Monitor
Making the health sector work for patients

Exploring international acute care models: summary of online debate

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1. Background

In December 2014, we published a study that looked at acute service line models in other countries to help inform current thinking on potential new models of care in the NHS in England.

Many commissioners and providers are already working to implement new models of care, some of which are based on successful models from overseas. However, evidence from our study suggests that there are models in use abroad that could support efficiency or quality improvements if they were more consistently used in the NHS. These are:

- 'risk tiering' for maternity and paediatric services
- greater use of technology, particularly to deliver care remotely
- increasing use of GPs to deliver out-of-hours urgent care.

We understand that international models might need to be applied differently in the NHS so alongside the report we launched an online debate on using these models here. This ran from 4 December 2014 to 16 January 2015. During this time we heard from a range of people including providers, commissioners, charities, royal colleges and national bodies. We also received feedback from a number of parties who sent their comments to us at jointhedebate@monitor.gov.uk. Following our online debate, we ran workshops as part of a wider strategy development conference in London and Leeds, with speakers from the NHS who are already using some of these models.

This document summarises the views we heard, and sets out the steps we will take to feed them into the work to develop new models of care, highlighted in the NHS Five Year Forward View. This includes the 'New Models of Care' programme Monitor has implemented with NHS England and the NHS Trust Development Authority to support the development of new models of care and to tackle national challenges.

2. Risk tiering in paediatric and maternity services

Our report found that some other health systems appear to calibrate tiers of risk more clearly, with well-defined tiered roles for smaller providers and clearer responsibilities between providers in different risk tiers. For example, in Stockholm County, Sweden, maternity units have greater tiering around the risk level of women giving birth, particularly those delivering prematurely. In Ontario, Canada, specialist providers deliver secondary and tertiary paediatric care to a large catchment area and only limited short-stay and minor surgical procedures take place outside of specialist children's hospitals. In general, formal networks and transfer protocols between facilities support this model, and clinical standards in some systems are developed in parallel with provider risk tiers, so that they match the risk profile of patients the provider is caring for. Evidence from these systems suggests that risk tiering offers benefits by allowing low risk patients to be treated closer to home, with less intensive use of resources, and specialist staff to be concentrated in fewer high risk units.

We asked for your views on the use of risk tiering for paediatric and maternity services in an NHS context. We heard from several respondents that, to a certain extent, this already exists in the NHS. One respondent told us that as a tertiary children's provider, they already have a network of shared clinical support for paediatric services with district general hospitals, and that it works well but is small scale and was established through good clinical relationships. They expressed interest in exploring how this might be achieved at larger scale with strong care pathways and patient experience driving the model.

2.1. Measures that may help support wider use of this model

We heard that where risk tiering is used in England, it is often not well understood by patients and the public, and that public opposition to change in obstetric and paediatric services prevents wider use of this model. One respondent noted that, while evidence suggests the NHS needs fewer centres for the management of high risk patients, clinicians and the royal colleges need to develop a clear message to support this approach. This was consistent with another respondent who supported the wider use of this model but told us that, as with all major service change, this needs to be clinically led to enable support from politicians and the public. Respondents told us that it will also be important to educate patients and the public, and to work with them to communicate the evidence clearly and ensure they understand the differences between services provided at different tiers and the risks and benefits involved. This could include busting myths for lower risk services, eg by sharing examples of when women choose to give birth at home.

Two respondents suggested that workforce changes may be required to support the wider use of this model, such as, for example, extending the role of midwives and other healthcare professionals to minimise the numbers of women who need to

move tier during labour. Training and education will be required to ensure these professionals are confident to work in new ways. Such measures would also support the development of this model in rural or remote areas, where, for example, a general surgeon could be trained to do an emergency caesarean section.

We heard that it may be possible to co-locate midwifery-led units with consultant-led services as this would enable the transfer of patients if a consultant is needed in any emergency, as well as redeployment of midwives if the midwifery-led unit is quiet. The respondent noted that under this model, maternity and paediatric services may be available at fewer sites but each site would have both high and low risk options available. This could help to minimise risk to patients and maximise efficiency. Another respondent agreed that this might represent the ideal arrangement but in practice it may not be possible for all sites to have both high and low risk paediatric and maternity services.

One respondent told us that it might be possible to apply risk tiering in other services, such as intensive care medicine, which already has the critical systems to help deliver such a model. This respondent also suggested that consideration may need to be given to the cost and effectiveness of arrangements for patients needing to shift tiers unexpectedly.

The view that risk tiering could be applied to other services is consistent with one of the major themes that emerged in the NHS Five Year Forward View, around the potential to apply risk tiering and networking models more widely. In addition, there are many areas where such models are already working successfully in the NHS, including stroke, cardiac and trauma services.

Finally, we heard that implementing this model more widely may mean that transitional funding is required to help providers develop and embed these practices.

2.2. Insights for our work on new models of care

The main messages we are taking away for our work with partners on the NHS Five Year Forward View and the New Models of Care programme are that we should:

- recognise the importance of making the case for risk tiering to the public, particularly where some providers are not able to treat higher risk patients
- recognise the role of royal colleges and other standard-setting bodies in developing clear, evidence-based messages to support new clinical models
- recognise the need to think differently about training and workforce roles that may be required to support this model.

3. Greater use of technology

Our research suggested that some other health systems have used technology to improve efficiency and patient outcomes by delivering care remotely and enabling record-sharing along the full patient pathway. For example, in Arkansas, USA, we found evidence that the use of electronic intensive care units, where spoke sites are supported by consultant-led hubs, had the potential to improve clinical outcomes and reduce length of stay. In Canada, the use of an electronic child health record, which provides a comprehensive patient record across both primary and secondary care, appeared to reduce duplication of testing, enable faster decision-making in an emergency and encourage better disease management and follow-up care. The main factors supporting the greater use of technology were high levels of clinical engagement, a willingess to invest in the technology itself, shared network and governance arrangements, and support from national organisations.

This model was popular with the participants in our online discussion. In general, respondents agreed that increasing use of technology can lead to benefits such as higher quality of care, better patient experience and greater staff productivity. One respondent told us that the wider use of technology, alongside spoke sites supported by consultant-led hubs, may be a good option particularly for critical care and other services that do not depend on the operating technique of specialists.

We heard of several examples of where this model is already in use in the NHS. For example, a short-term assessment, rehabilitation and reablement service managed by London North West Healthcare NHS Trust and Brent Clinical Commissioning Group (CCG) uses technology to support virtual ward rounds, and allow patients and community-based staff to have consultations with hospital doctors from patients' own homes. Another example is the telestroke service implemented by trusts in the East of England, where patients arriving out of hours are able to receive expert assessment from a stroke physician via video link. The physicians, who are appointed on a rota basis, are also able to advise on the use of clot-busting drugs, allowing thrombolysis to be given in more remote units and avoiding the delay of having to refer patients to a central hub.

3.1. Challenges to implementing new technology

Participants at our workshops in London and Leeds agreed that greater use of technology to deliver care was a good idea, but noted that the practicalities of implementing new technology can be difficult. Several people told us that information governance is a substantial barrier to the use of electronic care systems, both in terms of actual risks (such as the protection of patient data) but also by contributing to reluctance at board or senior levels to invest in such systems. We discussed how this barrier could be overcome, for example, by using patient portals in which patients own and control the data they share.

Evidence from our report showed there can be a large financial outlay involved in implementing new technology, which in the current climate, may act as another barrier to the wider use of this model. One respondent suggested that a way to mitigate this might be to maximise the use of patients’ own technology. For example, many patients already use smartphones and tablets, and software such as Skype. It might be possible for patients to send information about their condition to GPs and doctors in specific circumstances, such as for routine outpatient appointments that do not require a face-to-face consultation.

We heard that the regulatory framework can also act as a barrier to investment. One respondent told us that the return on investment in technology needs to be considered over a five-year cycle. However, the current regulatory framework rarely allows this time period for delivery and people may lack confidence that investments in technology will deliver a revenue return as any gains are often swallowed by further pressures.

3.2. Insights for our work on new models of care

The main messages we are taking away for our work with partners on the NHS Five Year Forward View and the New Models of Care programme are that we should:

- identify examples of where models that make greater use of technology are working well in the NHS, and draw out lessons for other areas
- identify how information governance issues have been overcome by some organisations and help to design options that address, or provide assurance on, these issues
- ensure that regulatory barriers to investing in technology are addressed or removed.

4. Increasing use of GPs for out-of-hours urgent care

Our research found that in the Netherlands, GPs are the gatekeepers of urgent care as well as elective care, with 39% of A&E referrals coming through GPs, compared to just 5% in the NHS. GPs in the Netherlands are mandated to provide out-of-hours care. This is primarily delivered through consortia of GPs operating at large scale from physical locations. These consortia seemed to provide effective coverage for patients and improved work−life balance for GPs, with GPs working fewer out-of-hours on call hours since forming these consortia. A key feature of the model is co-location with acute facilities. Where this was not the case, many GP services were planning to co-locate unless there were specific physical barriers preventing this. In terms of benefits, we found that this model has the potential to contribute to fewer A&E attendances, improve GP job satisfaction and make better use of resources.

Many people taking part in the online discussion gave examples of where this model, or variations of it, is already being used in the NHS. Most people also expressed support for the wider use of this model. One respondent told us that they have trialled various models of GPs triaging patients and acting as the gatekeeper to urgent care. They found that, as a result, they were able to divert between 14% and 20% of self-referrals to more appropriate services. Another respondent wrote that in their area they are moving to clusters of GPs located within community hubs acting as the gateway into the urgent care system. This means that patients requiring care at any time of day can call their GP and be triaged from there.

Most people also supported co-locating out-of-hours GP services with acute facilities, to ensure that GPs have access to the diagnostics and specialists required to deliver care to all patients, and to minimise the risk of duplicating these services in the community. One respondent told us that co-locating GPs with acute facilities would also reduce confusion for patients, who would be able to go to one place and be triaged to the appropriate services. However, another respondent suggested that co-location might work against the principle of moving care out of hospitals and into the community.

4.1. Measures that may help to support wider use of this model

Several respondents considered that it would be easier to achieve wider use of this model if GP services were managed by secondary care providers, or if secondary care providers were able to run GP practices and directly employ GP staff. One respondent told us that this would lead to greater integration between primary and secondary care as service delivery could be jointly planned.

We heard that while out-of-hours GP care may help to reduce the number of A&E attendances, we also need to ensure there is sufficient social and community care available out of hours. For example, access to 24/7 community nursing would allow people nearing the end of life to access care and support at home, instead of being

admitted to hospital due. We heard that the ‘Macmillan Specialist Care at Home’ service, which uses consultant-led community based multidisciplinary teams to provide palliative and end-of-life care for cancer patients, has been shown to decrease the number of emergency A&E admissions and improve the patient experience by allowing more patients to remain at home.

There was a general view that an important aspect of the debate around out-of-hours care relates to the behaviour and perceptions of patients and the public. Several respondents considered that, regardless of the model, the NHS needs to educate patients and the public to improve their understanding of where and when to access urgent out-of-hours care. One respondent suggested that this could mean rationalising the array of services available (urgent care centres, minor injury units, NHS 111, out-of-hours GP services, primary care centres and walk-in centres, among others), and moving towards a similar model to the Netherlands, with patients attending A&E through a referral from primary or secondary care, or via the ambulance service. Another respondent suggested that there might be a range of different models, depending on local needs (for example, a densely populated urban area is likely to need a different model to a rural location) and advocated investing in public health engagement and messaging to communicate changes.

Finally, a few respondents commented that framing the debate around the concept ‘out of hours’ was unhelpful, and that a truly transformative approach would be to consider 24/7 access, as services need to be available when patients need them.

4.2. Insights for our work on new models of care

The main messages we are taking away for our work with partners on the NHS Five Year Forward View and the New Models of Care programme are that we should:

- consider access to out-of-hours services across the whole system, including mental health, community and social car.
- recognise that there is more than one way to organise the relationship between the GP and the acute provider, and that the best organisational model is likely to be locally determined
- give consideration to understanding and anticipating how patients will react to different options for accessing urgent out-of-hours care.

5. Other ideas

Several people wrote to us with ideas of how to improve care in the NHS, ranging from adopting components of the Scottish health system to extending or creating new workforce roles. We also received specific examples of where new models of care are already being implemented in the NHS. Some of the ideas are summarised below.

5.1. Better integration between community and acute care

We heard that secondary providers could better integrate or work more closely with the community, for example by employing community outreach geriatricians to help elderly patients develop the skills to recognise common illnesses earlier. We were told that the two biggest causes of non-elective admission for patients over 75 years are pneumonia and urinary tract infections. If the patients could recognise these illnesses earlier, they could help to prevent them from becoming acute and therefore avoid going to hospital. The increased geriatrician resource could also be used in the hospital to provide inpatient surgical liaison services.

5.2. Increased focus on sharing learning

One respondent wrote that there is a lot of work under way across the NHS to identify and pilot radical new models of care but the sector needs to become better at sharing learning on what has and has not worked. This could help to facilitate the spread and take-up of successful ideas and models, minimise duplication and achieve value across the system, given that all local health economies are trying to deliver similar outcomes.

5.3. Advanced critical care practitioners

We heard that the Faculty of Intensive Care Medicine supports the training of advanced critical care practitioners (ACCPs) and their incorporation into the intensive care medicine workforce to increase flexibility. However, the workforce funding plans of some Local Education and Training Boards may not include provisions for the training of ACCPs and this deter trusts from training additional practitioners who are needed to fill a workforce gap in critical care.

6. Conclusion

In summary, we will consider these ideas and the feedback we have received in our work where relevant. In particular, we have shared the insights with NHS England, who are leading on the programme of work to implement the NHS Five Year Forward View. We hope that this summary of our online debate will also be useful to the sector in developing local thinking around potential new models of care.