in both medical and nursing staff, and an increasing number of GP practices are closing. Addressing these issues is a necessary precursor to success
11. It is possible that many of the initiatives explored in this report have been too small and haven't been supported by wider system interventions and incentives, and have therefore failed to shift the balance of care and deliver net savings. A more radical approach to the design and scale of the models being used might be required, but this will take time and resources to support the transition.
12. While out-of-hospital care may be better for patients, it is not likely to be cheaper for the NHS in the short to medium term – and certainly not within the tight timescales under which the STPs are expected to deliver change. The wider problem remains: more patient-centred, efficient and appropriate models of care require more investment than is likely to be possible given the current funding envelope

Effect of an Intensive Outpatient Program to Augment Primary Care for High-Need Veterans Affairs Patients – A Randomized Clinical Trial. JAMA, December 2016

Question Does an intensive outpatient program for high-need patients change utilization patterns and reduce costs in an integrated setting with a patient-centered medical home?
Findings In this randomized clinical trial of a Veterans Affairs intensive outpatient care program, the intervention was well received by a random sample of high-risk and high-cost patients but achieved reductions in hospitalization rates and costs similar to those of usual Veterans Affairs primary care.
Meaning Implementing intensive outpatient care programs in integrated settings with well-established medical homes may not prevent hospitalizations or achieve substantial cost savings.
http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2594282

David Oliver. Preventing hospital admission: we need evidence based policy rather than "policy based evidence". BMJ September 2014;
http://www.bmj.com/content/349/bmj.g5538

"In July 2014 commissioners throughout England published projections for reductions in urgent admissions to their local hospitals.1 But the size and speed of these reductions were not informed by any credible peer reviewed evidence—they rarely are.

Recent reviews by the Universities of Cardiff and Bristol on admission prevention and by the health think tank the Nuffield Trust on new models of service in the community, found that the big and rapid reductions were illusory, once the findings had been peer reviewed and control data taken into account." [other references in article]

Reducing emergency admissions: are we on the right track? **Roland M, Abel G 2012. BMJ 2012;345;e6017, 16 September 2012**
http://www.bmj.com/content/345/bmj.e6017 - [further 22 references in article]

"*Most admissions come from low risk patients, and the greatest effect on admissions will be made by reducing risk factors in the whole population ... even with the high risk group, the numbers start to cause a problem for any form of case management intervention - 5 percent of an average general practitioners list is 85 patients. To manage this caseload would require 1 to 1.5 case managers per GP. This would require a huge investment of NHS resources in an intervention for which there is no strong evidence that it reduces emergency admissions."*

http://www.biomedcentral.com/content/pdf/1744-8603-9-43.pdf Does investment in the health sector promote or inhibit economic growth?

http://www.hsj.co.uk/Journals/2014/11/18/l/q/r/HSJ141121_FRAILOLDERPEOPLE_LO-RES.pdf Commission on hospital Care for Frail Older People HSJ and Serco

Interventions to reduce unplanned hospital admissions. **S Purdy. Bristol University. 2012.** A series of systematic reviews of 18000 studies and includes a very handy 2-page summary of evidence.
http://www.bristol.ac.uk/primaryhealthcare/researchpublications/researchreports/

Executive summary:
*"**Background:** The overall aim of this series of systematic reviews was to evaluate the effectiveness and cost-effectiveness of interventions to reduce UHA* [unplanned hospital admission]. *Our primary outcome measures of interest were reduction in risk of unplanned admission or readmission to a secondary care acute hospital, for any speciality or condition. We planned to look at all controlled studies namely randomised trials (RCTs), controlled clinical trials, controlled before and after studies and interrupted time series. If applicable, we planned to look at the cost effectiveness of these interventions."*

*"**Conclusions:** This review represents one of the most comprehensive sources of evidence on interventions for unplanned hospital admissions. There was evidence that education/self-management, exercise/rehabilitation and telemedicine in selected patient populations, and specialist heart failure interventions can help reduce unplanned admissions. However, the evidence to date suggests that majority of the remaining interventions included in these reviews do not help reduce unplanned admissions in a wide range of patients. There was insufficient evidence to determine whether home visits, pay by performance schemes, A & E services and continuity of care reduce unplanned admissions."*

Executive summary of findings under individual categories
Overall **case management** did not have any effect on UHA although we did find three positive heart failure studies in which the interventions involved specialist care from a cardiologist*"*
"specialist clinics for heart failure patients, which included clinic appointments and monitoring over a 12 month period reduced UHA. … There was no evidence to suggest that specialist clinics reduced UHA in asthma patients or in older people."
Community interventions: Overall, the evidence is too limited to make definitive conclusions. However, there is a suggestion that visiting acutely at risk populations may result in less UHA e.g. failure to thrive infants, heart failure patients.
Care pathways and guidelines: There is no convincing evidence to make any firm conclusions regarding the effect of these approaches on UHA, although it is important to point out that data are limited for most conditions.
Medication review: no evidence of an effect … in older people, and on those with heart failure or asthma carried out by clinical, community or research pharmacists … the evidence was limited to two studies for asthma patients.
Education & self-management: Cochrane reviews concluded that education with self-management reduced UHA in adults with asthma, and in COPD patients but not in children with asthma. There is weak evidence for the role of education in reducing UHA in heart failure patients.
Exercise & rehabilitation: Cochrane reviews conclude that pulmonary rehabilitation is a highly effective and safe intervention to reduce UHA in patients who have recently suffered an exacerbation of COPD, exercise based cardiac rehabilitation for coronary heart disease is effective in reducing UHA in shorter term studies, therapy based rehabilitation targeted towards stroke patients living at home did not appear to improve UHA and there were limited data on the effect of fall prevention interventions
Telemedicine is implicated in reduced UHA for heart disease, diabetes, hypertension and the older people.
Vaccine programs: … the effect of influenza vaccinations on a variety of vulnerable patients. A review on asthma patients reported both asthma-related and all cause hospital admissions. No effects on admissions were reported. A review on seasonal influenza vaccination in people aged over 65 years old looked at non-RCTs. The authors concluded that the available evidence is of poor quality and provides no guidance for outcomes including UHA. A review on health workers who work with the elderly showed no effect on UHA.
Hospital at home: This was a topic covered by a recent Cochrane review of hospital at home following early discharge. Readmission rates were significantly increased for older people with a mixture of conditions allocated to hospital at home services.
We found insufficient evidence (a lack of studies) to make any conclusions on the role of finance schemes, emergency department interventions and continuity of care for the reduction of UHA.

4: Effect of targeted intervention to population 'at risk' of admissions

http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/red_cross_research_report_final.pdf The effect of the British Red Cross 'Support at home service'' on hospital utilisation. Nuffield Trust

"We analysed data on hospital use in the six months after referral to Support at Home. The Red Cross group had a 19% higher rate of emergency admissions than the control group. Accident and emergency visits were also similarly higher. Nonemergency admissions, however, were 15% lower in the Red Cross group than in the matched control group. There

was no significant difference between the two groups in terms of outpatient attendances." [extract from executive summary]

Effect of an Intensive Outpatient Program to Augment Primary Care for High-Need Veterans Affairs Patients. JAMA.February 2017.

http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2594282
'In this randomized clinical trial of a Veterans Affairs intensive outpatient care program, the intervention was well received by a random sample of high-risk and high-cost patients but achieved reductions in hospitalization rates and costs similar to those of usual Veterans Affairs primary care.'

5: On Integrated care

Health and social care integration. **National Audit Office. 6 February 2017**
https://www.nao.org.uk/report/health-and-social-care-integration/

1. Rising demand for services, combined with restricted or reduced funding, is putting pressure on local health and social care systems.
2. Nearly 20 years of initiatives to join up health and social care by successive governments has not led to system-wide integrated services.
3. The Departments* have not yet established a robust evidence base to show that integration leads to better outcomes for patients
4. There is no compelling evidence to show that integration in England leads to sustainable financial savings or reduced hospital activity
5. The Departments' expectations of the rate of progress of integration are over-optimistic.
6. Nationally, the Better Care Fund did not achieve its principal financial or service targets over 2015-16, its first year
7. Local areas achieved improvements in two areas at the national level.
8. The Departments are simplifying the Better Care Fund's assurance arrangements and will provide more funding from 2017-18
9. The Integrated Care and Support Pioneers Programme has not yet demonstrated improvements in patient outcomes or savings
10. NHS England's ambition to save £900 million through introducing new care models may be optimistic
11. The Departments and their partners are still developing their understanding of how to measure progress in integrating health and social care.
12. The Departments' governance and oversight across the range of integration initiatives is poor.
13. The Departments are not systematically addressing the main barriers to integration that they have identified.
14. Without full local authority engagement in the joint sustainability and transformation planning process, there is a risk that integration will become sidelined in the pursuit of NHS financial sustainability
15. NHS England has not assessed how pressures on adult social care may impact on the NHS
16. NHS England is diverting resources away from long-term transformation to plug short-term financial gaps

** Dept of Health; Dept of Communities & Local Govt; NHS England*

Accountable Care Systems and the National Health Service. KONP. November 2017

https://keepournhspublic.com/wp-content/uploads/2017/11/KONP-Briefing-Paper-ACOs-ACSs-2017-11-20.pdf

http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_summary/Reconfiguration-of-clinical-services-kings-fund-nov-2014.pdf The reconfiguration of clinical services: what is the evidence? Kings Fund. Candace Imison

http://www.nuffieldtrust.org.uk/sites/files/nuffield/evidence-base-for-integrated-care-251011.pdf http://www.nets.nihr.ac.uk/__data/assets/pdf_file/0005/81266/BP-08-1210-035.pdf
6: On impact of social care
David Oliver president, British Geriatrics Society, and visiting fellow, King's Fund. We cannot keep ignoring the crisis in social care. BMJ May 2015; http://www.bmj.com/content/350/bmj.h2684
7: Intermediate-based Care
http://www.nhsbenchmarking.nhs.uk/CubeCore/.uploads/NAIC/Reports/NAICReport2015FINALA4printableversion.pdf Executive summary begins: "Intermediate care and re-ablement services are a key plank of government healthcare policy to provide health and care closer to home." ***Improving access to intermediate care.*** **David Oliver. BMJ. 5 January 2017.** http://www.bmj.com/content/356/bmj.i6763
8: Telephonic case management
The Nuffield Trust (pp85-6) says there is mixed evidence on case management. Research at the University of Manchester published in 2015 is entitled "Effectiveness of Case Management for 'At Risk' Patients in Primary Care: A Systematic Review and Meta-Analysis". From the abstract (https://www.ncbi.nlm.nih.gov/pubmed/26186598): *This was the first meta-analytic review which examined the effects of case management on a wide range of outcomes and considered also the effects of key moderators. Current results do not support case management as an effective model, especially concerning reduction of secondary care use or total costs.* St Helens CCG claimed: "Stand alone telephonic case management has been estimated to reduce admissions by 5%." [Evidence for this not provided. Greg Dropkin. http://www.labournet.net/other/1703/stpaco2.html]

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