These slides are from an NHS Confederation session on the ‘shift of care from hospital to community’.

The session was run by the Strategy Unit using these slides. Some of the slides only really make sense with the voiceover, so are perhaps best viewed in context of the session recording (on the Confederation website).

One strong theme in the session was the need to look at the ‘left shift’ with a detailed, careful, empirical eye. Much has been tried, but too little is known. And ‘evaluation’ has too often meant ‘good practice case study’. This will not sustain a substantial shift of care.

So the Strategy Unit is keen to hear from people who want to do the detail: people who want to use evidence and analysis to transform care.

Please get in touch - strategy.unit@nhs.net – if this is you!

NHS Confederation

The Strategy Unit.

Reshaping the pattern of care: is the ‘left shift’ mission impossible?

Peter Spilsbury, Jennifer Wood, Fraser Battye

8th May 2025

NHS
Midlands and Lancashire
Commissioning Support Unit

A session of two halves

1: Why hasn't the 'left shift' happened to date?

2: What could be done differently this time?

A session of two halves

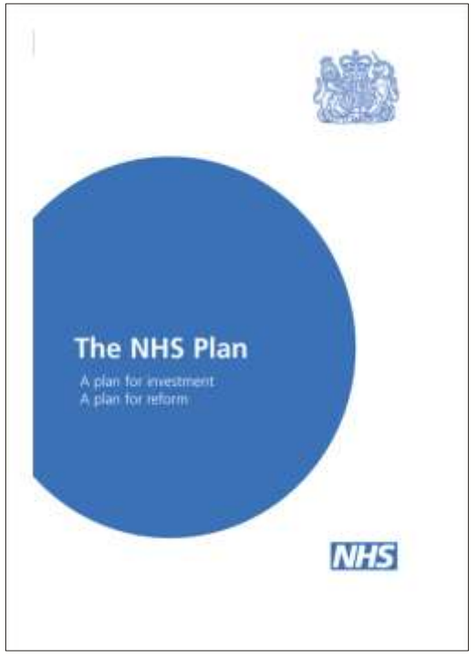
1: Why hasn't the 'left shift' happened to date?

2: What could be done differently this time?

"Since at least 2006, and arguably for much longer, successive governments have promised to shift care away from hospitals and into the community.

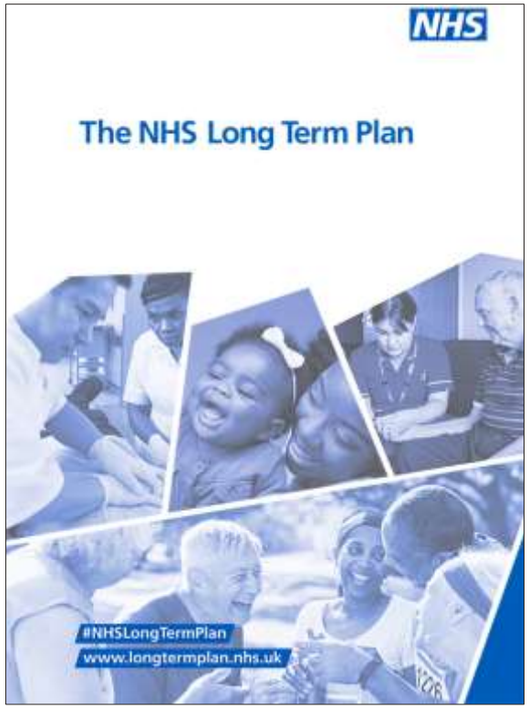
In practice, the reverse has happened…

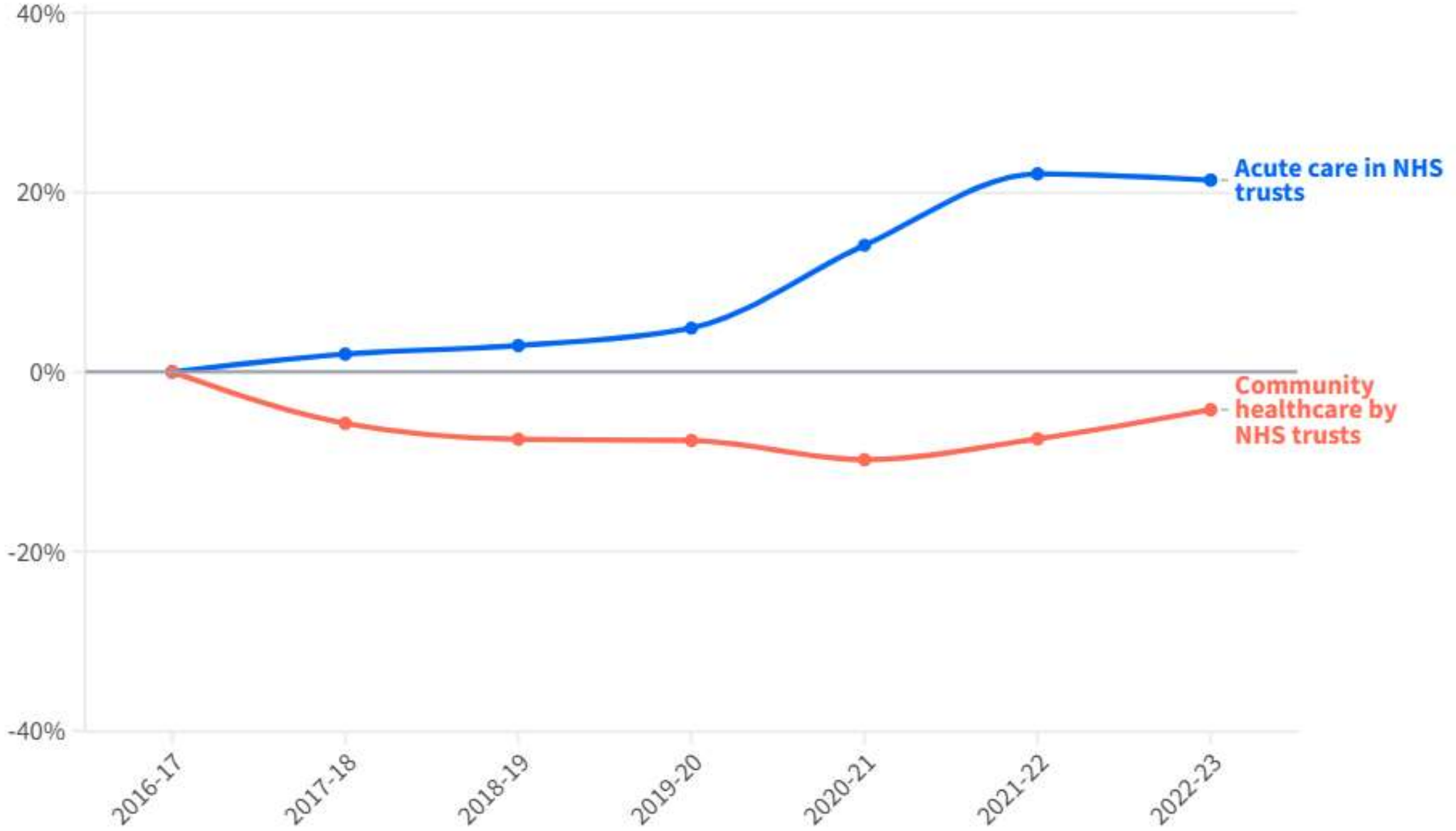
The 'left shift' could, in fact, be characterised as a 'right drift'."



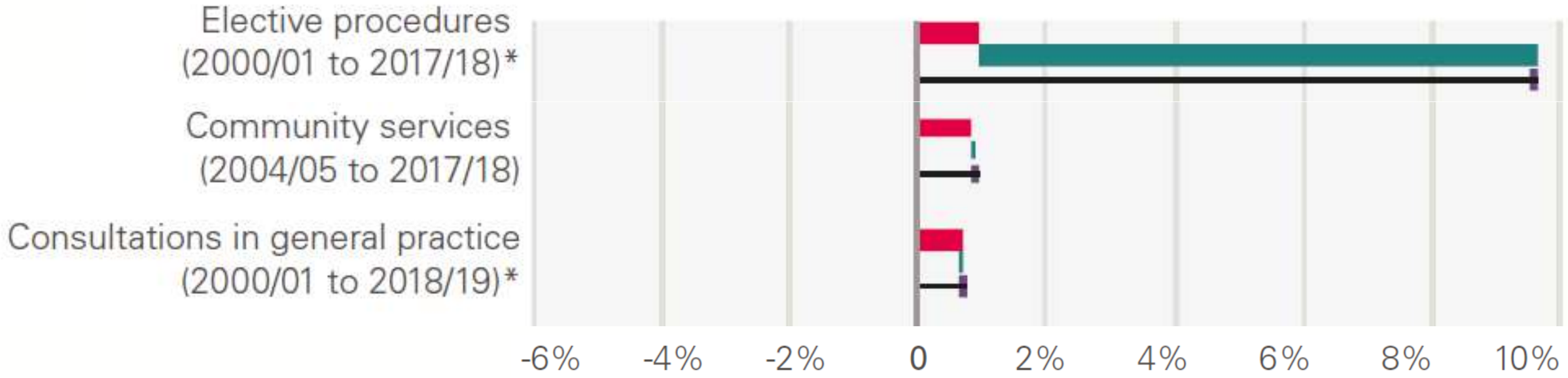
Etc…

…and it's not just the UK





Gainsbury S and Julian S (2024) "Where does the NHS money go?", Nuffield Trust explainer



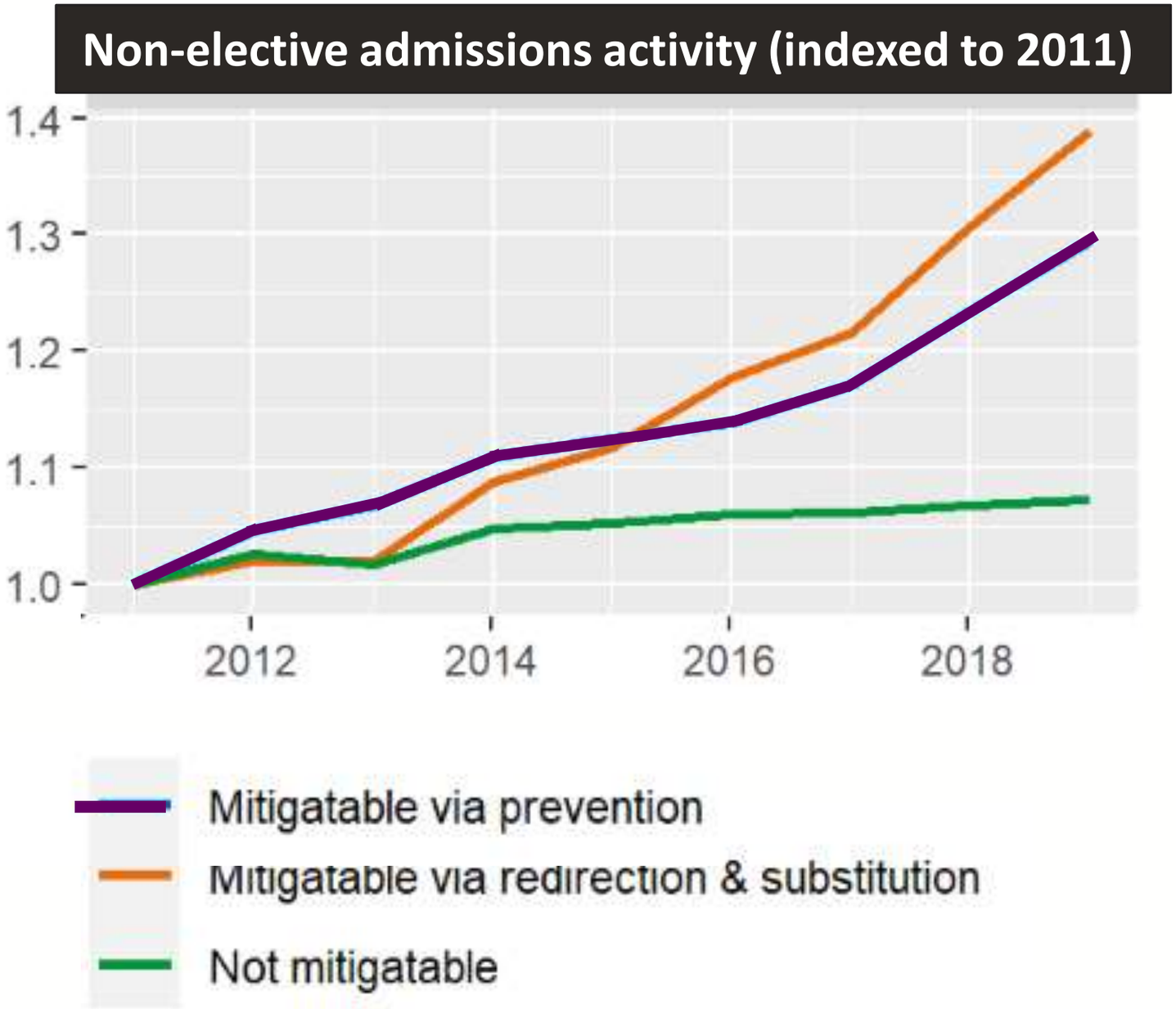
Strategy Unit analysis for the 2020 Health Foundation report 'The bigger picture'

Modelling for New Hospital Programme

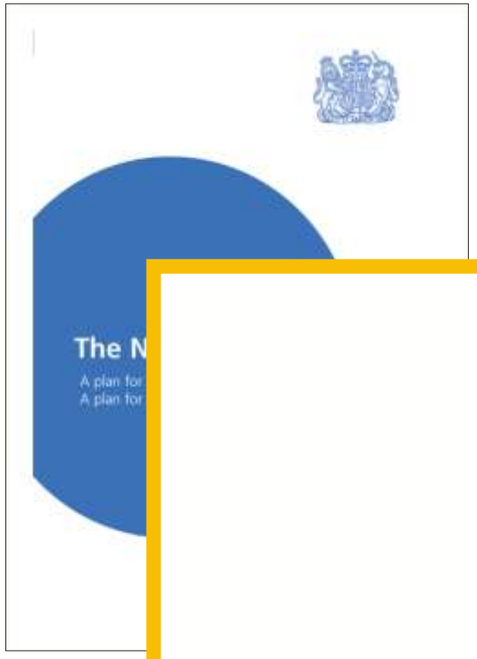
Hospital activity that could POTENTIALLY be **'mitigated' – or not**

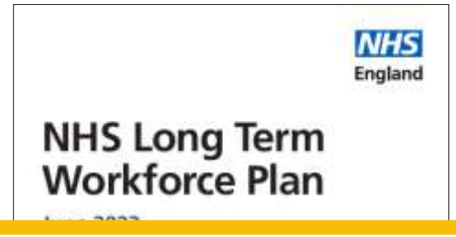
Through:

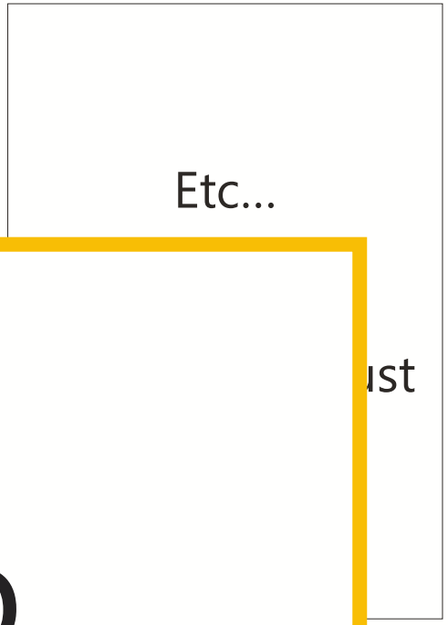
- **Prevention** (e.g. alcohol admissions)
- **Redirection / substitution** (e.g. mental health admissions via ED)
- De-adoption (not shown)



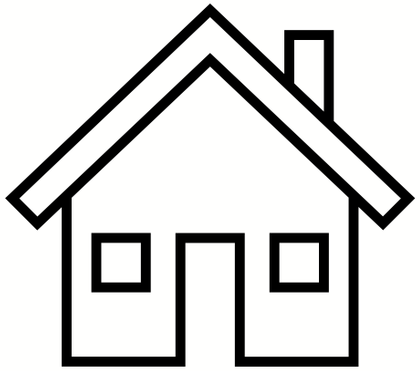
Wyatt et al (forthcoming) Estimating the macro level impact of efforts to mitigate hospital activity in English hospitals from 2013 to 2019: a retrospective database study.



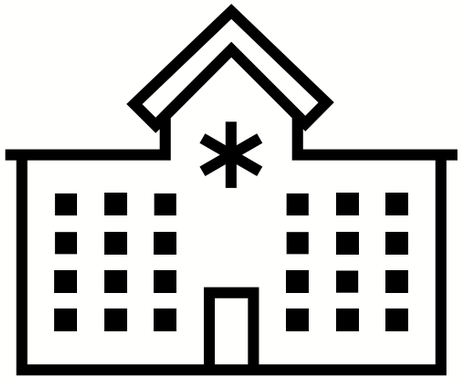




Missed opportunity to cumulate knowledge?



Policy aim: ‘left shift’



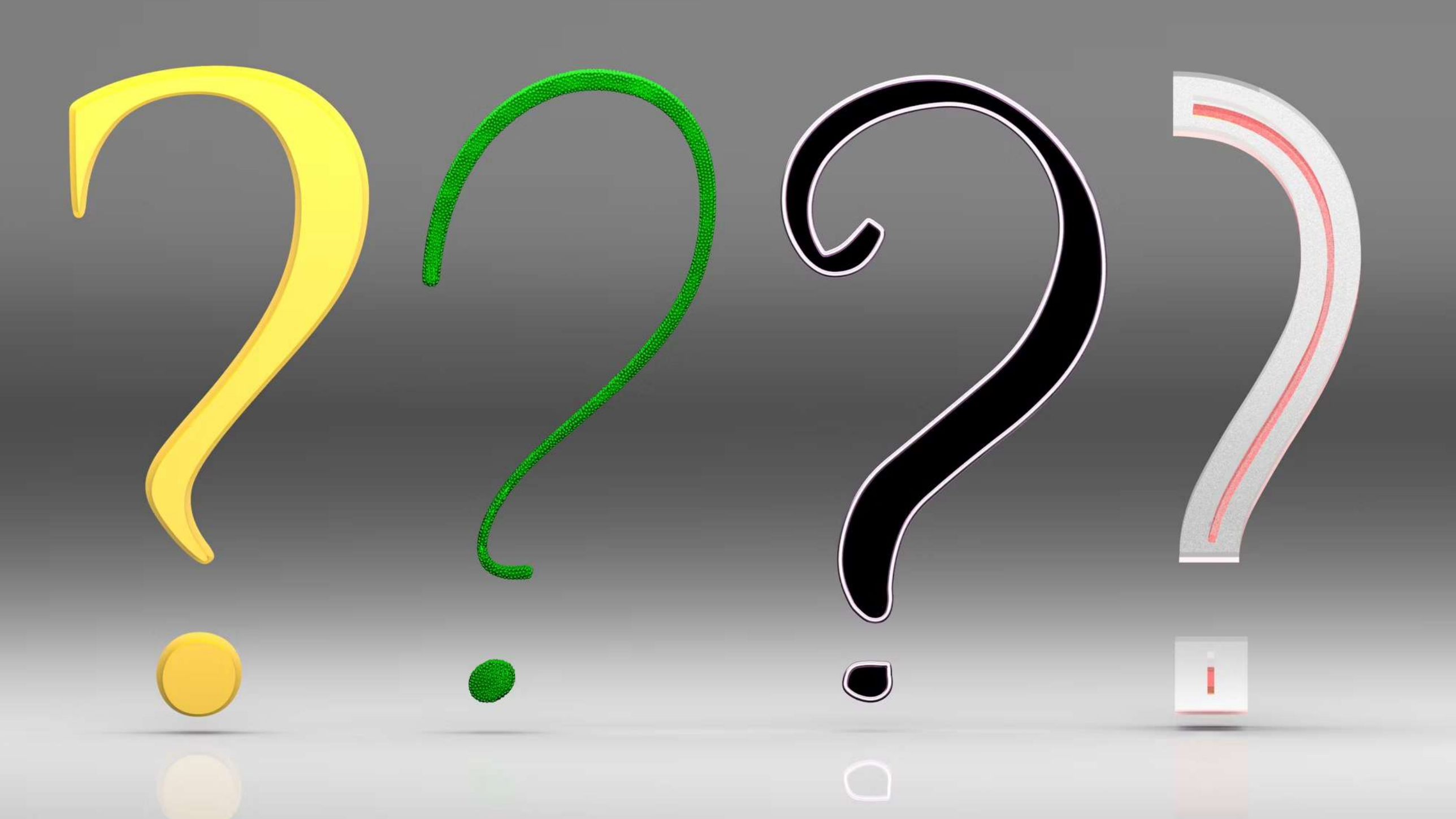
Factors tending towards the ‘right drift’

- Political salience, policy attention and ‘soft power’
- Commissioning attention and resource allocation
- Innovation and advances in treatment
- Contractual forms and incentives
- Capital investment
- Workforce
- Data, research attention and evidence

The right services will prevent hospital admissions

Prevention is cheaper than cure

Less expensive workforce leads to less expensive services



A session of two halves

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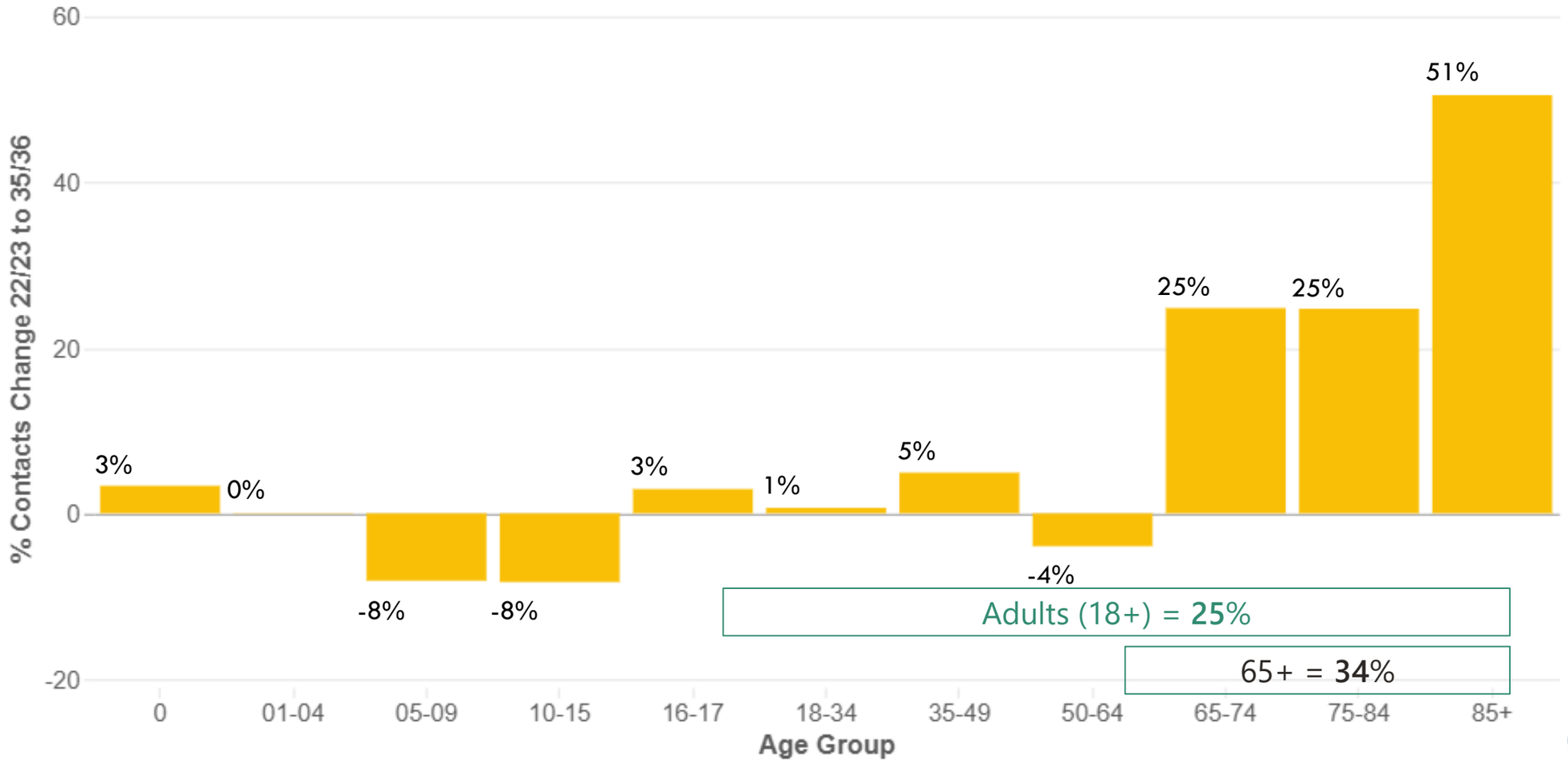
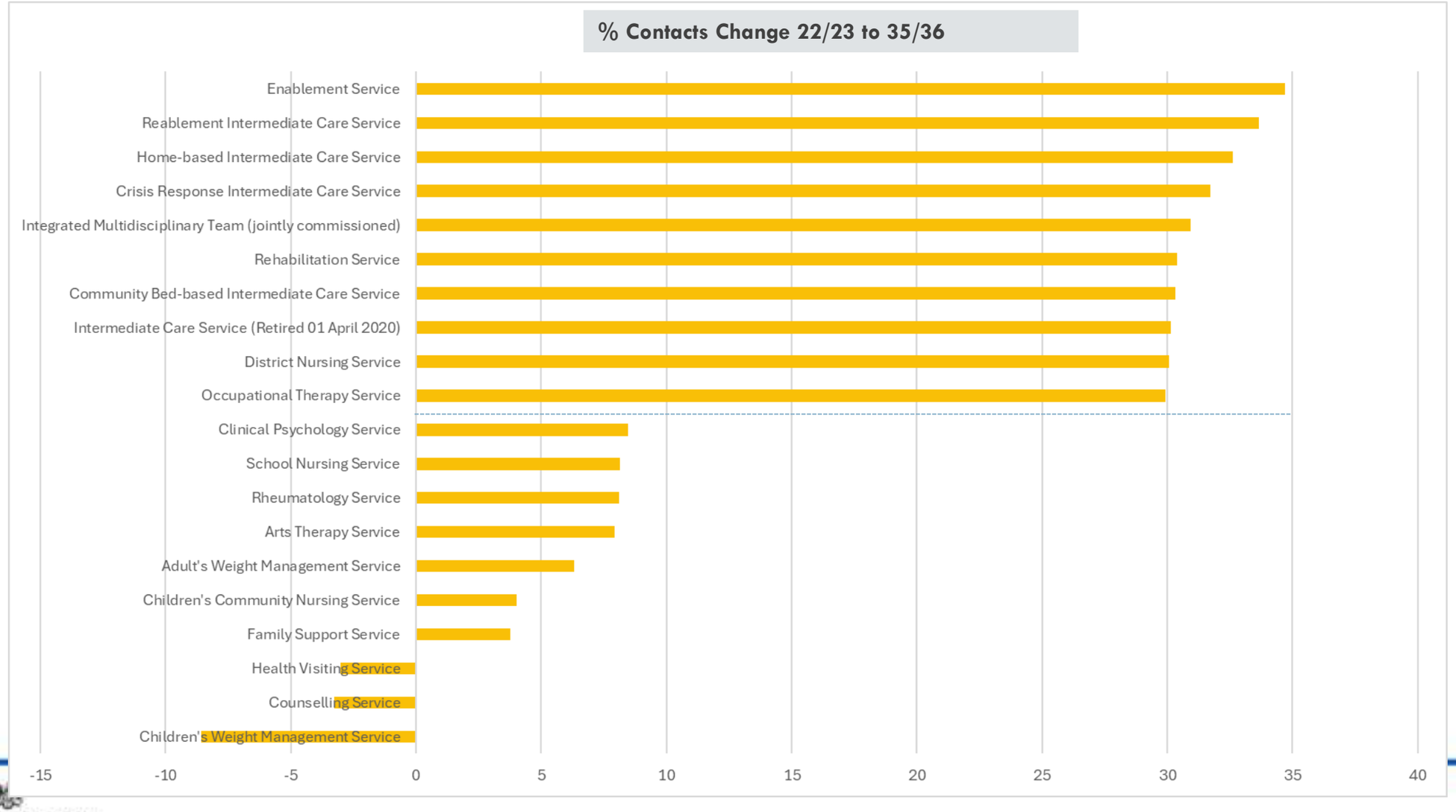
What is the likely impact of demographic change on core community service demand?

Proposition - community services need to accommodate a growing and aging population at 'current rates' if the existing need/service ratio is to be maintained and current hospital admission rates are not to worsen.

Net demographic growth in all community contacts by 2035/36 is 20% but this is not distributed evenly, and the growth rate is higher for services for older people



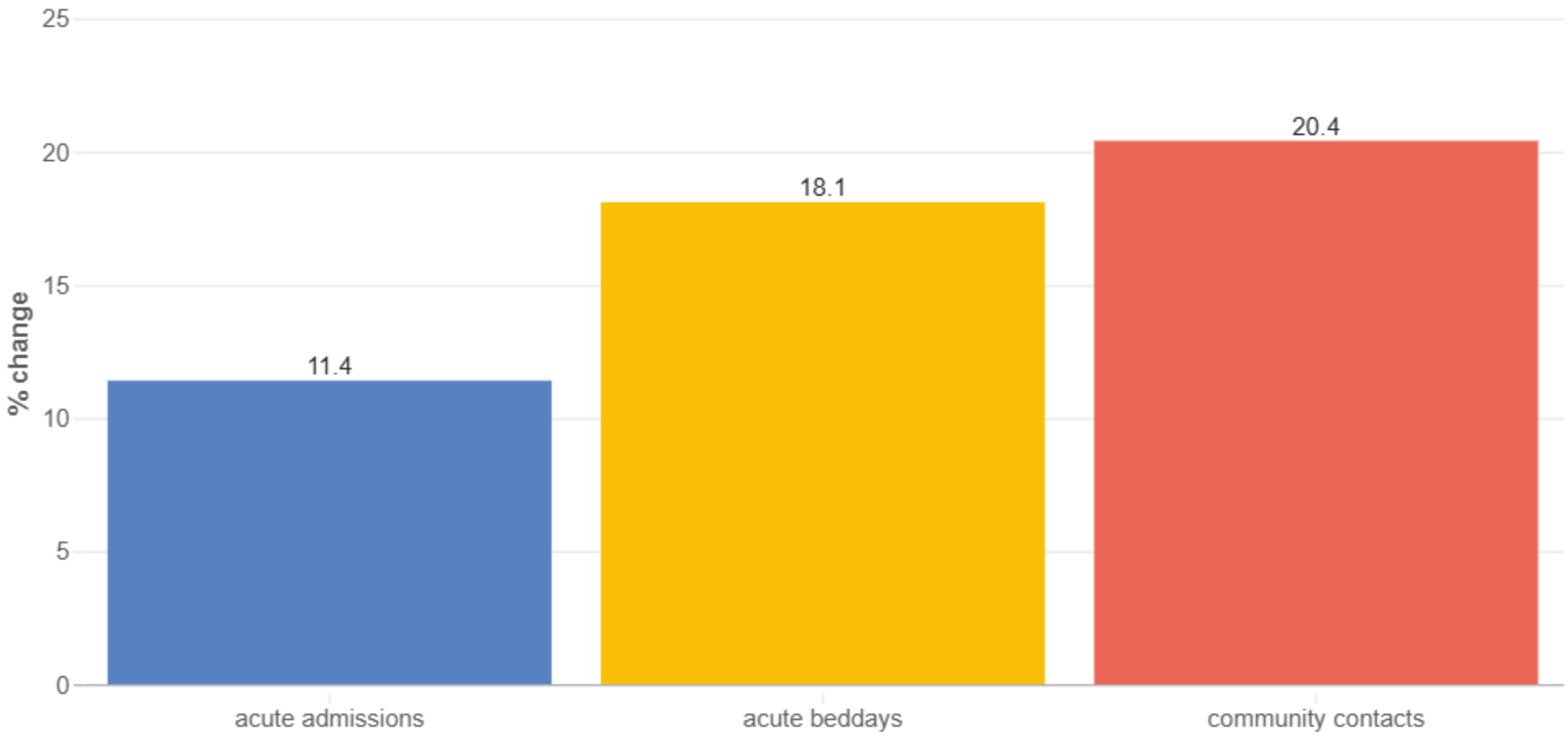
Demographic growth in 2035/36 for adults (18+) by team type - top 10 and bottom 10



Please note, recording of team type is poor, ~40% of contacts have no team type recorded.

How do demographic pressures compare?

All ages:



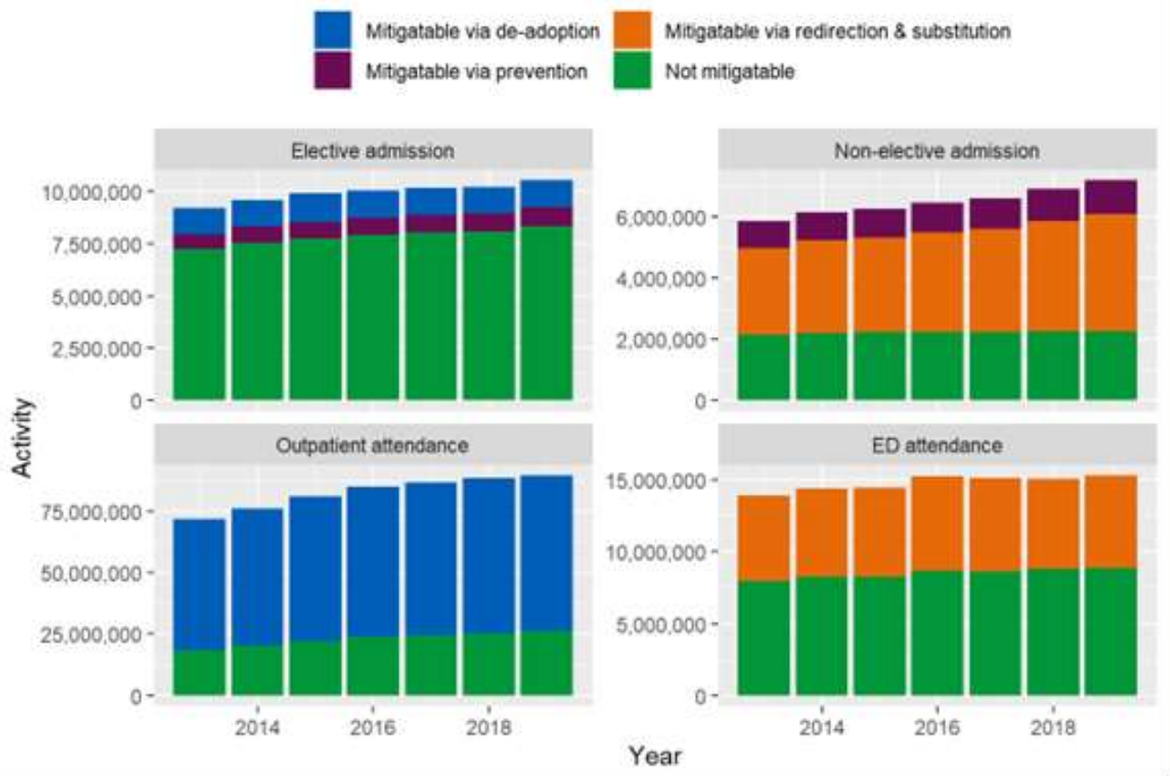
All compared to 2022/23 baseline.

What activity could move from hospital? Scaling the left shift by scenario, based on NHP Demand and Capacity Mitigators.

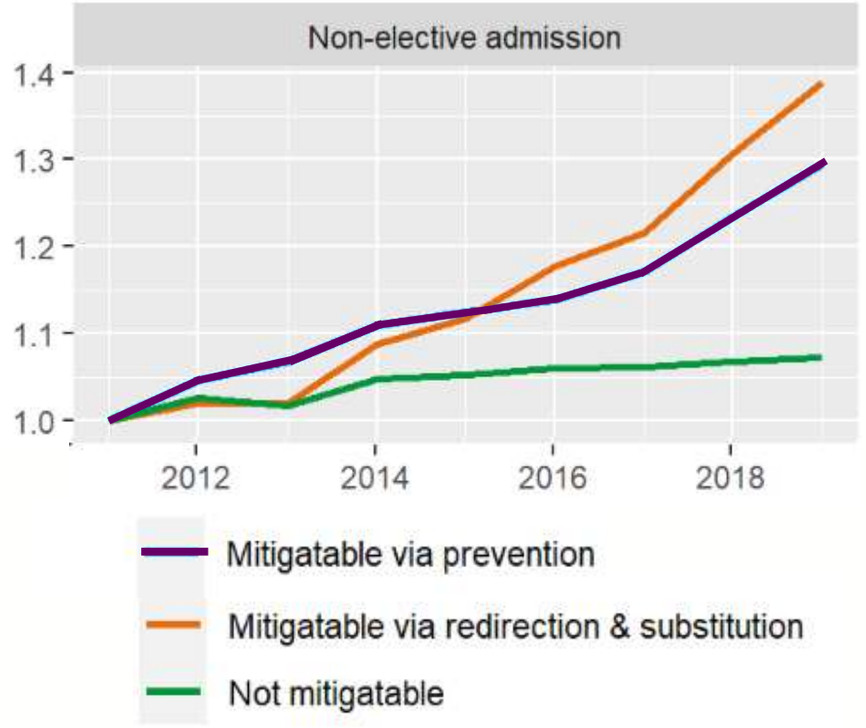
The 'base rate' for mitigation is zero or less. Historic trends show potentially mitigable activity[23] increasing, particularly in non-elective admissions.

Some of this trend is factored into non-demographic growth assumptions

Counts of hospital activity across points of delivery and mitigation class from 2013 to 2019.



Activity volumes indexed to the values in the initial year of 2011.



Mitigation Scenarios

Steady state

Demographic change but with no additional mitigation (base rate)

Average System Plans (NHP schemes)

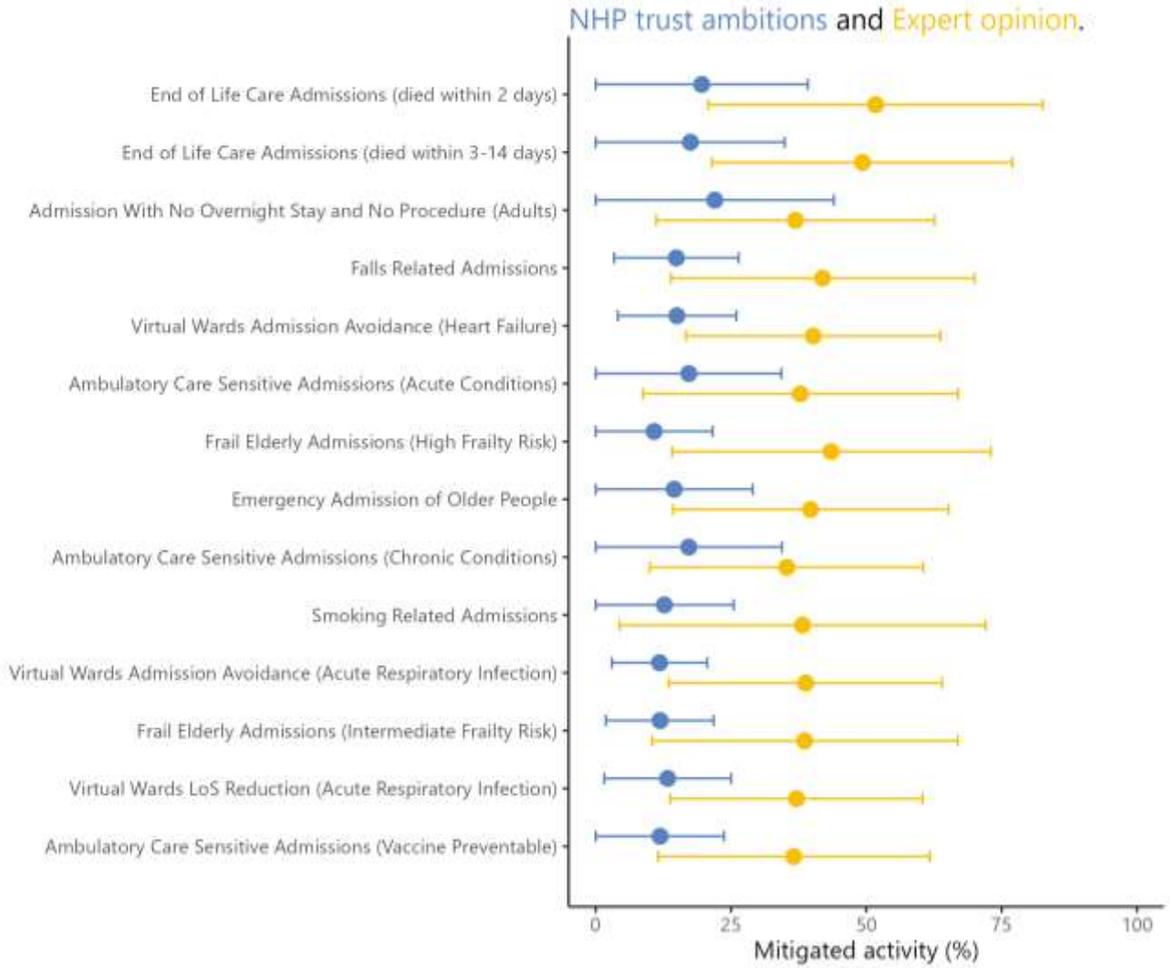
Carefully constructed average across 18 NHP schemes which have completed their demand and capacity modelling with their host systems. Mitigation levels based on local deliberative processes conducted with clinical/stakeholder engagement. Confirmed as aligned with realistic future system plans. NB This rate MUST be achieved if NHPs are not to prove undersized.

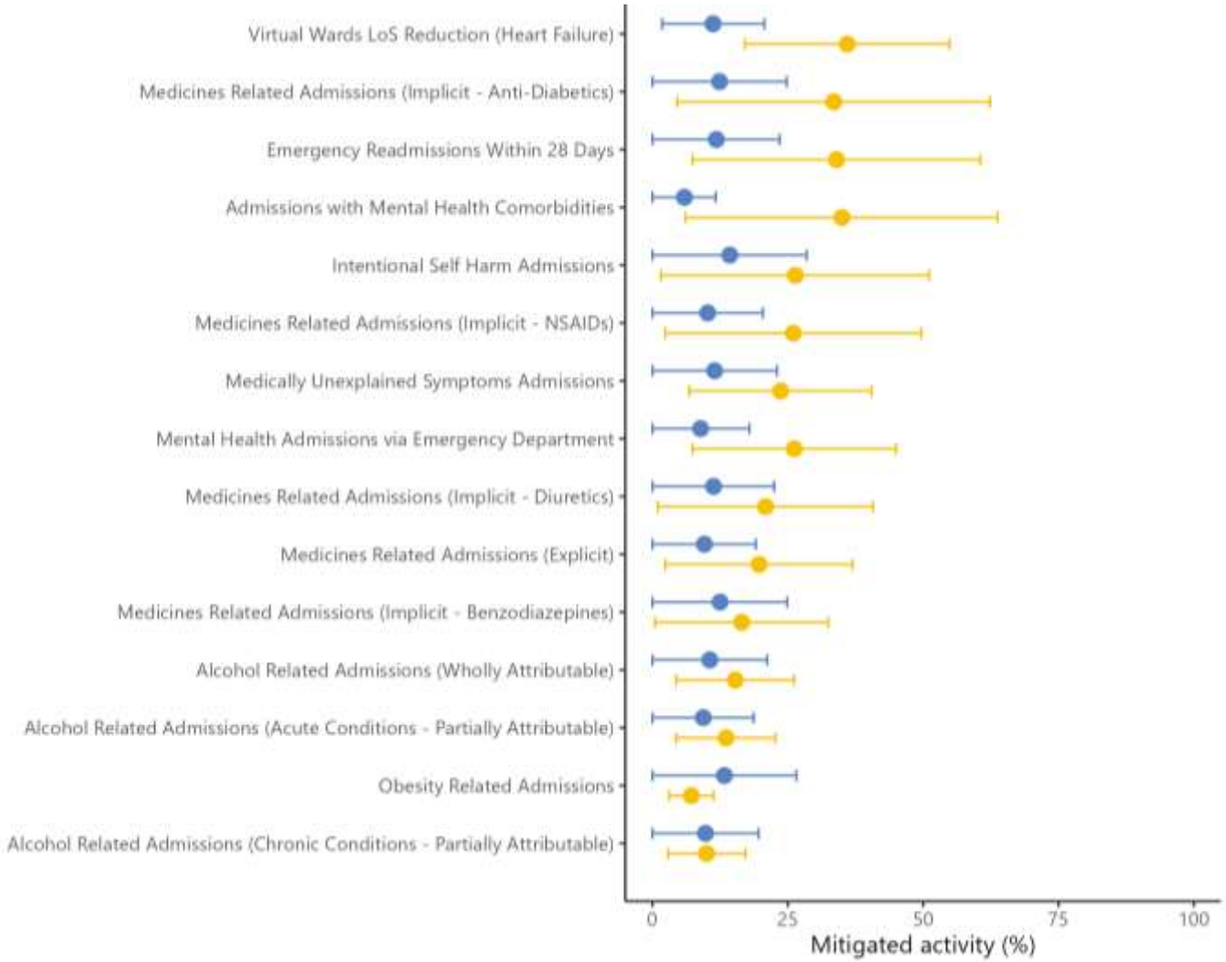
Largely Unconstrained (Expert Elicitation)

Potential rates if community services resourced at full cost for all shifted activity over and above inflation AND demographic growth. Capacity (and funding, adjusted for efficiency requirements) of community services grows over and above population growth and inflation so that it is calibrated to unplanned admitted activity for adults that is mitigatable.

Expert elicitation judgements - 2 scenarios for mitigation

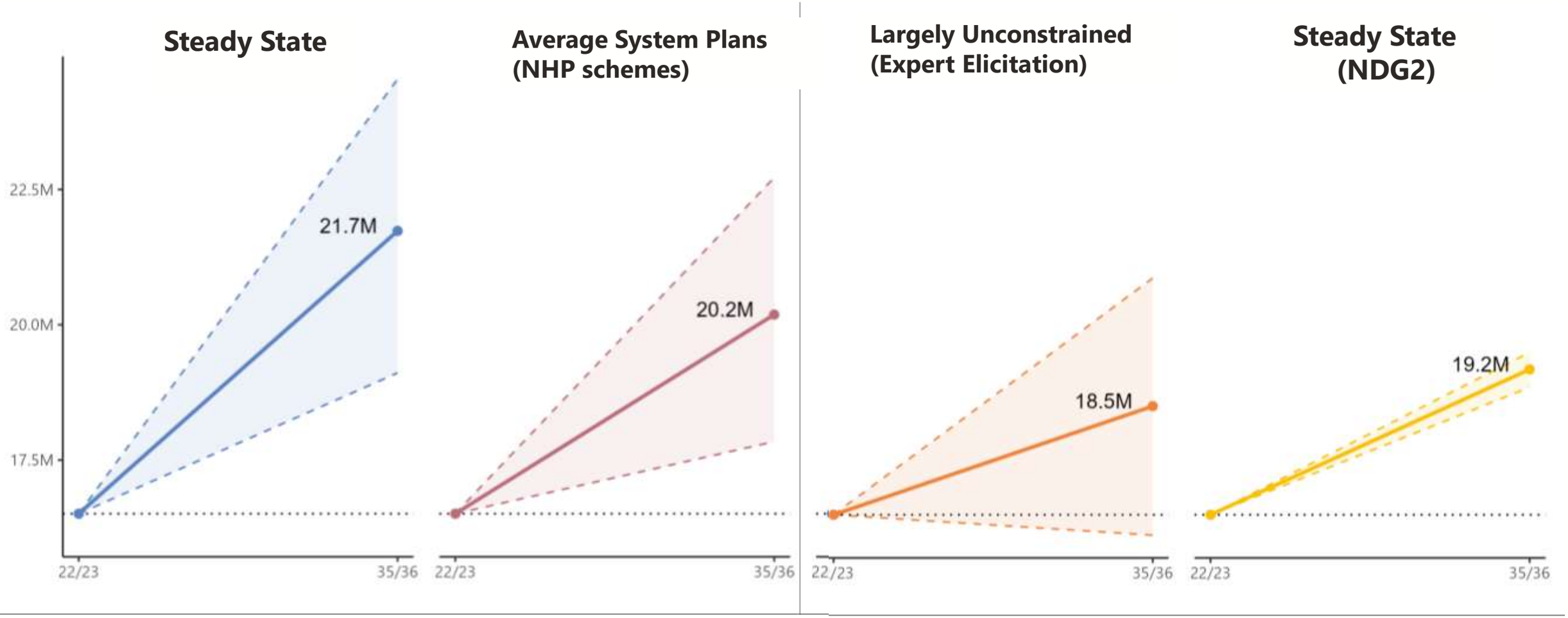
Average system plans (NHP) and Largely Unconstrained (NEE)





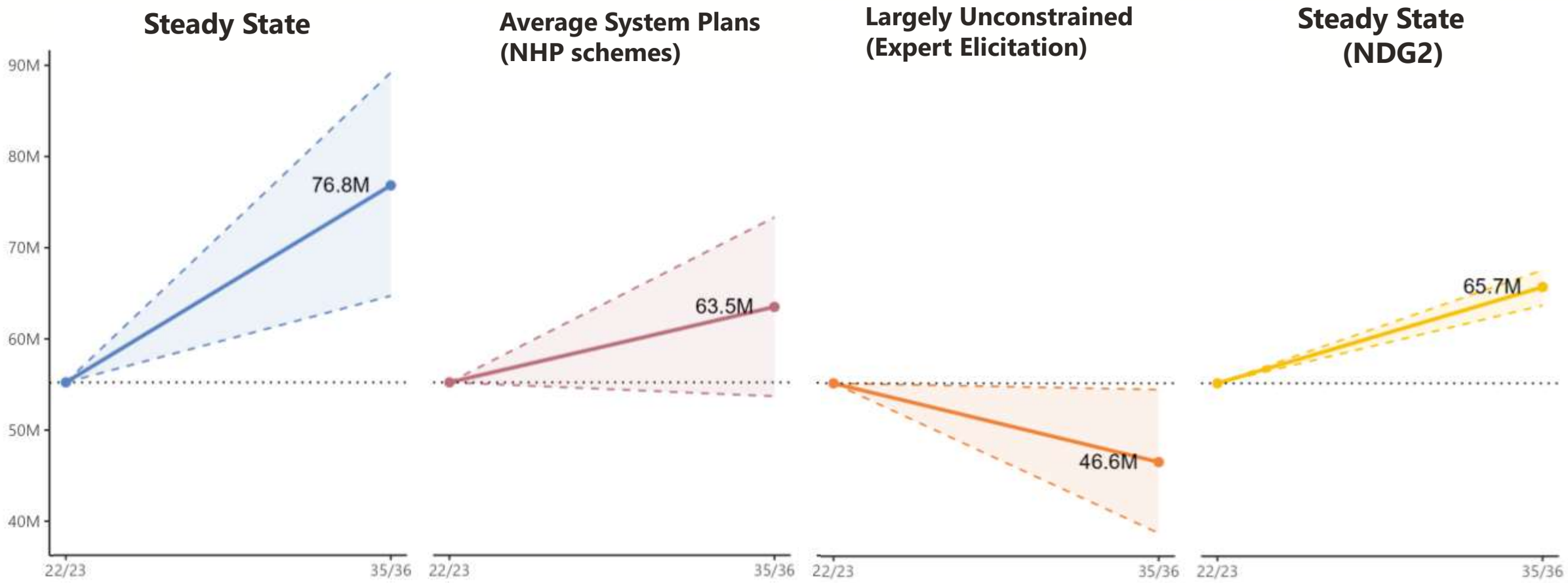
Projected admissions, from baseline of 16.5 million in 22/23

NDG3 unless stated otherwise



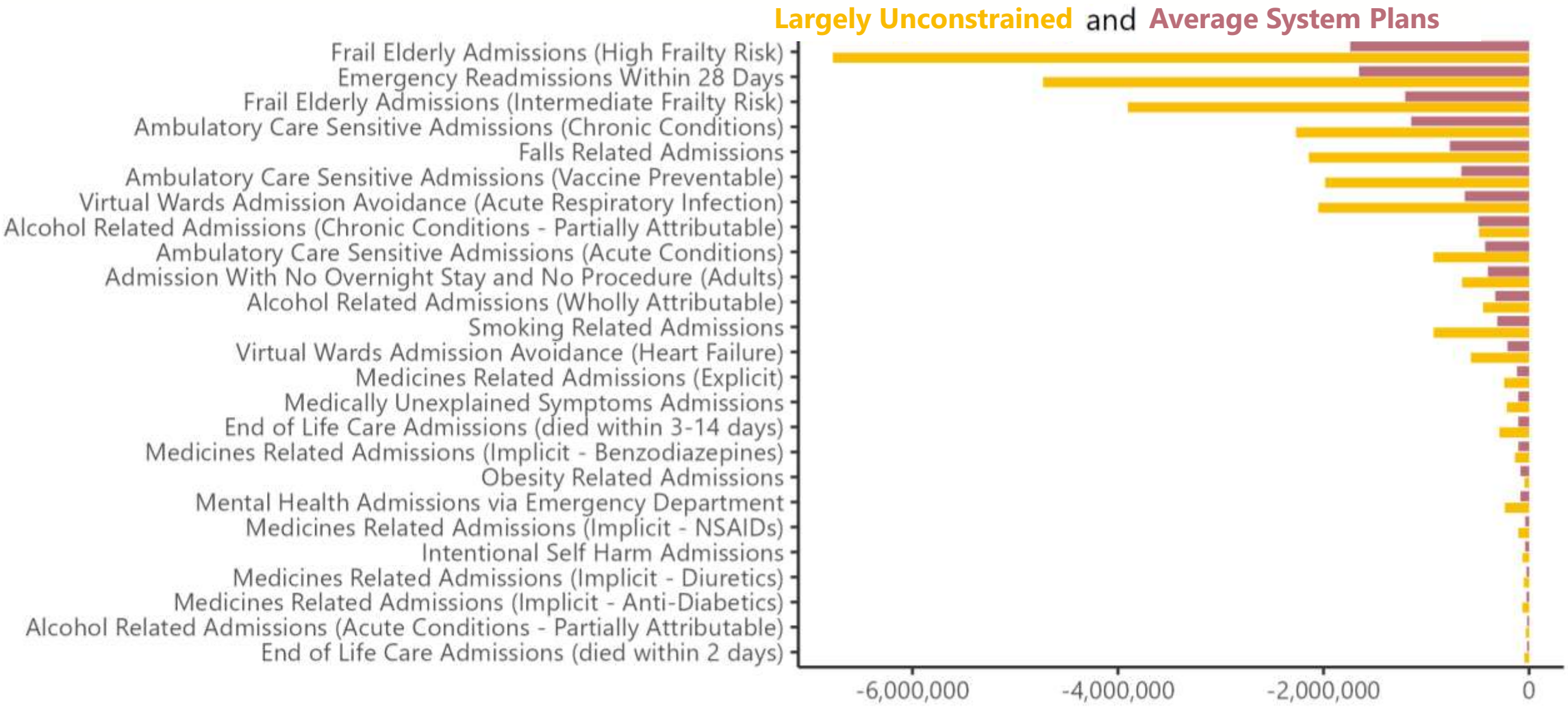
Average system plan rates for mitigation reduce the volume of admissions by the end year by **7%**
Largely unconstrained rates for mitigation reduce the volume of admissions by **15%**

Projected beddays, from baseline of 55 million in 22/23



Average System Plan rates for mitigation reduce the projected volume of beddays by **17%**
Largely Unconstrained rates for mitigation reduced the projected volume of beddays by **39%**

Admission Avoidance (number of bed days)



The admission avoidance impact on beddays has frailty and older people as key factors
There is also dependence on prevention mitigators

Indicative Cumulative impact

Translating Acute Resource to Community

Currently, there is no easy and accurate way to directly translate care in acute to community care. Our clustering of community contacts from CSDS aims to improve this.

In the meantime, we are taking assumptions from Moving healthcare closer to home: Financial Impacts (Monitor 2015).

This quality report considered relative costs of services by patient, explicitly factoring NNT, based on optimistic assumptions for type and number of patient (Fig1).

They then looked at investment needed to achieve the shift, including the time and money needed to set up schemes. (Fig 3).

Their conclusion was that services could **break even by year 5.** This assumed optimal organisation to achieve economies of scale, and double running or tapering costs.

On this basis, we have adopted a **1:1 cost ratio for conversion**, agnostic of time dimension.

Figure 1: Cost of a patient spell[7] on a community-based scheme in its fifth year compared to a spell for an equivalent patient in the acute hospital[8]

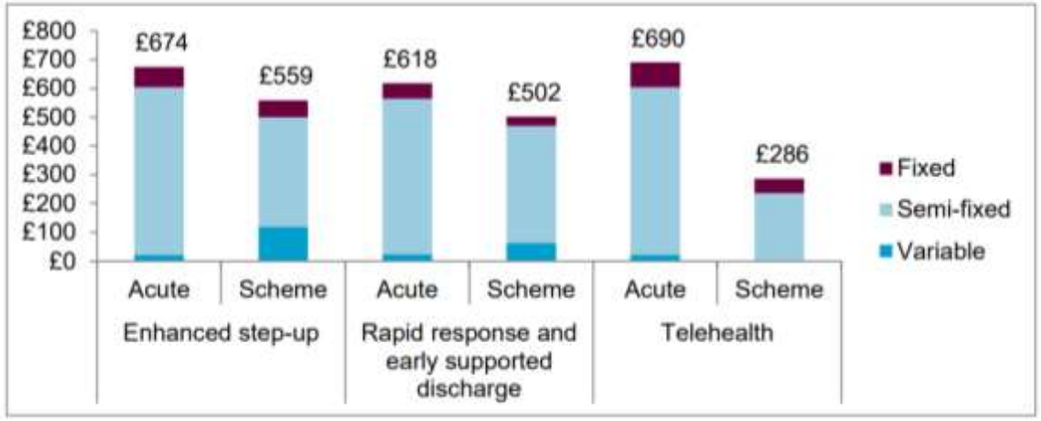
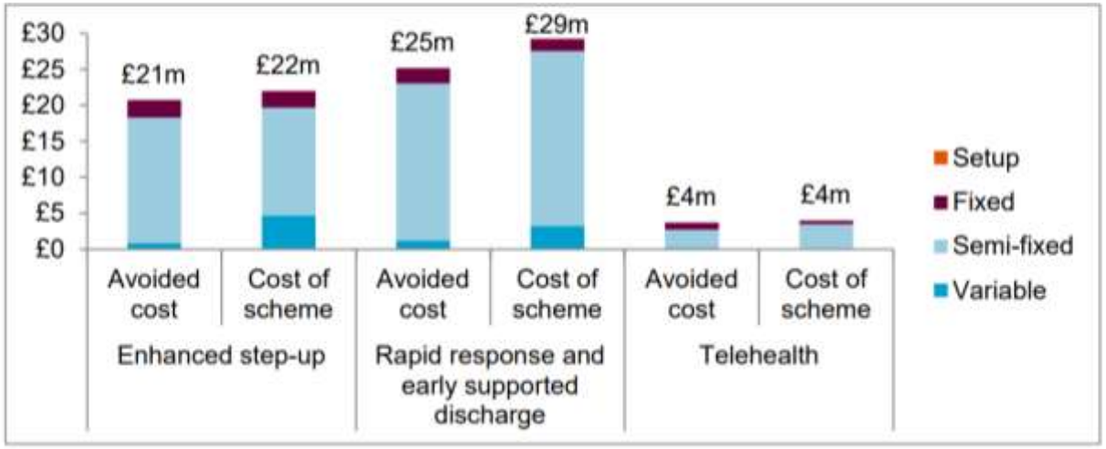


Figure 3: Total cumulative costs over five years of running each scheme compared to costs saved or avoided by the scheme across the local health economy (£m)[12]



Horizon year 2035/36

Steady State (base rate)

25-30% net growth in community services activity is needed to maintain current levels of community services for older people and not to worsen current hospital admission patterns.

Left Shift

To achieve Average System Plan (NHP) “left shift”, at least **£3.6bn** of activity needs to shift from Acute sectors

Cumulative impact

If baseline investment in community services of relevance is £11.9bn and the 1:1 resource equivalence assumption is applied, the combined requirement would be to grow community services by the final year:

Average system plans: 25-30% plus 31% [13%, 54%] **= 56-61%** [38% and 84%]

The Strategy Unit.

We've covered past failures, and scaled future challenges...

So what could be done differently this time?

Policy aim: 'left shift'

Factors tending towards the 'right drift'

- Political salience, policy attention and soft power
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The right services will prevent hospital admissions

What is needed to achieve the 'left shift'?

Resources from the session (all links)

Innovation, resources and the ‘right drift’ – Blog

New Hospital Programme – Model

Long-term local demographic change - Blog and tool

End of life - Report (positive effects)

Continuity of care - Report (positive effects)

Risk stratification and the need for better evaluation - Blog and paper

Wolverhampton 'PACs' - Evaluation (positive effect)

NHS Confederation

The Strategy Unit.

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