The future of primary and secondary care

Most analysts agree that one of the keys to the future of the NHS is a re-balancing of activity between primary care (general practice and community services) and secondary (hospital) care, combined with better, more coordinated working between these and other health and social care sectors. These proposals have major implications for the use of resources and of the NHS estate, and for professional careers and identities and raise a host of new questions.

How important is the location of services and will we have to close and sell off hospitals to really shift resources into primary care? How can tensions between generalist and specialists be resolved and real integration and joint working be achieved? Will the IT systems ever catch up with changing structures? How can we develop an evidence base for the effectiveness of the reforms, and how can we share best practice? Is it really possible to design services around patients, and how can the 'patient voice' truly be heard and heeded in service development? And finally, which, if any, of the proposals for change are going to save money? This last question is critical, not only because of the financial constraints now being placed on the NHS, but also because of recent evidence that seems to show that, while countries with strong primary care have better health outcomes and less health inequality, overall costs of health care may be higher.¹

We asked four people, who are particularly well placed to comment on the future of the service, to give us their perspectives on how things may develop in tomorrow's NHS.

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SHIFTING CARE FROM HOSPITALS TO 'COMMUNITY': A ROLE FOR HOSPITALS?

Mark Newbold

There is broad consensus that care must shift from hospital to community in the coming years, but is there a common understanding of what this means?

It is a shift in the model of care, not a move to a different building, that is needed. Demographic change dictates that a 'long-term conditions' model is now appropriate, given that most acute hospital admissions are for exacerbations of chronic illness, with or without frailty. This approach involves the active maintenance of health, so that acute flare-ups and the consequent need for urgent hospital admission are lessened. In this way wellbeing is improved and the need for in-patient capacity in hospitals is kept to a minimum.

The challenge is to organise the appropriate professionals to deliver this model of care. This matters more than the 'type' of employing organisation. There is a need for non-medical health and social care, and for generalist and specialist medical support.

My view is that specialist medical input, at least to diagnosis, initial assessment, and treatment planning, is essential. A life-long condition has enormous implications, and specialist expertise ensures optimum treatment and offers the best chance of maintaining health. It is what we would

want for ourselves.

Hospitals currently employ these specialists, and their teams. This could be changed, although most value working with specialist colleagues, rely on expensive diagnostic support, and have an in-patient commitment as well. However, many physician specialists now see their specialty evolving to manage patients on a 'year-round' basis, rather than just when they fall acutely ill. Some already do this: our cystic fibrosis service is a good example.

Specialists could work for organisations other than a hospital, but why is this change necessary? The core purpose of a hospital is to deliver specialist care, and it remains a logical home for specialists, so long as they deliver care differently. It would also eliminate the present divide between in-patient and continuing care.

The concern about hospitals taking on this role revolves around an over-focus on in-patient stays, driven by financial incentives and current culture. It is true that Tariff and Payment by Results prevent hospitals investing to reduce admission, but this can easily be changed. Cultural transformation will take longer, but many hospitals have started already, driven by recognition of the need to change emphasis, and the future of some medical specialties.

My acute trust now provides post-discharge care in the home, and an acute ambulatory medicine service to minimise admissions, as well as a range of traditional community services. We have expanded along the 'patient pathway' because it makes best use of our expertise and, crucially, allows us to minimise the in-patient part of the process. We have agreed a contract that incentivises us to reduce admissions, and it would now be easy to extend these services to offer patients with chronic disease, who are prone to admission, year-round care and support.

This approach responds to the population need, is minimally disruptive, creates integration of services for 'high need' patients, and offers a viable future for

"It is a shift in the model of care, not a move to a different building, that is needed."

hospitals. It supports the need for bed base contraction over time, which hospitals fully understand and appreciate. It would be easy to set up local collaborative arrangements with general practice to make expert generalist care available to those patients in less need of single specialty support.

As for the buildings, they should be accessible to patients and situated in their community, as indeed many hospitals are.

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THREE KEY FEATURES IN COMMUNITY HEALTHCARE CHANGES

James Reilly

Over two-thirds of all contacts in primary care are with people living with long-term conditions and over 70% of hospital admissions relate to predominantly older people with multiple long-term conditions. This group consumes over 80% of all NHS spend. However, the operating models of health care in all sectors of the NHS continue to be configured in the main around reactive responses to health crises. As a result our health system is becoming more over stretched. It is increasingly urgent that we systematically and proactively manage our patients with long-term conditions. There are three key features in the response of community health care: large scale change; integrated care in partnership; and responsiveness. Described below are the key features emerging in the partnership work occurring in north west and central London where our trust delivers community health services to a million Londoners living in four boroughs.

Over the past decade a range of intermediate care services delivering

“There are three key features in the community healthcare response: large scale change; integrated care in partnership with primary and social care; responsiveness.”

integrated responses have developed but are small in scale. Our first principle in grasping this challenge is that our plans must be at a whole population level and significant in scale. The adoption of predictive risk scoring is fundamental in identifying and targeting patient cohorts of a sufficient size, to enable proactive and preventative interventions which lead to better health outcomes and reduce the level of unplanned activity that is overheating the NHS. This requires shared data for planning and modelling purposes and data warehouse and sharing capabilities are being developed within frameworks of information sharing governance.

Inevitably, applying predictive risk assessments reveals how patient cohorts in the higher risk quadrants present with multiple conditions and comorbidities, especially in the majority frail older cohort. This gives rise to a second primary principle which is that our systems and interventions need to be integrated. Tangible integrated care has at its heart one single care plan, delivered by coordinated multidisciplinary teams, and supported by one integrated care record. Community healthcare services are changing their operating models to work in networks comprising primary and social care with contributions from relevant acute specialities operating in community settings. Such partnerships deploy the necessary multidisciplinary capability to proactively plan and work with these higher risk groups. No one has yet achieved an interactive integrated care record across these sectors but developmental work is making progress in shared information governance. Work is progressing in tackling the technical and contractual challenges to arrive at inter-

operative record systems. Organisational forms and governance arrangements are being adopted to give structure to the required partnerships which extend from colocated teams through to integrated care organisations.

The third challenge shaping community health care is responsiveness. To make a significant impact on A&E attendances and unplanned admission community, primary and social care are developing more timely responses to patient crises. The range of services emerging to safely bring and keep people at home include single referral and response points; care coordinator navigators empowered to raise care levels within a 2–4 hour time window; rapid response teams combining nurse and home social care capability to assess, treat, and stabilise over a 2–3 day period; early supported discharge schemes where the monitor and recovery episode of a hospital stay are supported in the patient's own home; intensive rehabilitation and reablement programmes; enhanced end-of-life care support at home and in care homes.

To reach these goals requires sustained partnership working mobilising the will and effort of both commissioners and providers. A strong common purpose around doing the right thing at all times to meet the needs of our highest risk patients is vital to create the environment for these developments to progress.

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“A strong common purpose around doing the right thing at all times to meet the needs of our highest risk patients is vital ...”

GIVING PATIENTS A BETTER HEALTHCARE EXPERIENCE

Renata Drinkwater

The NHS landscape is going through a radical transformation. Partly, the reforms have been driven by a strong rhetoric, firmly placed on bringing health care closer to patients' homes and their communities. On the ground, however, a key part of the jigsaw, patients themselves and their experience, still seems to be missing.

While research has reiterated the need to put patients first, it is not uncommon for patients not to be meaningfully included and engaged in relevant discussions and studies that will shape the future of the care they receive.

As *What is Integrated Care? An Overview of Integrated Care in the NHS*, a report published by the Nuffield Trust in June 2011, pointed out 'there is a need for a shared vision in which the service user perspective and patient experience is central'.

Therefore, one of the main issues facing those working to create a more integrated and seamless service for patients living with long-term conditions is to truly listen to and engage service users.

People living with one or more long-term diseases have specific needs, which will undoubtedly pose many challenges to the system. At the moment, patients experience a fragmented and uncoordinated service. Communication between primary and secondary care is disjointed, and there

are no coherent links to community-based services.

The focus has been on the disease rather than on the person. A new system will have to see the patient in a holistic way and create the appropriate mechanisms to ensure care is delivered in a personalised and effective way. This includes community-based care that is skilful, competent, and delivered in a timely manner.

Key questions around when, how, and why to integrate services will have to be answered with the patient's perspective at the heart of this process, and Self Management UK will be campaigning to ensure that this happens.

According to a King's Fund paper, *Making Integrated Care Happen at Scale and Pace*, published last March, there are different ways of integrating care, from 'real' integration by merging organisations through to 'virtual' integration in the form of networks and alliances.

The paper says evidence shows that patients and their families have a better experience when organisations and services work together. This is not surprising, given that, at the moment, someone suffering from a chronic disease will have a hard time trying to find even a thread of integration in their care pathway.

Patients are sent from pillar to post, having to negotiate their way around primary, secondary care, and community services, which work independently and do not have the habit of talking to each other.

Frustratingly, patients are forced to repeat their story numerous times. The situation is even worse for those with more than one disease or who need to access both physical and mental health services.

An integrated approach, with some element of choice, which is important, will give patients the experience of being looked after by a team.

Whether services will be close to home is not paramount. Having access to services locally can be, of course, positive and desirable. However, what patients want and need is the right care, delivered at the right time, and in the right place. It is about

having a personalised plan, delivered by fully conversant parts who have access to the same pool of information.

Making Integrated Care Happen at Scale and Pace states that there is 'scope to support and empower users through approaches such as care planning, the use of case managers, care navigators and advocates to support people with complex needs, support for self-care, and the use of telecare and telehealth where these approaches have been shown to be cost-effective'.

This seamless approach to health care is not impossible but it will require time, effort, and resources. More importantly, it will require bringing patients back into the conversation and allowing them to take a lead role in how services are designed and delivered.

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TAKING CARE

Howard Stote

We have some of the best hospitals and clinicians in the world, but hospitals work most effectively when delivering high intensity, short-term treatment. With an ageing population, more people are living with long-term conditions. Many patients now attending hospitals can be much better treated either in their homes or in a GP's surgery.

To use a cliché, 'treatment in the community' is more convenient for the patient and can be more cost-effective, rather than cheaper, for the health service.

No one wants to be in hospital, yet according to Mike Farrar, Chief Executive of the NHS Confederation, figures

"Communication between primary and secondary care is disjointed, and there are no coherent links to community-based services."

"Our aim is to encourage patients to become experts in their own conditions, enabling them to make more informed choices about treatment and to rely less on others to provide care for them."

published in 2011 showed that one-quarter of patients being treated in hospital at the time, would have been better off being treated by NHS staff in their home.

A priority for the clinical commissioning group (CCG) in Bexley is to reduce hospital stays, where this is right for the patient, and transferring the resources saved into high-quality, community services. Coupled with the aim of raising standards in general practice and promoting early intervention, we see this as the blueprint for health services of the future.

In addition to avoiding unnecessary hospital admissions, we are looking to improve the care of long-term conditions and provide better care for older people. Our aim is to encourage patients to become experts in their own conditions, enabling them to make more informed choices about treatment and to rely less on others to provide care for them. Not least, we want to prevent illness in the first place.

This is exactly the approach we are taking in Bexley. Take our award winning primary care chest pain clinic, which sees patients travel from the borough to London for CT scanning instead of invasive angiography. The scheme is designed and run by local GPs and a cardiologist. It has already resulted in savings of around £1.3 million, as well as greatly improving patient outcomes with patient satisfaction levels approaching 100%.

Another good example is Bexley's diabetes service where patients receive care through their family doctor, with the back-up of a consultant community diabetologist. Established with excellent practice development and patient training

based in a primary care setting, we could show in the first year how effective it was. We have delivered one of the best improvements in HbA1c nationally, significantly better than the previous hospital-based service. The service is much more convenient for the patient; it has driven up standards and is more cost-effective to run.

There is a strong value-for-money argument for doing this, but it is not, and must not, be solely about saving money. It is about spending what we have got more wisely. If you redesign services based solely on the premise of saving money, patients will simply not accept it and it will not work. You have to involve patients in the decision making, let them see the clinical arguments and the facts behind what is being proposed and allow them to have a say in the final outcome. Only then will it be a success.

That is why in Bexley we have members of the public on our 17 strong, governing body. One is responsible for patient engagement and another is the chair of our patient council, an umbrella body that brings together over 20 organisations that represent and speak-up for patients in the borough.

Patients accept change if they can see that change is about using resources in a better way to deliver better services and outcomes for them. If these changes result in savings, then these are welcomed as long as they are not seen to be the motivation behind the change, and the resources saved are re-invested in further service improvements.

With the CCG in place, initially, patients

will not see much difference, but as we gradually redesign more services to make them more patient-focused, delivering far better patient outcomes, patients will notice an improvement. They will also notice far more services based in the community near where they live, either at their home or in the GP surgery, with less emphasis on hospital appointments.

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