A review of lessons from previous initiatives to improve patient flow and shift care from hospitals to the community – overview report

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Introduction

Current government policy seeks to make ‘three strategic shifts’:

1. **Moving care from hospitals to communities**
2. **Making better use of technology**
3. **Preventing sickness, not just treating it**

The focus here is on the first of these aims - moving care from hospitals to communities. While this has long been a policy aspiration, previous attempts to shift care are widely perceived to have been insufficient to rebalance the health care system. Some argue that the balance may even have shifted the other way, inadvertently serving to prioritise hospital-based care at the expense of primary care and community-based support. As the then Chief Executive of NHS England observed (NHS England et al., 2016, p.4):

"If anyone ten years ago had said: ‘Here’s what the NHS should do – cut the share of funding for primary care and grow the number of hospital specialists three times faster than GPs’, they’d have been laughed out of court. But looking back over a decade, that exactly what’s happened."

This is not for the want of trying. Almost 20 years ago, the *Our Health, Our Care, Our Say* White Paper set out measures to achieve a strategic shift from hospital-based services to ‘care closer to home’ (Department of Health, 2006, p.17):

"Our longer-term aim is to bring about a sustained realignment of the whole health and social care system. Far more services will be delivered – safely and effectively – in settings closer to home…Year on year, as NHS budgets rise, we will see higher growth in prevention, primary and community care than in secondary care, and also resources will shift from the latter to the former."

In 2014, the *NHS Five Year Forward View* was clear that (NHS England, 2014, p.16):

"The traditional divide between primary care, community services, and hospitals – largely unaltered since the birth of the NHS – is increasingly a barrier to the personalised and coordinated health services patients need. And just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three.

Over the next five years and beyond, the NHS will increasingly need to dissolve these traditional boundaries. Long term conditions are now a central task of the NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected ‘episodes’ of care. As a result, there is now quite wide consensus on the direction we will be taking. Increasingly we need to manage systems – networks of care – not just organisations. Out-of-hospital care needs to become a much larger part of what the NHS does. Services need to be integrated around the patient…"

By 2019, *The NHS Long Term Plan* was adamant that (NHS England, 2019, p.13):

"We will boost ‘out-of-hospital’ care, and finally dissolve the historic divide between primary and community health services."

More recently, UKRI’s Research & Development Missions Accelerator Programme (RDMAP) seeks to support several aspects of the current government’s aspiration to shift care from hospital to community, including how best to support people living with dementia. To shape future funding calls, UKRI commissioned an independent review of lessons from previous initiatives which included aims relevant to improving patient flow and/or shifting care from hospitals into the community.

UK Research and Innovation

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Our approach

Against this background, the University of Birmingham's Health Services Management Centre (HSMC), Department of Social Work and Social Care (SWSC) and Centre for Evidence and Implementation Science (CEIS) synthesised existing knowledge in order to identify successful initiatives aimed at improving patient flow and/or shifting care from hospitals to the community, key lessons learned and key gaps in evidence. Throughout, the emphasis was on strategic and systemic attempts to shift care, rather than on the myriad of individual, small-scale pilot projects that may have existed at any one moment in time.

The independent review included:

- ***An online policy roundtable for previous healthservice policy makers, leaders and health and social care researchers who have been involved in previous attempts to shift care***. An invited audience of key stakeholders who had been involved in previous attempts to shift care over more than the last 20 years (in England) took part in a 'Chatham House' roundtable. Presentations from key figures who were leading this work in the early-mid 2000s, the early 2010s and in the current context were following by group exploration. Discussions included what previous policies were hoping to achieve; how they went about it; what happened in practice; what helped and hindered; lessons learned; and things participants know now that they wished they knew then/advice they would give to current colleagues. The roundtable was designed to capture crucial practical and experiential learning in a safe space that may not otherwise be readily available. Where people were not able to attend the roundtable, they sent in personal thoughts and reflections around these questions for the research team to include in the current report. In total 20 stakeholders took part.

- ***A narrative review of key government White/Green Papers and official reviews*** since the election of New Labour in 1997. The aim was to map out why policy makers wanted to shift care to the community; what they were hoping to achieve; what mechanisms and actions were proposed; what evidence was cited to suggest this might be effective; what they saw as potential barriers and success factors; whether the proposed changes were evaluated; and what they achieved in practice. In total, 12 documents were included (selected as landmark policy documents at different periods of time and/or due to their significance in terms of attempts to shift care; see Figure 1). As health policy in the UK is a devolved matter, these focused on policies in England – although the broader themes identified may well also be applicable in other nations of the UK.

- A ***rapid evidence synthesis*** of relevant publishedacademic literature since 2000. This searched databases such as Medline, Social Policy and Practice, CINAHL, PsycINFO, Sociological Abstracts, Social Science Citation Index, Applied Social Sciences Index and Abstracts (ASSIA), Social Work Abstracts and the International Bibliography of the Social Sciences (IBSS). It was performed iteratively over five stages: (1) clarification of review scope; (2) initial scope development; (3) evidence search; (4) evidence selection, quality appraisal, data extraction and analysis; and (5) drawing conclusions and recommendations. The search identified 7718 potentially relevant studies (21 duplicates were removed). Following dual title and abstract screening, 211 articles were included in full text review. A final 65 studies were included for data extraction and synthesis. Despite seeking to concentrate on well-evidenced, systematic attempts to shift care, the review suggested that most studies/pilots were small-scale and/or non-strategic in focus, and that relatively few adopted rigorous experimental designs.

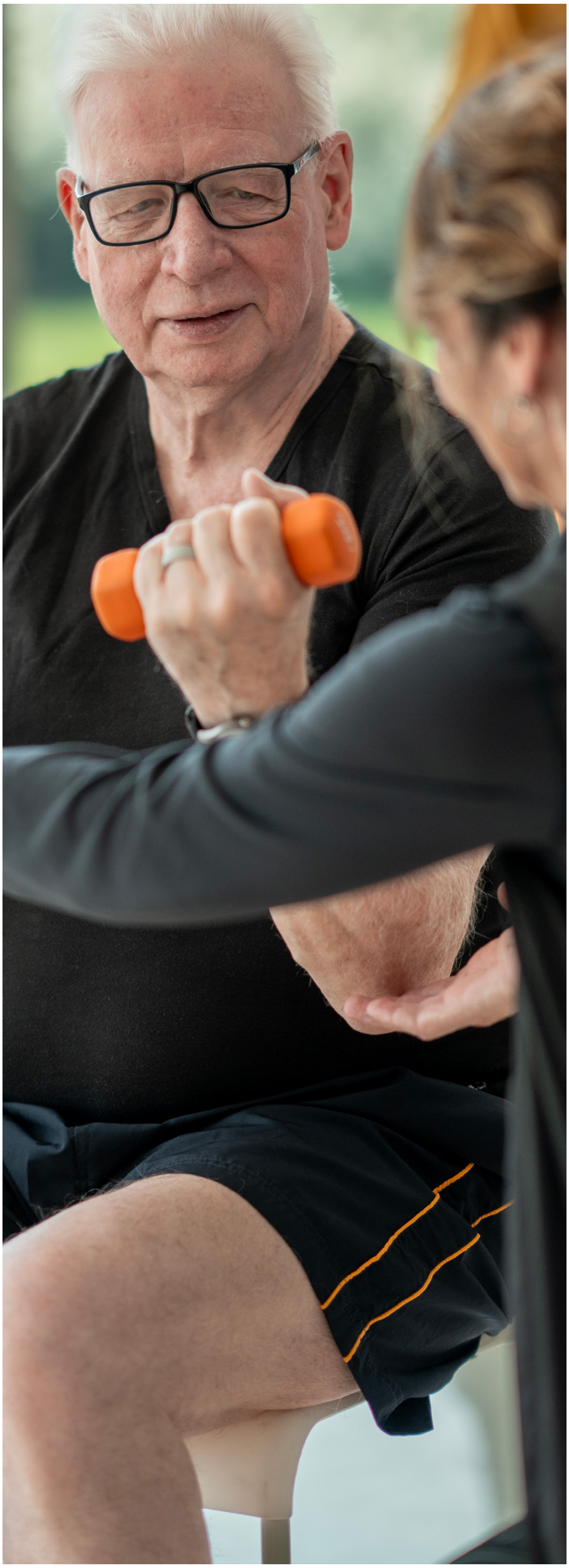

Figure 1: 12 key policies

- 1997 New NHS White Paper
- 2000 NHS Plan
- 2004 NHS Improvement Plan
- 2006 Our Health, Our Care, Our Say
- 2007 Interim Darzi Review
- 2008 Final Darzi Review
- 2010 Liberating the NHS White Paper
- 2014 Five Year Forward View
- 2019 NHS Long Term Plan
- 2021 Integration and Innovation
- 2023 Hewitt Review
- 2024 Darzi Review

Insights from each review component were integrated to form the ten key themes set out below in this overview report. (Component reports are available in full as linked appendices via the University of Birmingham webpages).

1. Being clear on the outcomes to be achieved, what approach is most likely to be effective and why this might work when previous attempts did not

Throughout previous attempts to shift care, a common issue has been a failure to agree on the outcomes to be achieved. At different stages, different people have sought to improve efficiency in acute care; improve patient experience; deliver care in more convenient, homely settings; tackle health inequalities; free up money to re-invest in other priorities; and/or actively save money. These are all potentially laudable aims, but are very different - it feels unlikely that one set of policies could ever really achieve all these different aims simultaneously.

In empirical research, broad outcomes such as 'reduction in hospital admissions' may be important but of limited utility in practice, since baseline admission threshold varies widely between geographical areas on the basis of availability of inpatient and community resources, and user and clinician preferences. Perhaps linked to these debates about desired outcomes, the performance measures that services are asked to deliver have not necessarily shifted when care has moved into the community. As a result, there is often a clear sense of the priorities, key measures and relative performance in acute care, but much less clarity in some community settings. If 'what's measured is what matters', then key performance indicators (KPIs) send a clear signal about the extent to which we are serious about shifting care.

More generally, policy claims have often been 'heroic' in nature and in their assumptions about what's possible. They therefore tend to over-promise and under-deliver, and to be unclear on the mechanisms that will enable such a shift.

There was little evidence of learning from previous policy initiatives and failures. Typically, similar themes and issues are identified repeatedly over time, without any real sense of how a current approach might differ from something similar in the past that was deemed not to have worked.

The review of previous policies also found that different language is used over time, often without defining exactly what is meant. Examples here include the notion of 'integrated care' or 'partnership working', which can often mean different things to different people. Paraphrasing Mark Twain, such terms have been described by Powell and Dowling (2006, p.305) as *"the indefinable in pursuit of the unachievable."*

In the rapid evidence synthesis, very few studies detailed clear outcomes to be achieved from the introduction of the new care models and services they evaluated or explored. As many studies were qualitative, outcomes were often exploratory and descriptive. The exception were a small number of Randomised Controlled Trials, which were often focused on specific interventions, but which did outline primary and secondary outcomes and intervention approaches.

All this means that future research and policy should be clear on the outcomes to be achieved, how well current services achieve these (or not), proposed actions and the evidence that warrants such approaches being attempted and tested. Frameworks such as 'theories of change' and 'realist evaluation' (which seek to understand the relationship between context, mechanism/process and outcome) may therefore be helpful ways forward.

2. Working at sufficient scale to rebalance the system

A number of previous policy initiatives have been small, time-limited pilots. No studies were identified in the rapid review which described strategic and systemic attempts to shift care across the nation, with local and some regional programmes identified most frequently. While local pilots can provide helpful lessons (see, for example, Ham et al., 2008; Lewis et al., 2021; DHSC, 2025), they have not proved sufficient to significantly shift care and have tended to adopt unrealistic aspirations and timescales. Future research should therefore focus on strategic and systemic attempts to shift care, rather than individual/small pilots (or at least on innovations which have the potential to be scaled and a plan for more widespread adoption of successful approaches).

Going forwards, attempts to shift care will need to be sustained over the long term, rather than reverting back to previous ways of working when things get difficult. There will be some very challenging national and local political issues to resolve. For example, if data suggests that we need to downgrade an A&E or close a hospital in order to shift care, will this be acceptable to local people and will it be supported by local and national political leaders? As an illustration of these risks, some roundtable participants described their involvement in previous reforms when some community services were encouraged to 'spin out' of the NHS and to pilot new organisational forms, such as social enterprise. Those involved were passionate about delivering better care and creating better working conditions for staff. However, they were also worried that they would be seen as 'privatising the NHS' and that policy would change, leaving them 'out on a limb' and isolated.

Taking a step back from current debates, the transformation of mental health services from the 1960s onwards was seen by roundtable participants as an example of care moving from asylums to the community, albeit with lots of caveats about how well this was done in practice. A review by Gilburt et al (2014) draws out key lessons for debates around shifting care from hospitals to the community, including the importance of *"an honest, powerful, well-communicated narrative that goes beyond technical and clinical issue"*; investing in new capacity before existing capacity can be closed; recognising that complex system change produces unexpected results; and acknowledging that change requires *"high-quality and stable leadership that supports the needs of stakeholders and is consistent with the direction of change."* The review was also clear that *"simply moving the location of care without redesigning is not enough - existing services should not simply be replicated in new settings"* (p.1).

3. Being clear about how proposals will be implemented in practice

In the early 2000s, *The NHS Plan* (Department of Health, 2000) was felt by roundtable participants to be primarily focused on acute care and specialist services. This was a response to annual winter crises, long elective waits and longstanding neglect of some of the major clinical priorities (such as cancer and coronary heart disease). In response, key reforms included new financial incentives (with the money following the patient), increased capacity in the private sector and via Independent Sector Treatment Centres, Foundation Trust status for high performing hospitals, a series of National Service Frameworks and support to improve flow through hospital via the work of the Modernisation Agency. By the late 2000s, significant progress had been made through a combination of reform and additional funding.

It was not until 2006 that the White Paper *Our Health, Our Care, Our Say* (Department of Health, 2006) attempted to set out a vision for shifting care from hospitals to the community, reforming community services and promoting more integrated care. However, the White Paper lacked a credible implementation plan, and there was nothing comparable to the scale, focus and sustained commitment behind the acute care reforms of the earlier 2000s. Funding was restricted following the global financial crisis, making it much harder to maintain spending on hospitals whilst also investing in community alternatives. On reflection, roundtable participants concluded that *'if you will the ends of shifting care from hospitals to community you will need to will the means'* – and that this has never really happened in practice, with predictable results. This is supported in the wider research, with very few studies detailing clear protocols and plans for implementation and scaling for the new care models being evaluated. As a result, there is a need for any research that is commissioned to be clear on how any innovation might be implemented in practice, how it might scale, financial implications and how to fund any transition to new ways of working (given that the current financial context means that scope for double running costs might be limited).

4. Making sure wider policy, incentives and enablers are aligned

At the roundtable, the balance of power in the NHS was felt to have always tilted towards acute hospitals and specialist care, with the share of NHS budget going to acute services continuing to increase, even when policy pointed in another direction. This was not felt to be a 'conspiracy' in any way, but simply a social and political reality, based on the importance that the public and the media place on hospitals.

This makes it more important that attempts to shift care are not just individual announcements, but that wider policy is fully aligned with this aim. If future aspirations are to be achieved, the whole system will need to be fully focused on this aim (including payment mechanisms; performance measures and incentives; capital funding; IT; education and training; leadership development; communications, and so on). Some coverage of the recent spending review had talked about capital spending on 'schools and hospitals', perhaps inadvertently re-inforcing the sense that health care is mainly about hospitals, rather than people, families, communities and a range of different services that all play a role in promoting health and well-being.

5. Leading change

The rapid review found little empirical evidence around the leadership skills required to shift care or how these should be developed. In seeking to fill this gap in knowledge, roundtable participants felt that meaningful change was more likely when:

- There is significant alignment between the aims of national politicians and health service leaders (especially if the Treasury and the Prime Minister are also supportive of the direction of travel).
- Reforms become so embedded that they can survive periodic changes in Secretary of State – rather than a scenario where a new person is appointed with new priorities, and the previous person's agenda is never referred to again.
- There is widespread understanding and acceptance of the need to change and a clear call to action. Although an extreme case, some people mentioned the relationships and creativity that emerged in response to COVID-19 as examples of what can be possible when we work together to focus on what really matters.
- Reforms are rooted in local neighbourhoods and the kinds of lives that people and communities want to lead.
- Attempts are made to bring local people with you as services change (paying attention to the politics of service change), rather than changes being seen as a potential 'attack' on beloved local services.
- The focus is on cultural and practical change within front-line clinical teams, not simply merging organisational structures.
- Practical support on the ground is provided to share learning and assist local leaders.

More generally, previous evidence suggests that attempts to shift care may struggle unless there is much better understanding of how to lead large-scale change (recognising the need to see the NHS as a 'complex adaptive system' and to focus on creating receptive contexts – see, for example, Pettigrew et al., 1992; Ferlie and Shortell, 2003; Ham et al., 2008; Ham, 2023).

6. Making sure the right people are involved

Several previous policy documents and research studies adopt a 'hospital-centric' view of the world – focusing on initiatives at the edge of acute care ('step-up'/'step-down' type approaches), rather than a more genuinely preventative, long-term agenda that starts with people's lives and communities. Often, the focus is on 'lift and shift' approaches, which try to take a hospital-based service and simply relocate it, rather than starting with the person and working out from there.

Roundtable participants felt that such approaches had not worked in the past, and that something different would be needed in future. In particular, they identified three main elements of 'making sure the right people are involved':

- Previous attempts to shift care were felt to have downplayed the role of people and communities, the voluntary and community sector, social care, public health and broader local government. Where these were considered, they tended to be seen as a way of supporting hospitals, rather than in their own right and on their own terms. Approaches that are not just inclusive of, but that also start from more person- and community-centred places, would therefore be welcomed. In particular, local authorities are often seen as leaders of local place, and can be more familiar with working with the politics of service change. Their role is crucial, as are approaches which amplify the voices of people and communities.
- General practice was seen as *'the jewel of the NHS',* yet we have repeatedly struggled to find ways to support general practice to make an even greater contribution at greater scale, and to focus support on areas where need is greatest. Some previous initiatives were also felt to have been done *to* general practice rather than *with* it. There was a clear consensus that any reforms without a rejuvenated general practice at the heart are unlikely to be successful.
- Participants wanted to see a much greater focus on the workforce implications of shifting care, including understanding staff experiences of working in partnership at local level; what motivates front-line staff; how to create rewarding roles; and the workforce strategies and innovations needed to support the workforce of the future. Supporting staff to be better able to work across organisational and professional boundaries, and alongside people in local communities, will have implications for training and development; the balance between generalist and specialist skills; expertise in terms of physical and mental health; and the sorts of skills and contributions we value and celebrate in our health and social services.

7. Intervening early and understanding who needs the most support

Compared to other health systems, our approach to population health management and to identifying/targeting people most at risk of deterioration may be under-developed. Typically, some insurance-based systems were felt to be better at identifying such individuals and intervening early, before they experience a crisis (and in financial terms, become very expensive). One example might be frail older people with multiple long-term conditions (including dementia) – who are often poorly served by our current pattern of services and are some of the people most likely to become 'stuck' in hospital. This implies approaches and techniques which are better at understanding the current and future needs of specific individuals, groups and communities; better at tackling health inequalities; and much better at targeting support at those who might benefit most, at an early stage.

Although this has never been widespread in the NHS, there were previous attempts to incorporate learning from a US model ('Kaiser Permanente'), including in areas such as Torbay, Solihull and Northumberland (Ham et al., 2003; Ham, 2010; Thistlethwaite, 2011). Insights from Kaiser included its integration of care, by combining the roles of insurer and provider, and directly providing care both inside and outside hospital, with specialists and generalists working together and no incentive to build up resources in hospital at the expense of other services. However, this was also underpinned by a focus on chronic disease, population health management and risk stratification (Alderwick et al., 2015, p.12):

"Among other things, integration of care at Kaiser Permanente is supported by population risk stratification, an emphasis on prevention and self-management, disease management and the use of care pathways for common conditions, case management for patients with complex needs, extensive use of technology and population data, and a model of multispecialty medical practice where unplanned hospital admissions are seen as a 'system failure'."

Beyond some of these individual examples, the evidence synthesis struggled to identify interventions that had been found to be both feasible and cost-effective.

8. Living well with dementia

As older people and people living with dementia constitute a large proportion of hospital inpatients, these groups are necessarily affected by shifting 'care closer to home'. As the *Five Year Forward View* (NHS England, 2014) pointed out, two thirds of patients admitted to hospital are over 65, and more than a quarter of hospital inpatients have dementia. According to the *NHS Long Term Plan* (NHS England, 2019), one in six people over the age of 80 has dementia and 70% of people in care homes have dementia or severe memory problems.

However, there are few explicit and meaningful mentions of 'dementia' in policy documents such as *Our Health, Our Care, Our Say* (2006) (six), Darzi's initial review (one in 2007 and one in 2008), the *Five Year Forward View* (2014) (15), *NHS Long Term Plan* (2019) (27), The Hewitt Review (2023) (three) and The Darzi Review (2024) (11). Moreover, there are even fewer in the context of care closer to home. The *Five Year Forward View* (2014) briefly discussed 'support for people with dementia', declaring that many people with dementia living in care homes are not getting their health needs regularly assessed and met, with one consequence being avoidable admissions to hospital. *The NHS Long Term Plan* (2019) argued for expanded community multi-disciplinary teams which would include 'dementia workers'. It noted that home-based and wearable monitoring equipment will increasingly enable the NHS to predict and prevent events that would otherwise have led to a hospital admission (which could include a location tracker to provide freedom with security for someone with dementia). However, the Hewitt Review (2023) warned that it is vital to recognise that many NHS patients and users of social care are amongst those least able to use digital solutions, whether because of frailty, economic disadvantage, language issues or physical, cognitive or other impairments (including dementia).

Roundtable participants also discussed scope for a different approach in future. Rather than just focusing on clinical pathways as people's condition changes (or mainly on research to slow the onset of dementia), there may also be scope for a more 'social' pathway which is about living well with dementia (see, for example, Crowther, 2024; NHS Greater Manchester et al., 2024). For example, plans in Greater Manchester include a commitment to reducing unplanned and crisis service usage – but also around having choice and control over daily life, living in your own home for as long as possible, having a sense of purpose, maintaining a sense of identity, feeling connected to your community (and to communities which are accepting and supportive of people with dementia), having positive relationships, and having access to reliable and affordable transport.

9. Learning from elsewhere

Whilst recognising that we cannot just 'import' approaches wholesale from elsewhere, there may be scope to learn from other systems. In previous policy, various international examples are mentioned – but the evidence for the claims made is not also fully clear, and there is little consideration of how such insights might be successfully translated into a UK context. Although the evidence synthesis excluded non-UK research, one study explored how the UK can learn from different models of community hospitals in Australia, Finland, Italy, Norway and Scotland – providing potentially helpful learning. While our roundtable and review of previous policies focused on England, the devolved nature of our health and social services means that there is also significant scope for mutual learning across the four nations of the UK.

More generally, roundtable participants felt that the NHS could be better at learning from other sectors, with scope for previous initiatives such as 'Sure Start' or 'Home Treatment Teams' for people with mental health problems to contribute to current debates. These were initially felt to be well-funded; locally-based, with strong links to local communities; and to have significant autonomy to do whatever was needed to make a difference. It was also recognised that these were long-term interventions and that change would be slow and sometimes difficult to see in the heat of the moment, but that they were nonetheless contributing to positive outcomes. Participants felt that both became less effective as funding reduced, ways of working became more standardised and bureaucratic, and performance management became more narrow. Other models such as the 'Rapid Assessment Interface and Discharge' (RAID) service (which provided in-reach psychiatric liaison service to prevent avoidable admissions to inpatient wards and mitigate longer lengths of stay) were also felt to have been positive (see, for example, Strategy Unit, 2018; Tadros et al., 2013).

If future policy aspirations are to be delivered, research which can identify (and meaningfully translate) relevant lessons for health and social care from other sectors, from across the four nations of the UK and/or internationally may be fruitful.

10. New technology

While the benefits of new and emerging technology can prove difficult to realise in practice, there are clearly significant opportunities here. As but one example, participants at the roundtable felt that technology-enabled rapid/real-time dialogue between patients, primary and community services and specialist teams could optimise care, rather than relying on what one person described as the *"1950s single disease conveyor belt of outpatients."*

In the evidence synthesis, numerous studies examined the implementation or development of new technologies. For example, a retrospective observational study of COVID-19 Oximetry@home in North Hampshire found an association with a reduction in hospital length of stay, but no significant reduction in intensive care unit admissions. A community outreach colorectal clinic significantly reduced waiting time for routine referrals from a mean of 10.5 weeks to 5.9 weeks after six months. The rate of patient 'Do Not Attends' was also significantly lower in the community service. However, the wider literature suggests that current services can struggle to harness potential benefits, and that issues of implementation, involvement and engagement, training and development, ethics and cultural change might be just as important as the technology itself (see, for example, Glasby et al., 2023).

Summary – and implications for future R&D

With different policies over time seeking – but struggling – to shift care, there is merit in taking stock of where we have come from, where we are now and what might prove fruitful next.

Whilst our evidence synthesis sought to focus on identifying and describing strategic and systemic attempts to shift care, most of the published evidence describes multiple small-scale, single site or single region evaluations. There was a paucity of studies adopting rigorous experimental designs, and any shifts in activity from hospital to the community were typically regarded as small, non-strategic, piecemeal, and not directly underpinned by resource shifts.

'Shifting care' may be a laudable aim, but is unlikely to be realised unless we are explicit about the outcomes we are seeking; clear on how we will implement and scale the multi-level changes that are needed; serious and sustained in our intent; focused on the realities of joint working on the ground; mindful of the role of a wide range of different partners; place people, families and communities at the centre; focus on the needs of people with dementia; harness the potential benefits of new technology; learn appropriate lessons from elsewhere; and start from the lives that people want to lead in the places where they live, rather than simply moving services from one location to another.

Against this background, future R&D could helpfully:

- Combine rigorous experimental designs with research which starts with the outcomes that matter to people and communities and is based on meaningful co-production and/or co-research. These are sometimes seen as speaking to different disciplines and research traditions, so there may be scope for an overall programme which includes a range of disciplines and methods and/or research studies and teams which can convincingly combine the best of these approaches.
- Be clear on the outcomes to be achieved, how well current services achieve these (or not), proposed actions and the evidence that warrants such approaches being attempted and evaluated. Frameworks such as 'theories of change' and 'realist evaluation' (which seek to understand the relationship between context, mechanism/process and outcome) may therefore be helpful ways forward.
- Focus on strategic and systemic attempts to shift care, rather than individual/small pilots (or at least on innovations which have the potential to be scaled and a plan for more widespread adoption of successful approaches).
- Be clear on how any innovation might be implemented in practice – what is the implementation strategy being adopted, how might it scale, what are the financial implications and how might any transition to new ways of working be funded (given scope for double running costs might currently be limited)?
- Consider the leadership skills needed to shift care and the workforce implications.
- More fully recognise and illuminate the role of people and communities, the voluntary and community sector, general practice, social care, public health and broader local government.
- Be much more inclusive of the experiences of people living with dementia, including a focus on living well with dementia.
- Improve approaches to population health management, identifying and better supporting individuals and groups who might benefit most from early action.
- Draw on lessons from other UK nations, other sectors and other systems(recognising the need for learning to be meaningfully translated).
- Harness the potential benefits of new and emerging technology, whilst recognising and working with the cultural adoption challenges that this may entail.

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