
Building the case for clinical care in the home at scale

First report of the expert panel

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Contents

Introduction	1	Members of the expert panel group
Why are we focusing on clinical care in the home? Christine Outram, chair of the expert panel	1	Christine Outram The Christie NHS Foundation Trust
Defining the services and measuring their worth James Featherstone	2–3	Angela Nelson Janssen
Defining clinical homecare	4	Atiya Kenworthy Alexion UK
Scope of the homecare market	5–7	Garrett Taylor AMG Nursing and Care Services
Explaining the services	8	Helen Birtwhistle NHS Confederation
Approach	9	Jacqui Graves Macmillan Cancer Support
Service one: home cancer care	10–11	Joe Bassett East of England NHS Collaborative Procurement Hub
Service two: end of life care	12–13	Olivia Kessel AbbVie
Service three: home treatment of long-term conditions	14–15	Omowunmi Akindolie King's College Hospital
Service four: timely discharge from hospital	16–17	Richard Greville ABPI
Service five: virtual wards	18–19	Wendy Spicer Royal Free London NHS FT
Creating wider value	20–21	James Featherstone Healthcare at Home Ltd
Continuing to build the case for clinical care at home	22–23	William Roberts New Care Models Team, NHS England
Acknowledgements	24	
Footnotes	24	

Members of the panel attended the meetings in a personal capacity and this report does not necessarily reflect the views of their organisations

Why are we focusing on clinical care in the home?

by Christine Outram, chair of the expert panel

The plethora of NHS strategies, frameworks and plans that commissioners and providers use to deliver services seem to agree on at least one thing: much acute care needs to move away from hospital buildings and be provided closer to home. There is now a growing evidence base to suggest that in many cases this should be taken one step further, with hospital-type services delivered, under the guidance of hospital trusts, directly in a person's usual place of residence.

I have encountered such services, often in pilots or at small scale, in many of the commissioning roles I have held in my career and always thought they might merit further exploration and expansion. So I was delighted to be asked to chair the market inquiry into the efficacy and effectiveness of these types of services.

Over the past few months, with guidance from our expert panel and wider stakeholders, we have debated, defined and investigated what these services might look like and the benefits they will bring, first to patients and then to the wider health and care system. The evidence makes a compelling case, showing the value this can bring to improving quality of life for the people experiencing this type of care as well as the potential financial savings.

This brings me to the Five Year Forward View¹. In this, clinical care in the home wasn't given the prominence of some of the other new ways of delivering health and care services. The panel's initial plan was to make the case that clinical care at home should be badged as a new care model but it became apparent during our discussions that this level of prescription would not be right. Services could be implemented as a standalone 'new care model' or as an integral part of other initiatives already in place.

We remain similarly agnostic about implementation. We have examined examples of services delivered by the NHS, private providers and the charity sector. All have their merits, and we are asking local commissioners to market test and procure the best solution for their area.

I would like to give a special thank you to my expert panel, who gave up their time so willingly and enthusiastically to steer us through the evidence and help us deliver this report. I am also grateful to Jim Featherstone at Healthcare at Home, who made his clinicians, product specialists and data available for scrutiny. Finally I'd like to acknowledge the research team at ZPB Associates and Healthcare at Home, who had the unenviable task of synthesising all our deliberations into this report.

The next step is for local leaders to explore how to make it work in their area and deliver expert and efficient care that improves quality of life.



Christine Outram

Christine Outram has worked in a number of senior leadership roles in local and national commissioning organisations. She is currently Chair of the Christie NHS Foundation Trust.

Defining the services and measuring their worth

by James Featherstone Ph.D

With the focus of care provision shifting to what the patient wants, rather than the setting that the care is provided in, the NHS – as a whole – has been challenged to rethink ways of delivering care. Seven separate new care models are presented within the Five Year Forward View. Clinical homecare does not feature either as an individual model or as an integrated part of each. The concern, and the reason for undertaking this work, is to address this oversight and trigger debate across the sector about where clinical homecare fits.

This is why, in June 2015, Healthcare at Home Ltd announced it was to convene a market inquiry to examine the value that complex clinical homecare could bring to the NHS. We, and other industry leaders, felt that clinical homecare did not have the prominence it deserved in the Five Year Forward View. Maybe this was partly because we, the industry (and by that I mean private, pharmaceutical, voluntary sector and NHS providers), had not done enough to articulate the benefits of clinical homecare.

Informal discussions quickly showed that colleagues were keen to devote time and attention to telling the clinical homecare story. As the market leader, we thought we should make resource, people and data available to make this happen. I was delighted that Christine Outram agreed to be our independent chair. Her experience with local and national health care organisations has been invaluable.

This report marks the first output from the inquiry. We have explained what we mean by clinical care in the home and agreed a definition (page 4) of the care services on offer. It is helpful to make clinical services stand out from other activities that take place in a person's place of residence.

“We, and other industry leaders, felt that clinical homecare did not have the prominence it deserved in the Five Year Forward View.”

We have then dived deeply into five areas of service: cancer, long-term conditions, end of life care, virtual wards and timely discharge services. We have explained the services and their benefits and suggested metrics that can be used to measure outputs and outcomes. We have tried to make this section as practical as possible and we hope boards of provider organisations will use this to evaluate whether they could improve care and quality in their area. This should also help to ensure that excellent services are procured, developed and measured. These examples are described on pages 8 to 19.

Getting these definitions agreed and in place has been a useful task, but the inquiry has always had a much more important mandate: to define the units of value that the different models of clinical homecare can deliver. Value that is recognised by the NHS, pharma and of course patients; value that the industry can align behind and deliver, thus driving solutions that make a material difference to the provision and outcomes of healthcare in this country today.

I need not dwell on the challenges facing the health and care system. As a minimum we need three per cent savings, but that would still leave us £8bn in the red². This year there will be 850,000 people in the UK with dementia³ and half the people born since 1960 will have some form of cancer during their lifetime⁴. By 2030 there will be 20 million people over 60⁵. These are the kind of problems the inquiry members began to debate.

We think these units of value might fall into four broad categories:

- > Care in the home can lead to better adherence and a reduction in non-clinical medication drop-off. It can mean that patients suffer fewer relapses, fewer re-admissions and recover faster.
- > Care in the home can lead to reablement and improved quality of life. It is more likely to fit around the patient, allowing them to recover more quickly or have a better chance of living well with their condition. It gives them the best chance to return to a routine, including returning to work for those who wish to, that is best for them and their wellbeing. In turn this reablement can reduce pressure on hospitals and free capacity.
- > Care in the home can activate patients. It gives them the best environment in which to self-manage their conditions. This includes self-administration of medicines and control of treatment choices, times and places. Patient activation will be a key enabler for health and care systems to meet demand.
- > Care in the home can yield financial savings. Our analysis is provisional and needs more investigation but initial findings indicate that the services outlined in this report comfortably meet the three per cent efficiency savings prescribed in the Five Year Forward View.

To an extent, the four broad categories outlined are still just hypotheses. We need more data to prove this, and the metrics suggested in this report will help us do so. I'm delighted Christine and members of the expert panel have agreed to continue our work, with the next focus on investigating how and with what data we can evidence these units of value.

We will publish the results of this in due course, but in the meantime I hope boards of every provider organisation use this report as a guide to determine which services should be delivered in the home to best serve their population.

This report started out with the aim of elevating the debate that clinical homecare as a solution would deliver on the key 'value criteria' laid out in the Five Year Forward View. We felt that it was an obvious omission considering the value that the various models of clinical homecare can deliver. I think we have achieved this and strongly believe that clinical homecare should be an integral way of delivering new care models.



James Featherstone Ph.D is chief operating officer at Healthcare at Home Ltd. He is an expert in patient support programmes that drive adherence and persistence and the wider value these can bring.

Defining clinical homecare

The market has lacked a clear definition of clinical homecare and, therefore, understanding of how it can contribute to the future health system.

To address this, the expert panel in consultation with wider stakeholders has developed a single definition of **clinical care in the home** and tested it with a wide group of market leaders.

Clinical care in the home is:

Integrated care, treatment and support that takes place in a person's home or place of residence. This can directly reduce the need for or prevent an overnight or inpatient stay in hospital or a day case or outpatient visit. This can include patients with more severe conditions and those with long-term conditions. Normally, the hospital or NHS provider retains responsibility for patient care.

What is the size and breadth of the homecare market?

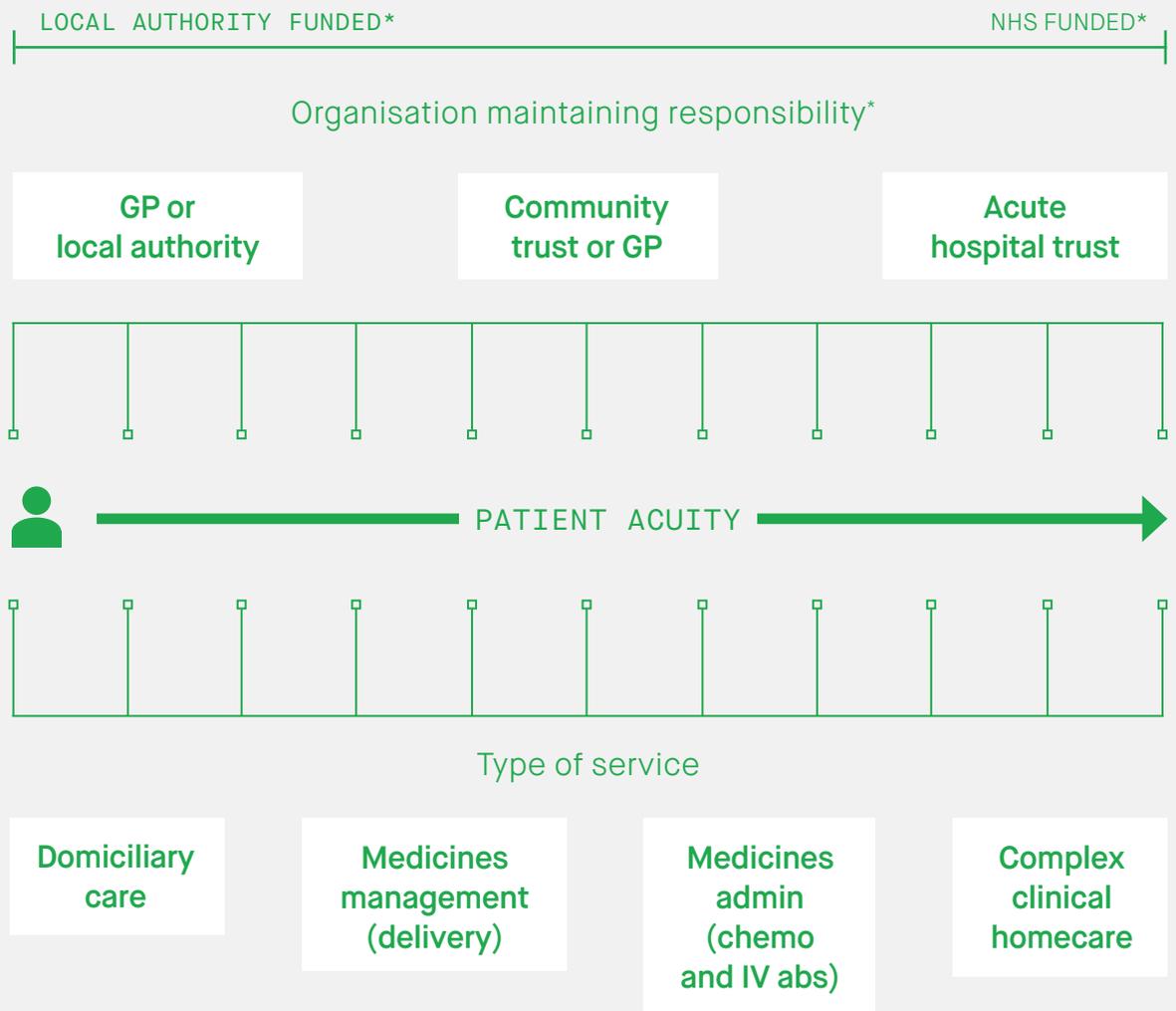
The homecare market in the UK is worth an estimated \$6.2bn and encompasses a broad and diverse range of services, from domiciliary care through to complex clinical homecare. It is a high-growth sector not only nationally but globally, with an estimated global market of \$372 billion.⁶

Domiciliary care comprises the delivery of personal care and support services to individuals in their own home. It ranges from personal care, such as help with washing and dressing, to domestic work and housekeeping to ensuring medication is taken on time. It rarely involves any clinical-based care.

Clinical homecare includes a range of medicines services such as dispensing and delivering medication to patients homes with or without associated nursing services as well as the treatment of higher acuity patients in the form of a virtual ward or complex home cancer care.

The clinical homecare market is growing at more than 20 per cent a year, with revenue to homecare companies exceeding \$1.5 billion⁷: It is that part of the market that is the focus of this report.

Scope of the homecare market



A SPOTLIGHT ON:

National Clinical Homecare Association

The National Clinical Homecare Association (NCHA), established in 2006, is an industry body representing organisations whose primary activity is providing clinical homecare services to people receiving care from the NHS, charitable and independent sectors in the UK.

It is a membership organisation, which acts as a central source of information for the sector, and promotes high standards in clinical homecare and influences and lobbies on healthcare policy on behalf of members.

*This is in typical circumstances

The size of the
homecare market:

Global market

\$372bn
by 2015⁸

European market

\$12.6bn
by 2015⁹

UK homecare market
(all client types, 2012):

\$6.2bn¹⁰

Growth and sales of national
clinical homecare market in 2013¹¹:

Per annum growth at

23%

Net profit of industry just over

1%

Revenue to homecare
companies more than

\$1.5bn

More than

\$1.2bn
deliveries annually

A Cochrane meta-analysis found that care in hospital at home programmes was associated with a 38 per cent reduction in mortality at six months compared with hospital treatment.

Why home and not close to home

The opportunity to be treated in their usual place of residence offers patients and their carers a greater sense of control, comfort and convenience in their care. It demonstrates how care can be designed to fit around individual needs, not organisational boundaries.

The evidence below proves that care in the home is associated with better health outcomes for patients. Not only does it reduce inconvenient and often stressful travel, particularly for elderly patients, care in the home has fewer iatrogenic complications and instances of functional decline.¹² Emergency hospital admissions or delayed discharge are critical points in the care pathway where patients are at risk of acquiring secondary problems.

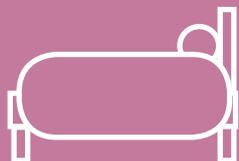
A 2009 Cochrane meta-analysis found that care in hospital at home programmes was associated with a 38 per cent reduction in mortality at six months compared with hospital treatment.¹³ In addition, one US study found that per patient cost for homecare patients was 19 per cent lower than mean hospital costs for comparison groups. This was predominately derived from shorter length of stay and lower use of clinical testing.¹⁴

Not only can clinical homecare mitigate clinical and psychological risks, it has also been shown to improve patient experience. A 2006 study into hospital at home care found that clinical homecare patients experienced greater satisfaction than acute hospital inpatients, particularly with admission processes and the comfort and convenience associated with care.¹⁵

By eliminating care transition gaps, patients and carers have a more seamless care experience and greater control over treatment. The sense of independence gained from being treated in a home environment is a significant outcome for patients and carers.

“The evidence proves that care in the home is associated with better health outcomes for patients.”

Explaining the services



Approach

Successful homecare services, ideally co-designed by the service provider and commissioner, are centred around the needs of the patient.

As a result, many are services individual to that health economy and local commissioner. That said, while details such as clinical and governance arrangements may change from service to service, there are a core number of functions that clinical homecare can fulfil nationwide.

This section outlines five examples of clinical homecare. It is not meant to be an exhaustive list. Each example includes: a description of what the service is, where it has been used, the benefits to patients, families, carers and the system value measures.

Two examples focus around medication management and/or administration (home cancer care and treatment of long-term conditions) and three also include broader care services (virtual wards, timely discharge and end of life care).

The inclusion criteria

The expert panel looked first at the seven new care models described in the Five Year Forward View and second at the criteria being used to evaluate each of them. A new care model is simply a way of delivering treatment and services; it is not necessarily limited to a setting.

The Five Year Forward View set out a number of defining principles for new care models. We evaluated a number of different homecare service models using these principles, and all the examples in this report meet the following criteria.

THE SERVICE MUST BE ABLE TO:

- > Integrate primary and secondary care (multidisciplinary team working, reducing gaps, seamless transfer, having the health economy built around the patient).
- > Centralise specialist care while delivering locally.
- > Support local health communities to choose from among a range of radical new care delivery options.
- > Deliver more care at home, closer to home or in the community, with investment being shifted accordingly.
- > Support people to live independent lives in the community, including the frail elderly.
- > Contribute to making efficiency savings of at least three per cent.

1 Service one: home cancer care

Home cancer care covers a plethora of treatment regimens and supportive therapies. It focuses on the individual's needs as well as those of the extended family.



SERVICE DEFINITION

Cancer treatment can often be an exhausting process. On top of having to travel regularly to and from hospitals, there is the impact of the therapies themselves, which often cause fatigue and other significant side effects. Common treatments that can be administered in the home include injectable or oral chemotherapy.

Cancer diagnosis is increasing year on year, with one in two people in the UK now expected to get cancer at some point in their lives.¹⁶ This has resulted in an increase in pressure on NHS resources. This is a direct consequence of an ageing population combined with earlier diagnosis and improved survival due to better surgical techniques, advances in radiotherapy and more effective chemical treatments.

Home cancer care normally begins in hospital and then subsequent treatment episodes are arranged to be given in the patient's own home or clinically suitable location. Importantly, homecare is only part of the patient's treatment pathway and it is vital that all stakeholders responsible for the care of the patient are working as part of an integrated plan.

To operate at scale effectively, home cancer care needs to be configured in partnership with a cancer centre or unit, ensuring it makes economic sense for the trust while also being in the best interests of patients. Selecting regimens that require a shorter duration, as well as patients who live in a defined geographic area, enables

services to operate effectively at scale. Selecting appropriate home cancer care frees up hospital capacity in terms of nursing hours, chair days and so on.

A study carried out at the Christie NHS Foundation Trust showed that when patients received nursing care at home alongside treatment at home there were significantly fewer side effects and unplanned admissions compared to Christie best care alone.¹⁷

"We offer a community-focused service that maximises patient convenience, experience and outcomes. Our specialist nurses work locally to integrate services to enable the people we care for to live a more normal life."

Kate de Lord
Head of cancer, Healthcare at Home

EXAMPLE ONE

HEALTHCARE AT HOME

Healthcare at Home started offering cancer care to private patients in their own homes in 1992 and since then the service has grown rapidly, now carrying out more than 4,000 visits each month.

Features of the service

- > Patients are identified in partnership with the referring hospital clinicians. Healthcare at Home's drugs and therapeutics committee assesses whether the treatment is safe to be administered in a home setting.
- > Services are provided in conjunction with normal NHS governance procedures.
- > Homecare can be selected for many reasons including length of treatment, distance of patient's home from hospital, hospital capacity pressures but primarily, patient benefit.
- > There is a 24-hour telephone advice for patients and their carers.
- > This service can be scalable in rural areas.

EXAMPLE TWO

NEWCASTLE HOSPITALS NHS FOUNDATION TRUST

A high proportion of all chemotherapy regimes offered by Newcastle Hospitals NHS Foundation Trust's cancer centre are capable of being delivered either at home or in the community.

The trust's results have shown improvement in continuity of care, and improvement in recruitment and retention rates due to staff rotating between hospital, community and people's homes. This creates a broader professional experience and variety.

Healthcare at Home
are now carrying
out more than

4,000

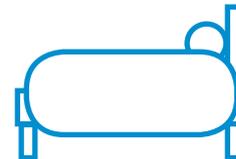
visits each month

SUGGESTED METRICS

- ▷ Patient activation measures¹⁸
- ▷ Measures of quality of life¹⁹
- ▷ The extent that the care at home led the patient to live as normal a routine as possible
- ▷ Measures of patient safety such as line infections, medication errors, extravasations and adverse events
- ▷ Waiting times: how quickly a patient's treatment starts from when it is recognised that treatment is needed
- ▷ Unplanned emergency admissions
- ▷ Chair days saved
- ▷ Measures of adherence, persistence and wastage
- ▷ Patient reported side effects
- ▷ Dose modifications
- ▷ Treatment interruptions
- ▷ Anxiety of the patient (compared to those being treated in hospital)
- ▷ Patient Reported Outcome Measures (PROMs)²⁰
- ▷ The NHS friends and family test²¹
- ▷ Measures of patient experience, such as whether the person was treated with dignity and respect

2 Service two: end of life care

This service gives people living with a life-limiting condition a choice about where they want to die and provides a person centred approach.



SERVICE DEFINITION

This has implications on where care is given and on how, where and when clinical interventions are staged. It provides care and support for the person to live and die in the place and manner of their choosing, and the emotional and practical support needed to deal with the practicalities of the imminent end of their life.

A close working relationship with primary care and other service providers is needed to identify people who may need to use this type of home care. It is also needed to help provide the care and assistance throughout the care plan.

Where possible, an early referral – often when people are still having active treatment – allows time to build strong relationships, proactively plan ahead and get practical and emotional support where needed. Clearly, because of the nature of the care, the focus is on palliative not curative.

Throughout the planning and delivery of this service, there have to be strong working relationships between the provider, the trust, the GP and any other care and support provider who comes to the home. These not only benefit the individual but the ongoing relationship and coordinated provision of care with the organisations*.

In The National Survey of Bereaved people (Voices, 2013), 79 per cent of people were reported to want to die at home but only 35 per cent of people actually did.²²

79%

of people were reported
to want to die at home
but only 35 per cent
of people actually did.

*Note: that evidence given to the inquiry suggests that these services can be more expensive but have a clear benefit to the patient and their families. This needs further validation.

EXAMPLE

MACMILLAN SPECIALIST CARE AT HOME MODEL

This model works in partnership to provide this palliative care service to people in the community. Specifically, it has been working with Midhurst Community Services since 2006. The service here is a consultant-led, multidisciplinary team that provides integrated, community-based care to people with cancer and other life-limiting conditions towards the end of life.

It provides round-the-clock, hands-on care and advice. This includes a range of palliative interventions including intravenous infusions, paracentesis and intrathecal analgesia.

The aims of the service are to ensure that personal choice is maximised and that there is close working across providers including NHS, local authority, voluntary, charitable and private sectors.

Service findings²³

- > 84 per cent of people died in their preferred place of death in 2012/13, significantly above the national average
- > The service has resulted in fewer A&E visits and nights in hospital by the people who use it
- > By using their different specialisms, team members ensure a person-centred approach and optimum use of time
- > Evaluators of the end of life service estimate efficiencies of 20 per cent

“In the last month of my mother’s life, the community nurses, Macmillan team and GP really worked together for her. It was fantastic having her at home and being part of our daily life as it had always been. I think our grieving process has been easier because she died at home, surrounded by her family. The level of palliative care she received was amazing and I couldn’t speak more highly of the team.”

Woman whose mother had cancer

The family were supported by the Midhurst Macmillan Specialist Palliative Care Service

SUGGESTED METRICS

- ▷ Percentage of people with an advance care plan in place that outlines their personal preferences
- ▷ Percentage of people who died in their preferred place of death
- ▷ Number of unplanned emergency admissions to hospital
- ▷ Adherence to the advance care plan and the extent to which the person’s wishes were respected
- ▷ Measures of quality of life
- ▷ The extent to which the person approaching the end of life, their families and carers are communicated with and offered information, in an accessible and sensitive way in response to their needs and preferences
- ▷ The extent to which the person approaching the end of life has their physical and specific psychological needs safely, effectively and appropriately met at any time of day or night, including access to medicines and equipment
- ▷ Measures of patient experience, such as whether the family/carers felt the person and themselves were treated with dignity and respect

3 Service three: home treatment of long-term conditions

Although there are many examples of long-term conditions that can be treated at home, the expert panel has focused on the use of biologics.



SERVICE DEFINITION

Biologic drugs have emerged as an important advance in the treatment of Inflammatory diseases including rheumatoid arthritis, juvenile idiopathic arthritis, ankylosing spondylitis, psoriatic arthritis, psoriasis, Crohn's disease and ulcerative colitis. These chronic conditions – which can cause pain, debilitation, loss of independence and premature mortality – clearly have a detrimental impact on a person's quality of life and place a significant financial burden on society. For example, a third of people with rheumatoid arthritis stop working within two years of diagnosis.²⁴

Biologics are well suited to the homecare model because required frequency of administration makes this more convenient for patients. Homecare ensures that the medicines are kept at the required temperature throughout the whole process.

By prescribing and delivering to the home, the patient doesn't need to go to the hospital, even as an outpatient. This saves them time and may also save the hospital money.

Homecare can potentially improve patient outcomes when using biologic drugs. It presents the opportunity for a variety of touch points with the patient, from the delivery driver to the nurse.

Homecare can also monitor patients at risk of harm from biologic treatment, such as opportunistic infection, facilitating rapid access to assessment and treatment, thus preventing treatment breaks from hindering management of the disease and long-term outcome of the condition.

In time, treatment at home can lead to wider benefits being created as patients learn to administer their own medication and take control of their condition more fully.

This service line is covered by the Royal Pharmaceutical Society²⁵ professional standards for homecare services in England, which aim to ensure that patients experience a consistent quality of homecare services.

The National Clinical Homecare Association reports that mean persistence* on homecare is 500 days compared to mean persistence in community of 315 days. An enhanced homecare service, featuring bespoke nursing support, had a mean persistence of 708 days compared with 437 days in the aggregated standard service cohort.²⁶

Market research by Abbvie²⁷ has found that when patients were asked if they would prefer to collect their medicines or have a homecare service, they said they would prefer homecare but wanted a service that operates around them. Homecare reduced their nervousness, especially as the drugs need to be kept at a specific temperature.

* This means how long people continue to stay on the treatment course prescribed and how well they adhere to the required dosage and frequency

EXAMPLE

HEALTHCARE AT HOME

Healthcare at Home delivers biologic medication to 80,000 patients every year. Patients remain under the care of the consultant at the referring centre (hospital trust). The enhanced service, commissioned by the manufacturer of the biologic and provided by the homecare medicines service provider, allows patients to have a one-hour consultation with a specialist nurse during which patients are informed about their medication and condition.

Specialist nurses are able to identify barriers to treatment which may result in intentional or unintentional non-adherence to treatment. Patients are able to access continuing support, through the specialist nurse, who has regular communication with the referring centre. Patients also have telephone access to a dedicated specialist biologics pharmacist and the 24-hour care bureau.

Subsequent delivery of medication is carried out by dedicated drivers who are also able to unpack the deliveries, and remove the delivery packaging and waste materials from patients homes.

“The key benefits of home care may be summarised as a home-based patient-orientated service that is proven to improve persistency with the medicine. It may further contribute toward beneficial patient experience which has the option to be further evaluated using the Patient Activation Measure – a measurement which assesses an individual’s knowledge, skill, and confidence in managing one’s own health and healthcare.”

Dr Olivia Kessel
AbbVie Care, Division Director

SUGGESTED METRICS

- ▷ The extent to which the care at home leads the patient to live as normal a routine as possible
- ▷ Measures of quality of life
- ▷ Measures of adherence, persistence and wastage
- ▷ Infections and complications and their cost
- ▷ Unplanned admissions for complications
- ▷ Patient activation measures
- ▷ The NHS friends and family test
- ▷ Measures of patient experience, such as whether the person was treated with dignity and respect

4 Service four: timely discharge from hospital

When a patient is ready to leave hospital but social care services are not able to mobilise quickly enough, a rapid response service enables safe discharge.



SERVICE DEFINITION

It is usually beneficial to the patient to be at home as quickly as possible within a familiar environment, but the lack of joined-up services to make ready discharge – from medicines availability to any adaptations needed in the home – means patients stay in hospital unnecessarily. This service takes place when patients are medically fit for discharge from hospital but there is not an appropriate environment to discharge them to.

It bridges the gap between health and social care provision so that acute and community hospitals can maintain sufficient capacity and flow. This is in contrast to the virtual ward example on pages 18–19 where patients are not yet medically fit but can go home early with close management from the hospital trust.

A rapid response home care service enables discharge safely to the home as soon as patients are medically fit for discharge. The aim is to facilitate prompt discharge, on the day the patient is declared medically fit, freeing up capacity and supporting patient flow within the acute or community hospitals and enabling people to return home as soon as possible.

The service is supported with nurses experienced in renal, rehabilitation, neurology, motor neurone disease and multiple sclerosis, spinal and brain injury, and paediatric complex care.

A SPOTLIGHT ON:

Can clinical home care help with workforce pressures?

A combination of funding constraints and an ageing nursing workforce means that healthcare organisations are likely to encounter long-term problems in the recruitment and retention of nursing staff²⁸.

The number of trained nurses on the Nursing and Midwifery Council's UK register for all practicing nurses began to decline in 2008, and has continued to fall; The reasons for the decrease include migration patterns, age of the workforce and a reduction in the number of training places available²⁹.

Central to delivering outcome-based, value-driven clinical care at home is ensuring that the right people, with the right skills, are in the right place, at the right time every time. Multidisciplinary teams play a pivotal role in the delivery of safe and effective home care services, and often staff can be better or more efficiently used, and in some cases overall staffing numbers can be reduced.

Proposals to reduce the shortfall in the nursing workforce include commissioning an adequate supply of training posts, reducing attrition rates in nurse training and increasing retention of trained staff. These are of course long-term goals but in the meantime, implementing the service lines in this report can result in staff being used more efficiently.

Jill Ireland, lead nurse, Healthcare At Home

EXAMPLE

AMG NURSING AND CARE SERVICES

AMG Nursing and Care Services³⁰ is working with University Hospital North Midlands on a pilot, which started in January 2015. This has been adapted to local needs and has the capacity to support the immediate discharge of up to 40 people a week while they await long-term care provision. During the pilot period January to October the service has enabled over 800 patients to be discharged without delay.

Its staff visit the person's home within 30 minutes of arrival and settle them back in, so if there are problems in discharge they can be addressed and the nurse responds immediately.

In January, two clients were taken on who had learning disabilities and mental health issues. The service was brought in after they had waited six weeks in hospital because no care provider could be found. While they needed an element of personal assistance, the clients' main concerns were about catheter care. The focus of the care plan design was to educate both clients in self-care. As a consequence, one no longer needs the support of any agency and the other has reduced from four calls a day to one call a day.

Features of the service

- > Facilitates immediate discharge (at the point that the patient is assessed as medically fit), preventing delays
- > Enables patients to flow through the system and releases capacity in the acute sector
- > It's an integral element of the care pathway supporting seamless transition between health and social care
- > It reduces the potential for hospital acquired illnesses and infections and improves patient satisfaction of their acute and community hospital experience.
- > Allows agencies to respond to the long-term care needs in a way that ensures that service integrity, safety and quality are protected and maintained

“AMG as a provider within Staffordshire has played a pivotal role in ensuring a rapid responsive service to meet patients and families/carers out of hospital needs. The importance of ensuring once patients are declared medically stable to be discharged from the acute setting back to their normal place of residence is a priority to ensure high-quality care. Optimising patient care in this way has enabled these objectives to be met.”

Helen Lingham

Chief operating officer of University Hospitals of North Midlands

SUGGESTED METRICS

- ▷ Readmission rates: 28 days and three months
- ▷ Bed nights saved
- ▷ Length of stay
- ▷ Cancelled operations
- ▷ Time from when the patient was declared fit for discharge to when they were discharged, and any associated savings
- ▷ Adverse events e.g. secondary infections
- ▷ The NHS friends and family test
- ▷ Measures of patient experience, such as was the person treated with dignity and respect, coordination with social care, information about post-hospital support services

5 Service five: virtual wards

Virtual wards allow patients to receive hospital-level care in their own homes. They can be part of the solution to challenges around capacity, readmissions, cancelled operations and missed targets.



SERVICE DEFINITION

This service creates capacity in the system without increasing inpatient beds, by treating people in their own home or usual place of residence. This typically involves helping people to leave hospital earlier or to avoid hospital admission in the first place.

Virtual wards support integrated care models by allowing hospital consultants and GPs to retain clinical responsibility for the patient – undertaking their care planning and monitoring – while nurse-led multidisciplinary teams provide care in the person's usual place of residence.

There are two main streams of services provided under the virtual ward umbrella:

1. Recovery at Home: Step down

This service provides acute care to patients in their own home, enabling them to leave hospital earlier while remaining under the care of their hospital consultant.

Each specialty has a service designed with the hospital clinical teams to ensure that co-ordination happens throughout the process. This frees beds and releases capacity earlier than would ordinarily have been expected, while focusing on delivering excellent patient outcomes and experience.

Patients remain under the care of the hospital consultant, who defines an acute care plan prior to the transfer to home, and is responsible for

monitoring patient progress and adapting the treatment plan as necessary. Monitoring can be done through the review of clinical notes, which are uploaded into hospital EPRs, or in a number of other ways including a virtual ward round, phone calls with the patient and staff, and face-to-face patient reviews in clinics.

2. Admission Avoidance: Step Up

Under this model, patients remain under the care of their registered GP or the GP consortia that has been established to manage a virtual ward. Wherever possible, an assessment is carried out within two hours of referral, and interventions are implemented rapidly to ensure hospital attendance and admission can be avoided.

Referral into the service can come from GPs or out-of-hours GP services as well as ambulance teams, matrons and A&E consultants if a patient can be assessed, referred and discharged within the four-hour target.

Patients typically supported by admission avoidance schemes are those with exacerbations of long-term conditions, people presenting with ambulatory emergency care conditions or people in care homes who may be dehydrated or have low-level infections.

EXAMPLE

**UNIVERSITY HOSPITALS
SOUTHAMPTON NHS
FOUNDATION TRUST**

Over the past five years, the trust, supported by Healthcare at Home, has fully developed a virtual ward. It started with patients who needed physiotherapy and nursing care after surgery and more recently supports patients in medicine and elderly care.

On any given day, the trust has 45 patients supported at home who otherwise would have been in hospital. The trust sees this as part of an approach to be a 'hospital without walls'. This is one of many projects along this theme including teams of care of the elderly, doctors who work in localities, supporting patients when they live at home and when they are admitted to hospital, and specific medical support for patients in nursing homes through developing a supportive approach to anticipatory care planning.

This scheme is starting to yield impact: year-on-year hospital admissions are falling and the trust has used the capacity released to invest in specialist services and support its move to become a regional trauma centre.

“Clinical homecare provides more flexibility to patients as well as their families and carers along with the added comfort of recovering in their own home. I have been a longstanding advocate for this care model and by partnering with Healthcare at Home, we were able to make this care option a reality for patients at King’s College Hospital with the Children’s Outreach Team service, a tailored virtual ward for paediatrics. In addition to the value the service brings to our young patients, hospital beds are made available for children with more acute clinical needs, allowing us to use our inpatient beds more efficiently.”

Dr Omowunmi Akindolie

Consultant in ambulatory paediatrics at King’s College Hospital, worked with Healthcare at Home to pioneer the launch of the first dedicated children’s service

SUGGESTED METRICS

- ▷ Bed nights saved
- ▷ Length of stay
- ▷ Readmission rate
- ▷ Cancelled operations
- ▷ The extent to which time on the virtual ward has a positive impact on the person’s recovery
- ▷ Patient Reported Outcome Measures
- ▷ The NHS friends and family test
- ▷ Patient experience, such as whether the patient was treated with dignity and respect

Creating wider value

Financial savings are only a minor part of the contribution clinical care at home can make to NHS modernisation. Bigger system benefits are where the real value is to be found.

Researchers have been reluctant to put a financial figure on the impact of integrating care in terms of cash realised or costs saved. Indeed, a number of studies have concluded that integrated care will not save money, a recent example being the HSJ Commission³¹ on hospital care for frail elderly people. Monitor was similarly circumspect in its Moving Healthcare Closer to Home review.³² The principal arguments in favour are based on applying best practice and improving services and outcomes for people. Monitor notes that:

“In the long run, well-designed schemes that are suited to their local health economy and run efficiently could offer equal or better care than the local acute hospital at lower cost per patient. In addition, some schemes offer a local health economy more flexible capacity because fixed costs make up a smaller proportion of overall costs than care provided in acute hospitals, so these schemes can be brought in and used more easily.”

The Five Year Forward View included a requirement of three per cent efficiency savings for integrated care models. From looking at Healthcare at Home’s financial data and comparing the cost of these services against standard NHS tariffs for their dominant clinical service lines (home cancer care, home treatment using biologics and virtual wards), analysis shows that these models can be delivered comfortably to meet this three per cent savings requirement. The expert panel is exploring how it can do a more detailed validation of the financial impact in its further work.

For it to be more than a theory, NHS trusts must be able to actually yield these savings. Where a clinical home care service is being established, clinicians and managers should be able to either reduce capacity (assuming the home care service is cheaper); or look after more people by expanding capacity and potentially improving productivity.

Beyond short-term efficiency gains

Financial savings are only a minor part of the contribution clinical care at home can make to NHS modernisation.

Bigger system benefits are where the real value is to be found. This includes helping patients to manage their condition and be treated in more favourable environments (i.e. their place of residence), and enabling a healthcare system to function better so more patients get better quicker in a place where they feel more comfortable than in a hospital bed.

This report has demonstrated that trusts using clinical care at home effectively are able to make improvements such as lowering readmissions, reallocating beds and wards for more appropriate patients and, in some examples, permanently reducing the number of beds.

Throughout the deliberations, the expert panel began to identify the wider value that clinical care at home can bring to patients and their families and the system as a whole. These need further validation but initial discussions point to them falling into four broad categories:

1

CARE IN THE HOME CAN LEAD TO BETTER ADHERENCE AND A REDUCTION IN NON-CLINICAL MEDICATION DROP-OFF

It can mean that patients suffer fewer relapses, fewer re-admissions and faster recovery through closer patient care and timely clinical interventions if they show signs of non-compliance with medication. The benefits are potentially broad, ranging from patients who can return to work more quickly, hospitals having fewer re-admissions (driving better use of capacity) and reduced waiting times. It can in turn result in better overall disease management and patient outcomes.

2

CARE IN THE HOME CAN REDUCE PRESSURE ON ACUTE HOSPITALS

There are an increasing number of examples of how clinical home care can reduce pressure on hospitals by reducing unplanned admissions, bringing down waiting times and reducing cancelled operations, expediting integration with social care, preventing re-admissions and allowing capacity and ward space to be freed or more appropriately allocated. This in turn can improve patient experiences by offering them choice and treatment and support in a more familiar environment. Care at home reduces the risk of certain adverse events such as hospital acquired infections.

3

CARE IN THE HOME CAN LEAD TO REABLEMENT AND QUALITY OF LIFE

Reablement means helping people regain the ability to look after themselves following illness or injury. The Social Care Institute for Excellence reports that research evidence shows that reablement improves wellbeing and independence, prolongs people's ability to live at home and removes or reduces the need for commissioned care hours (in comparison with standard home care).³³

Also, clinical home care can mitigate clinical and psychological risks and has been shown to improve patient experience. It has much more chance to fit around the person, allowing them to recover quicker or have a better chance of living well with their condition. It gives them the best chance to return to a routine that is best for them and their wellbeing.

This often includes returning to work for those who wish to do so. Working-age ill health costs the national economy £100 billion a year.³⁴

4

CARE IN THE HOME CAN ACTIVATE PATIENTS

Patient activation is related to engagement in preventive behaviours, treatment and healthy behaviours. A 2014 study by The King's Fund³⁵ reported that patients with high levels of activation understand their role in the care process and feel capable of fulfilling that role. Individuals with long-term conditions who are more highly activated are more likely to engage in positive health behaviours and to manage their health conditions more effectively.

Clinical care at home may give people the best setting to self-manage their conditions. This includes self-administration of medicines and control of treatment choices, times and places. Patient activation will be a key driver to allow health and care systems to meet needs, as patients with low levels of activation are more likely to attend A&E departments, be hospitalised or re-admitted to hospital after being discharged.³⁶

UNITS OF VALUE HIGHLIGHTED IN THE REPORT:

- > Newcastle Hospitals NHS Foundation Trust has a cancer centre where it is now able to deliver a high proportion of all its chemotherapy regimes either at home or in the community – reducing bed days by taking patients out of the hospital.
- > University Hospital Southampton NHSFT's year-on-year hospital admissions are falling and it has used the capacity released by its virtual wards to invest in specialist services and support its move to become a regional trauma centre.
- > 84 per cent of people on the Midhurst Macmillan Specialist Palliative Care Service died in their preferred place of death in 2012/13, which is significantly above the national average.
- > The Midhurst service has also resulted in fewer A&E visits and nights in hospital for the people who use it.
- > Persistence for patients receiving their biologics at home is 500 days compared with mean persistence in community of 315 days.

Continuing to build the case for clinical care at home

The publication of this report marks the end of the first phase of the work of the expert panel. It presents five examples of clinical homecare, which, if implemented at scale, could yield a number of patient benefits and financial savings. The research team consulted widely to achieve this, speaking to more than 30 local and national organisations, all of whom have given useful information to make the business case for these services.

The work, however, needs further validation through gathering, in a comprehensive and consistent manner, outcome data to prove the value of medication and clinical interventions, and that money spent by the NHS is money well spent, allowing greater focus in those areas of highest value or indeed disinvestment in others.

The case for clinical care at home is not only emerging but is becoming compelling. There is more and more evidence of its contribution to quality of life, patient benefits, cost reduction and wider system value.

Leaders of health systems, including vanguards, should appraise this, adapt it to local needs and consider implementing one or more of the service lines in this report.

The expert panel has made a commitment to continue its work by focusing on further defining, measuring and evidencing these units of value and the role clinical care at home can play as an enabler. This can only be a positive thing for the NHS. A validated 'value proposition' that is recognised by the NHS will drive the clinical homecare industry to strive beyond simple cost efficiencies, which are 'table stakes' for any specialised service industry provider.

This will challenge the service industry to articulate long-term patient value that by nature will drive productivity and efficiency within the NHS. The panel would be delighted to widen this scope, and organisations or individuals who would like to contribute should get in touch at james.featherstone@hah.co.uk

The end focus is of course on delivering superior outcomes for the person as a clinical patient and delivering choice and a superior treatment experience for the person as a consumer. Then, as defined in this report, clinical homecare can truly become a value adding solution and an integral part of the NHS healthcare delivery model.

A SPOTLIGHT ON:**Homecare Medicines Service**

The homecare medicines service is a model of care that was adopted by the NHS more than 20 years ago. Currently there are more than 230,000 patients in the UK who receive their medication and, where appropriate, associated care via this model.

Homecare medicines services should be distinguished from the other models of care within this document. Homecare medicine services are those services where the medication is dispensed by the homecare service provider and delivered to a patient's home or other appropriate nominated address. Examples one and three in this report would be classified as homecare medicines services.

The Royal Pharmaceutical Society defines the homecare medicines service as a service that delivers ongoing medicine supplies and, where necessary, associated care, initiated by the hospital prescriber, direct to the patient's home with their consent. The purpose of the homecare medicines service is to improve patient care and choice of their clinical treatment.

In 2010, a comprehensive review of service was commissioned by the chief pharmacist for England and in 2011 the results of that review were published in a report called Homecare Medicines – Towards a Vision for the Future (the Hackett report). This publication clearly states that the chief pharmacist is the responsible officer for homecare in each NHS hospital trust.

A SPOTLIGHT ON:**The National Medicines Homecare Committee (NHMC)**

The NHMC is a national committee made up of NHS, industry and Department of Health (DH) representatives. The key aim of the NHMC is to act as the national focus for developing and improving processes for homecare medicines services. It advises the NHS on all matters relating to homecare services and collaboratively works with the NCHA and Association of the British Pharmaceutical Industry (ABPI) to support best practice.

Homecare medicines services are commissioned by both manufacturers of pharmaceuticals and the NHS. Services commissioned by the NHS are governed by EU procurement law and, as such, services are tendered for and contracts are awarded accordingly.

The Department of Health Commercial Medicines Unit (DH CMU) has worked collaboratively with the NHS to produce a National Template Specification for Homecare Medicines Services. This template is used nationwide and sets the standard for services to NHS patients.

The DH CMU and NHMC also produced a national standard Key Performance Indicator dataset, which all homecare medicines service providers are expected to adopt and which is used by the NHS for contract monitoring purposes.

Further work on the governance of homecare and standardisation of documentation continues to be carried out by the DH CMU in collaboration with the NHMC.

The case for clinical care at home is not only emerging but is becoming compelling.

Acknowledgements

At the NHS Confederation annual conference in June 2015, Healthcare at Home Ltd announced it was supporting a market-wide inquiry to investigate the extent to which clinical homecare can contribute to achieving the challenges set out in NHS England's Five Year Forward View.

Christine Outram, chair of the Christie NHS Foundation Trust, convened an expert panel made up of leaders from across the market, including pharmacists, service providers, national and trade bodies and NHS representatives. The expert panel met twice to consider the evidence and content for this report.

The panel also hosted a market engagement event at the Royal College of GPs.

Organisations that contributed to the report

AbbVie Ltd
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Footnotes

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Contribute

To contribute to the work of the expert panel, help shape the next piece of work around units of value or seek advice on the role clinical care at home can play, contact James Featherstone at Healthcare at Home at: **james.featherstone@hah.co.uk**

About Healthcare at Home Ltd

Healthcare at Home is the UK's largest home healthcare provider, caring for more than 150,000 NHS and private patients each year throughout the UK.

Our vision is to enhance the way in which clinical and pharmaceutical services are provided for patients, their families and carers. Healthcare at Home strives to improve clinical outcomes for patients by allowing them to receive treatment in the comfort of their own home.

Healthcare at Home has a team of highly skilled clinicians to provide a number of treatments and services to patients that include end of life care, chemotherapy at home, Recovery at Home as well as medication management and optimisation for a range of conditions.

For more information about our services please visit our website: www.hah.co.uk

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