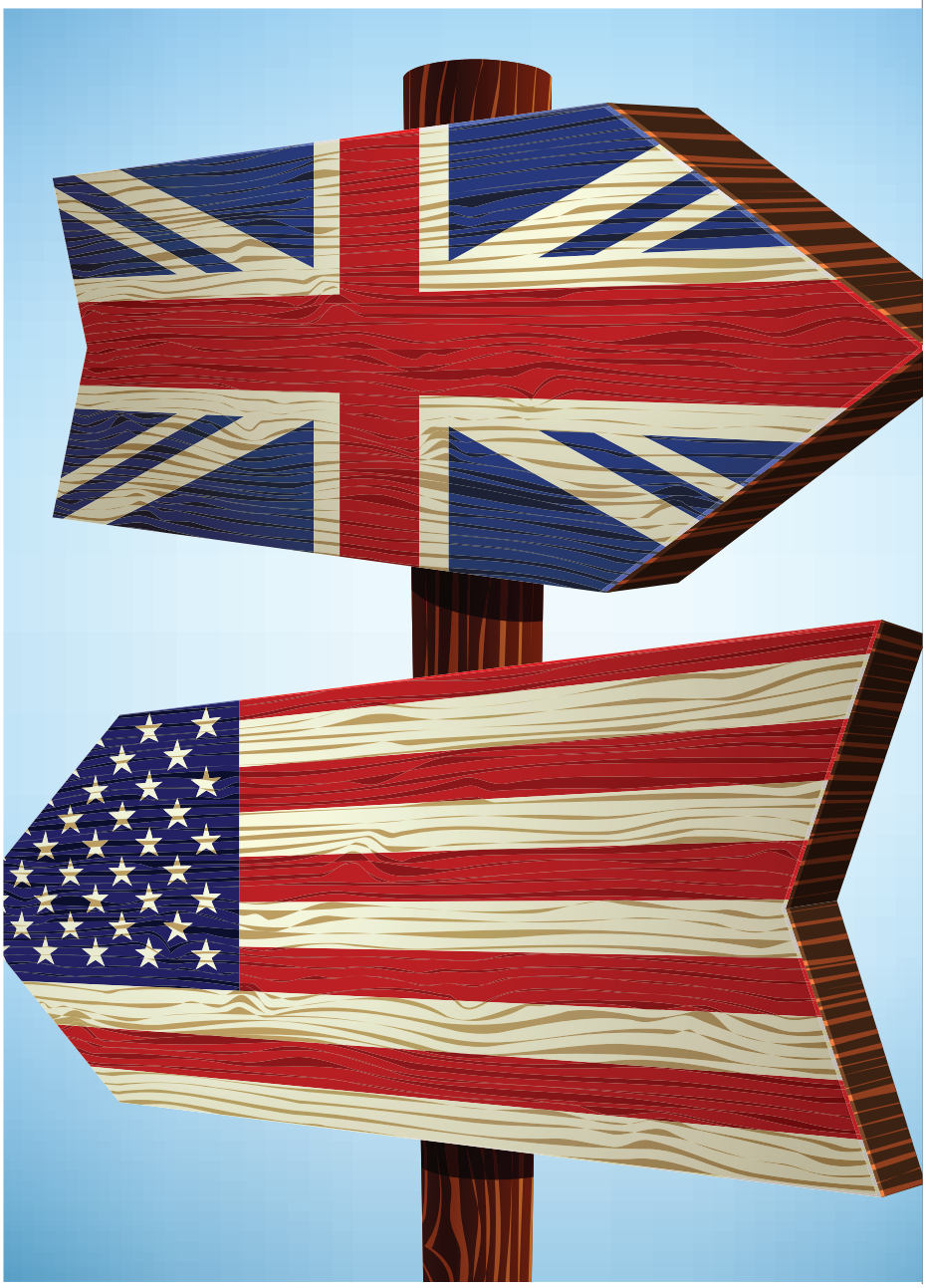
The NHS five year forward view: lessons from the United States in developing new care models

All political parties have endorsed NHS plans for greater integration of care in the next parliament. **Stephen Shortell and colleagues** use US experience to suggest what is needed to make it happen



The NHS five year forward view, published by NHS England and other NHS bodies, sets out a shared view on how services need to change and what models of care will be required in the future.[1] Its key arguments are that much more attention should be given to prevention and public health; patients should have far greater control of their care; and barriers in how care is provided should be broken down. This means putting in place new models of care in which care is much more integrated than at present.

Similarities exist between the proposed care models and the development of integrated systems in the US. Here, we outline two of the models proposed by NHS England and discuss how experience from the US may help inform how they are implemented.

Care models in the forward view

Two of the care models in the forward view have attracted particular attention. The first is called multispecialty community providers, in which general practitioners would work with a wider range of health and social care professionals than at present. These professionals would include some specialists currently working in hospital, such as geriatricians and paediatricians, as well as nurses, therapists, and social workers. The forward view argues that general practices would need to be organised through federations and networks to be able to make multispecialty community providers a reality.

The second model is described as primary and acute care systems. In this model single organisations would provide NHS general practice and hospital services for a listed population, together with mental health and community care services. These vertically integrated care organisations might be led by hospitals or by multispecialty community pro-

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viders. The forward view suggests that at their most radical, primary and acute care systems would take responsibility for the whole health needs of a registered list of patients under a delegated capitated budget.

The direction set by the forward view has been welcomed by all of the main political parties, and there is an emerging consensus that the care models it describes provide a basis for improving services in the next parliament and beyond. Although the ideas it outlines are not new, there is increasing recognition that the growing financial and service pressures in the NHS, most recently in hospital emergency departments,[2] cannot be tackled without transforming how health and care are delivered. Whatever form these changes take, a common thread is the need to break down barriers between services through greater integration of care.

Implications for general practitioners and specialists

General practitioners and specialists will be expected to work differently in the new care models better to meet changing population needs, particularly the growing numbers of older people with multimorbidity. Among other things, this means general practices working more closely with each other in federations and networks and specialists collaborating with primary care teams within multidisciplinary community providers or primary and acute care systems. Similar developments have taken place in other countries, particularly the US, where long established integrated systems such as Kaiser Permanente are founded on the principle of multispecialty medical practice.[3 4]

There are also similarities with the emergence of accountable care organisations (ACOs) in the US following the Affordable Care Act. These primarily involve hospitals and medical groups accepting responsibility for the cost and quality of care of a defined population with a capitated budget under a contractual arrangement with a public or private insurer. They generally fall into three types:[5] organisations with integrated delivery systems offering a relatively large number of services; smaller physician led medical groups offering a smaller number of services;[6] and a hybrid group led by a combination of hospitals, physicians, and health centres that offer an intermediate range of services.

The forward view explicitly acknowledges that primary and acute care systems are analogous to ACOs.[1] The health secretary, Jeremy Hunt, has also argued that reforms to the NHS are likely to lead to the emergence of ACO-like organisations in England. So what can the NHS learn from the experience in the US?[7]

Experience in the US

The emergence of ACOs needs to be seen in the context of managed care initiatives in the 1980s. Under these initiatives medical groups and provider networks attempted to provide care within budgets set on the basis of the number of people covered and their health risk. Although managed care schemes initially showed large reductions in hospital use and cost savings, they were criticised for failing to focus on quality of care. They also ran into difficulty when insurers reduced payments to reflect lower hospital use and restricted patient choice by requiring prior authorisation for certain services. The result was a backlash against managed care.[8]

Partly in response to these concerns, managed care evolved into integrated delivery networks in the 1990s, with a focus on better coordination of care as a means of improving quality and containing costs. Evaluations showed that most of these networks failed to deliver savings for reasons including poor information technology and ineffective coordination of care for patients with complex chronic needs. They also bolted together existing providers and processes rather than truly integrating clinical care.[9]

Long established integrated systems like Kaiser Permanente, Group Health Cooperative of Puget Sound, Geisinger, and Intermountain Healthcare have been more successful, partly because of their size, capabilities, and experience that they have gained over time. They have been able to develop cultures that support team based care with electronic health records, which facilitate greater patient engagement in care.

Evidence on ACOs

The US now has about 750 ACOs serving an estimated 20 million people.[10] Early evidence is mixed in regard to both cost and quality. The recent second year results on the Medicare Pioneer and Shared Savings ACOs show that they saved over $372m (£250m; €350m).[11] For the pioneer ACOs savings were significantly greater among those with higher baseline spending than those with lower baseline spending.[12] Measures of quality and patient experience also improved. However, most of the savings were attributable to a small number of high performing ACOs, and some pioneers have chosen to drop out of the Medicare programme. One reason for this is that the cost targets favoured organisations operating in high cost areas, making it easier for them to reduce costs and qualify for a share in savings than it was for those operating in low cost areas.

More positive results have emerged from the Massachusetts Alternative Quality Contract led by the private insurer Blue Cross Blue Shield. Medical groups and hospitals operate under a capitated budget that is linked to financial and quality incentives. After four years of experience, participating provider organisations continue to achieve cost savings in comparison with the control group and improved quality of care on selected chronic care measures.[13] Similar improvements have been reported from a Blue Shield initiative in northern California.[14]

Lessons for the NHS

The mixed experience of integrated systems and ACOs in the US points to opportunities and challenges for general practitioners and specialists working to implement the NHS forward view.

The first is the need to allow time to build the relationships and cultures that enable general practitioners and specialists to work together to improve care. Long established systems such as Kaiser Permanente do better than many other integrated systems because they have been able to build these relationships and cultures and create a foundation for delivering better outcomes at lower cost. Overcoming historical divisions between general practitioners and specialists in England will not happen quickly, and sustained effort will be needed to nurture collaborative clinical practice and team working.

Payment systems also need to be aligned behind new care models. The US is moving away from fee for service reimbursement for physicians and activity based funding for hospitals to systems that reward improvement in the quality of care, such as capitated budgets, bundled payments, and pay for performance. The current fragmented payment systems in England need to be changed quickly and radically to make collaborative care a reality, with a particular focus on capitated or similar budgets linked to the delivery of defined outcomes of care.

US experience shows that information technology, and especially the electronic patient care record, is a powerful enabler of integrated care. It can be used to develop predictive tools to identify likely high cost or high risk patients in advance so that early interventions can be initiated; to improve care at the point of service; to provide feedback for continuous quality improvement; and to facilitate the sharing of information across providers and settings of care. After the troubled history of the national programme for information technology in England, the focus has shifted to finding local solutions to linking otherwise separate systems and sharing patient information contained within these systems The promise of the new care models will be realised only if these efforts are accelerated—for example, through funding vanguard sites chosen to test these models.

Some of the biggest opportunities in the new care models relate to reducing use of hospitals, both through avoiding inappropriate hospital admissions and reducing length of stay. Integrated systems in the US have pursued these opportunities through case management of high risk patients and efforts to coordinate care through timely discharge from hospitals and follow up after discharge. Specific innovations include the use of hospitalists and discharge planners to improve flow in acute hospitals and using nurses to ensure smooth transitions between different care settings. Simple changes such as telephone follow-up with patients in the week after they return home from hospital are also used. The ability of general practitioners and specialists to work alongside each other is another factor in avoiding inappropriate hospital admissions because of the way it facilitates collaborative clinical practice and team work.

Both countries need to engage patients and families more actively in their care.[15 16] This will challenge even the best organised general practice and specialist providers because of the changes required in work flow, time commitments, delegation of tasks, and training in new communication methods. Actions should include health promotion outreach, involving patients and families in setting treatment goals and treatment options, discussion of end of life and advanced serious illness options, and involving patients in decisions affecting the overall organisation of the practice and its policies.

Next steps

A review of integrated delivery networks in the US in the 1990s concluded that they failed to live up to their promise because insufficient attention was given to implementation and execution.[9] The NHS will similarly not realise the potential of the forward view unless it puts in place new skills and capabilities in leadership, governance, and managerial and financial systems to support new care models. Of critical importance will be support for general practitioners and specialists to find the time to lead the development of these models when the NHS is under increasing financial and service pressure.

The benefits of integrated care occur primarily through clinical integration rather than organisational integration,[17] and this requires those responsible for providing care to be intimately involved in development of new models. Perhaps the biggest challenge is allowing sufficient time for new care models to evolve and mature, given the tendency in the NHS for policy makers to move rapidly from one initiative to the next before evidence of impact has been gathered. The political consensus that has emerged on the forward view and the collective commitment of NHS England and other national NHS bodies to its implementation provide grounds for optimism. This consensus now needs to be married with deep and genuine clinical engagement at all levels of the NHS.

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CASE REVIEW

Odynophagia and vomiting eight years after laparoscopic adjustable gastric banding

1 The gastric band has tilted along its horizontal axis so that the anterior and posterior sides of the band are no longer superimposed (fig 1). This suggests that the gastric band has slipped.
2 Gastric band slippage can predispose to ischaemia as a result of gastric prolapse, volvulus, or cranial herniation, resulting in infarction and perforation. Patients with these complications usually present with abdominal pain and, later on, develop signs of peritonitis.
3 Immediate and complete deflation of the gastric band is imperative, ideally using a non-coring Huber needle. Deflation is achieved by advancing the needle percutaneously, having palpated and stabilised the port between two fingers, until reaching the metal base of the port and then aspirating under aseptic conditions.
4 Laparoscopic removal of the gastric band must be considered in all patients in whom conservative management fails or in any acutely unwell patient.

STATISTICAL QUESTION

What are the odds?

Statements *b*, *c*, and *d* are true, whereas *a* is false.

CONTRIBUTIONS

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