Cordis Bright Blog

Interventions designed to reduce & manage demand: what do our recent studies tell us?

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Introduction

We have recently completed a number of evaluations concerning interventions which aim to reduce or manage demand for mainstream services. These innovations are increasingly common as health and social care services look for ways to reduce the strain they are experiencing. Having delivered a number of evaluations now, we thought it would be interesting to look across a selection of them to see if we can spot any emerging themes. In particular, we wondered:

1. Are there key factors which contribute to the success of these approaches?
2. How useful is the policy of investing in interventions designed to reduce or manage demand for mainstream services?

The studies we reviewed

Our evaluations used different methods to study trends in service usage for the period before and after each intervention. In some cases, this was on a patient by patient basis, and in other cases we used aggregate data. Here's a summary of the studies:

Intervention	Details	Aims for reductions in:
Intervention A	**A navigator model** to support people with multiple and complex needs to experience and engage in better, more co-ordinated support, in turn reducing expensive, unplanned service use, such as A&E attendances, through a trusting relationship with a main point of contact.	A&E attendances, non-elective admissions to hospital (NELs), nights in custody
Intervention B	A vanguard focused on **enhanced health in care homes.** It offers specialist interventions in care homes concerning telemedicine, clinical pharmacy, the Red Bag scheme, and additional Vanguard projects (care home staff training, sensory and reminiscence equipment, personalised music playlists and provision of bariatric equipment). The cost-benefit analysis within this evaluation	Emergency admissions, lengths of stay in hospital, pharmacy costs

Intervention	Details	Aims for reductions in:
	was conducted for the telemedicine and clinical pharmacy work, as these were the most embedded interventions.	
Intervention C	**Assistive Telecare and Telehealth technology** for those with long-term conditions to support people to live in care homes.	GP appointments/home visits, elective day and NEL admissions, A&E attendances.
Intervention D	**Brings together health, social care teams and community partners** through three main workstreams: 1) a 24/7 care package to support residents requiring short term support to live at home 2) multi-disciplinary teams in the community 3) GPs re-designing care for people with long-term health conditions. Wider offer includes risk stratification to identify patients most in need, evidence based clinical pathways and a programme of self-care and independence.	NELs, A&E attendances and intermediate care admissions
Intervention E	A vanguard focused on **improving co-ordination and reducing pressure on Urgent and Emergency Care Services** The evaluation focused on the Clinical Hub element which offered a single point of entry for those wishing to access primary care services.	A&E attendances
Intervention F	**An enhanced IAPT offer designed to support those with long-term physical health conditions**. It is designed to focus on self-management of the long-term conditions, as well as mental ill health.	A&E attendances, length of hospital stays, use of outpatient services and primary care

Reduced demand for mainstream services?

The evaluations show that the interventions have had mixed results, for example:

- Intervention A demonstrated the most **significant and attributable** reductions in unplanned interventions. Although it should be noted that the evaluation did not take into account cost incurred through increased use of other services (e.g. housing or GP appointments).
- Interventions C and F had some success in reducing mainstream service use in the **short-term,** but due the timescale allowed for the evaluation we could not yet demonstrate a longer-term or significant level of change.
- Some interventions had **mixed results**, reducing service use in some areas, but increasing it in others. In most (although not all) cases this had potential to be a

promising development (e.g. greater use of community-based GP and outpatient services, with a reduction in more expensive A&E or In-patient care).
- Other interventions did achieve a **reduction in use of mainstream service use** and a predicted cost-saving, but this was **small-scale**.

These findings prompt a few thoughts:

- The evaluation of Intervention A, which found the most positive impact, covered the longest period of time. This may mean that a more positive impact would have been evidenced in other interventions had we been able to evaluate over a longer time-span.

- To assess the impact of interventions on demand, good quantitative data is critical. However, accessing effective quantitative data across health and social care at the individual level is challenging for a range of reasons (e.g. data sharing requirements and the difficulty of gathering data that measures the "right" things).

- Where we have experienced gaps in quantitative data, qualitative data helps to build a broader picture. This can be key in situations where quantitative data shows inconclusive or negative results: qualitative data helps us explore whether the approach is inherently flawed, or whether it has potential but needs to be differently implemented. This can be key to ensuring that an approach with potential is not abandoned simply because the initial quantitative results are less encouraging that commissioners had hoped.

Common success factors for implementation

These evaluations also revealed some common themes around successful implementation. The list (as set out below) is probably not surprising or new: it does seem that we have a good understanding of *what* needs to happen. But these are difficult things to achieve in practice.

- **Effective consultation and needs assessment when establishing the service.** This supports the development of a clearly articulated model, vital to achieve buy-in from the workforce. It can also identify any additional input needed to ensure sites are ready. Consultation, particularly needs assessments to diagnose the problem, enables resources to be utilised in a more efficient and targeted way. This helps make sure that the "change" is the right solution to address the needs of the local context. Part of this process should include developing a **clear theory of change** including a **logic model** for the intervention.

- **Workforce.** Action plans for staff recruitment and retention can help make sure there is enough capacity and knowledge to roll out the intervention sustainably. Flexibility and willingness of staff to try new approaches and a continuation of training opportunities in relation to the intervention is also important in sustaining change. A realistic workforce strategy that is joined-up between health and social care can support the roll-out of integrated interventions, and help use resources in the most efficient way to address issues of training, recruitment and retention.

- **Clear strategic plan and implementation.** Sustained and systematic efforts to spread the message of the service to clinicians, frontline staff, and potential service users is

also key to achieving adequate referral rates. It is important to reaffirm the implementation plan and theory of change to management across all partner organisations to further **achieve "buy-in" from system leaders** across health and social care.

- **Positive and trusting relationships with service users. Co-production** is one way in which these relationships can be built. Once trusting relationships have been formed, clients are more likely to engage with a service. However, relationship-forming must be balanced with risk-management and appropriate professional practice.

- **Links to other services.** For longer term change to happen in people's lives, they need to engage with a range of services. Some people (for instance, those with multiple disadvantage, older people, or people with long term conditions who are isolated) are unable to access services that could help them unless they have support to do so. A challenge is that through supporting people to engage with services, interventions are creating more demand which agencies are not equipped to meet. Collaborative multi-agency working is needed to meet this challenge. Similarly, co-ordinated and streamlined support across services is also important to improve the efficiency of care and deliver more consistent clinical pathways.

- **Using evidence based-approaches to inform service design.** Some of the interventions we have looked at offer-specific approaches that have been shown to support successful divergences away from mainstream services. These include:

    - **Multi-disciplinary teams**. These can facilitate linking to other services by enabling a range of professionals (including from the voluntary and community sectors) to discuss patients and develop a person-centred approach to care.

    - **Risk stratification approach and emergency health care plans.** Improves proactive management through identifying patients most in need of support.

- **The support offered needs to be flexible and holistic***.* What works for one person may not work for another. In a navigator model, navigators need to take time to find out how best to help clients identify and build on their own strengths. For most statutory services and services delivered under contract to the statutory sector, this type of approach is simply not feasible.

- **Using monitoring and evaluation data to inform service design.** Measuring impact helps make sure that money is being spent effectively and targeted in the right way. To achieve this, effective performance management and evaluation approaches need to be in place from the start of the intervention.

Conclusions?

It's clear from the evidence that to have a chance at achieving long-term, system-wide change, providers, commissioners and designers must collaborate and consult with a range of partnership agencies, service users and frontline staff. This can help ensure interventions are effectively targeted and implemented, in order to have the best chance of reducing the current demand and financial strain on the system. The study-periods also need to be realistic, giving evaluators enough time to see if these interventions have an effect on service use.

Overall our studies find no evidence that the policy of investing in interventions designed to reduce demand on mainstream services is flawed. And philosophically, this approach is hugely appealing as it promotes benefits for both citizens / patients and the public purse. The problem is that everyone is in a hurry to prove: but it's when we take more time that we can demonstrate clearer results.