Hospital care at home

Supporting independent and healthy lives

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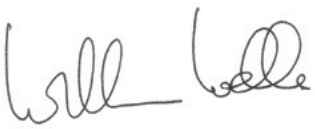
Healthcare at Home

dr foster® intelligence

Foreword



SIR WILLIAM WELLS

Over the years a great deal has been talked about providing hospital care at home, but comparatively little produced of practical value to commissioners and providers on its clinical effectiveness and comparative cost. When I was asked by Healthcare at Home Ltd to introduce this report, I accepted enthusiastically because:

- There is a political consensus that patients should be given greater choice and the emphasis of care shifted from hospital into the community and home
- Advances in medical science have significantly increased the scope of safe care outside the hospital
- Demographic pressures and the inflation of healthcare costs demand new solutions to the provision of care
- Evidence indicates that patients prefer to be treated in their own homes, provided it is safe and clinically effective
- One in five primary care trusts have reported having overspent their 2009/10 budget[1]
- The Audit Commission recently revealed that PCTs have spent all of their 6.5 per cent budget increase on hospital care and that outpatient numbers have grown by 7.8 per cent in 2008/09[2]
- Limited work has been published on the financial implications of moving healthcare into the home environment

As far as I am aware this is the first attempt, using models of home-based healthcare already being successfully implemented, to analyse the potential savings available across the NHS compared with the costs currently being incurred by providing similar care in hospitals.

From the four services analysed, the report's initial findings show that providing care in an environment preferred by patients could lead to savings of well in excess of £1 billion, at a conservative estimate.

This report is a start. It focuses on four key opportunities to realise both cost savings and benefits to patients, but there are other services and patient groups to be considered. I believe this report lays down two challenges to the NHS as it faces a squeeze on the public purse, pressure to demonstrate value for money and give patients a genuine choice of care. First, this report demonstrates that savings from unnecessary hospital activity are achievable – it is up to NHS managers to capture them. Second, experience to date has shown that small, incremental steps simply allow inefficiencies to return. If the NHS is to shift care to where people want it, it will have to do it boldly and now.

FOOTNOTES

[1] *Health Service Journal*, 19 November 2009, www.hsj.co.uk/news/finance

[2] *More for Less*, Audit Commission, 2009

Executive summary

- Successive policy initiatives have focused on the opportunities to realise a healthcare system that embraces the delivery of care and treatment outside hospital.

- Hospital admissions continue to rise, with over eight million people having been treated in hospitals in 2008/09.

- The evidence base regarding clinical effectiveness and patients' preference for home-based healthcare is developing, but recent analysis from the Audit Commission suggests there is little indication yet of a strategic shift at the front line.

- The crisis confronting the economy and the state of public finances is creating added pressure on the NHS to take bolder 'game-changing' action to deliver on this challenge.

- The analysis presented in this report aims to show commissioners and providers the opportunities offered by home-based healthcare, not only to realise cost savings but to improve patient outcomes and experiences.

The analysis

- Four services were selected where home-based healthcare models already exist as an alternative to hospital care, namely:
  - Care for people with selected long-term and ambulatory care sensitive (ACS) conditions
  - Enhanced supported discharge
  - Specialised cancer services (chemotherapy)
  - End-of-life healthcare

- For each service the current costs of inpatient and outpatient episodes of hospital care were calculated, using 2008/09 data from the Secondary Uses Service (SUS) together with tariff information.

- The costs of providing home-based healthcare to these populations were estimated, based on existing service models and assumptions from NHS Birmingham East and North (NHS BEN).

- Potential savings were identified in NHS BEN by comparing these figures and the savings were then extrapolated to the national level (for England only).

POTENTIAL SAVINGS
At a national level, home-based healthcare for the four services in question could represent savings of:

£180m-£210m
for long-term and other selected ACS conditions

£217m-£837m
for enhanced supported discharge

£46m-£73m
for specialised services (chemotherapy)

£160m
for end-of-life healthcare (estimate)

£540m-£1.2bn
for the four services combined

Introduction

NHS hospitals care for eight million patients a year of whom

12.5%

are admitted with ACS conditions

This report forms part of the search to find radical alternatives to the current organisation of health services in England. The existing system is struggling to provide enough people with an alternative to the assumption that if they are unwell they go to hospital for treatment.

The burden that this places on trusts has not helped hospitals to develop as research-driven institutions that provide the world's best treatments, surgery and diagnostics. Instead, trusts find themselves caring for eight million patients a year, 12.5 per cent of whom are admitted with ambulatory care sensitive (ACS) conditions at an annual cost of £1.86 billion[3].

This report aims to contribute to the debate on NHS reform in two fundamental ways. The first is by investigating in practical detail the mechanism by which a commissioner or provider would be able to extract or achieve some of the top-line savings described by McKinsey, Tribal and KPMG in their recent reviews of NHS cash savings or expenditure.

The second significant feature of this report is that it is based on a genuine alternative to the status quo, taken from an existing programme designed and implemented in the NHS. The baseline figures and analyses are from NHS Birmingham East and North (NHS BEN) where the primary care trust (PCT) is pioneering a major restructure of its services. The practicality of the analysis and recommendations in this report is being implemented in a real environment, with the confidence that similar projects in the UK have had very positive outcomes[4].

This report presents a fresh piece of analysis, looking at the financial benefits of moving care away from hospitals and into a home environment, providing commissioners with the economic evidence to support existing examples of improved patient experience, quality of care and patient choice.

Healthcare at Home Ltd commissioned Dr Foster Intelligence to provide analytical support to identify the potential savings and benefits to be derived from delivering a range of specific care and treatment services at home rather than in hospital. Using a private care provider model, the report presents findings in four areas:

- Care for people with long-term and ACS conditions
- Enhanced supported discharge
- Specialised cancer services (chemotherapy)
- End-of-life healthcare

Analysis is built on existing Healthcare at Home Ltd business models, and the services and assumptions are based on a programme running in NHS BEN. The methodology and analysis have been independently verified by Professor Alistair McGuire, head of health policy at the London School of Economics.

Dr Foster Intelligence has significant experience of analysing and exploring NHS efficiency, through examining routine hospital administrative data that records the treatments and tariffs of the eight million patients admitted to hospital each year. Dr Foster first addressed the topic of reducing unnecessary hospitalisations with its 2006 report *Keeping people out of hospital - the challenge of reducing emergency admissions*[5].

Healthcare at Home Ltd is the UK's leading provider of hi-tech home-based healthcare and also delivers on-site services throughout the NHS and independent sector. Established in 1992, it now employs close to 1,000 staff, approximately half of whom are clinicians. Operating from numerous locations in the UK, Healthcare at Home Ltd provides a broad range of nationwide services delivered locally to over 100,000 patients each year. While the NHS is its biggest customer, services are also funded by private medical insurers, pharmaceutical companies, charities and self-funding patients. At all times, patients remain under the overall care of their referring clinician, with whom Healthcare at Home Ltd maintains close contact.

FOOTNOTES

[3] Total tariff cost, ACS conditions, 2008/9. Analysis from Dr Foster Intelligence

[4] *Home Healthcare – an economic choice for the health service*, Northern Ireland Health Economic Group (NIHEG), 2008 and *Home healthcare: Emerging evidence for NHS commissioners*, O'Neill C and Wallis C, Journal of Care Services Management, Vol. 3 No. 4 pp 357-363, 2009

[5] *Keeping people out of hospital - the challenge of reducing emergency admissions*, Dr Foster Intelligence, 2006 www.drfoster.co.uk

1. Changing the game

15.4m
people in England alone have at least one long-term condition and this is likely to increase to 18 million by 2025[6]

The number of patients treated in NHS hospitals has risen by over

12%
in the past five years, increasing from approximately 7 million to 8 million

Evolving trends

In the past, healthcare was largely a story about hospitals. The Victorians built them because they had few effective medicines and needed to bring people into institutions to stop the spread of infectious disease. With the advances in medicine that followed, people were brought to hospital for invasive procedures and lengthy periods of recuperation. By the middle of the last century, it was to access new specialties and emerging technologies.

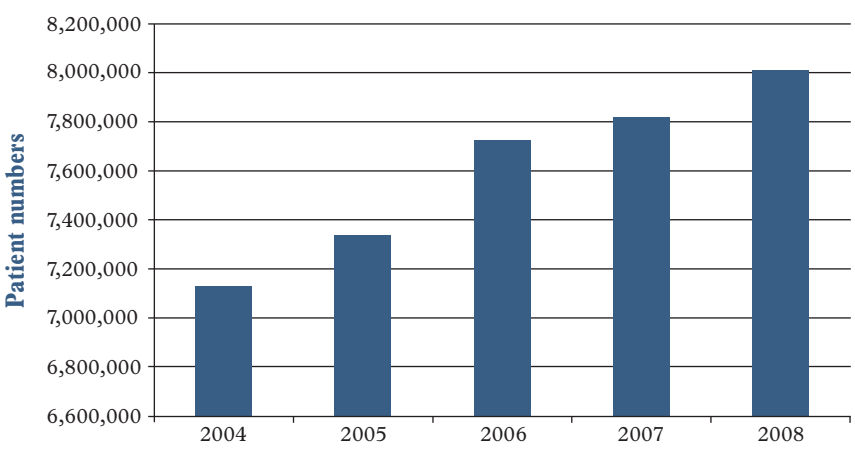
Recent developments in healthcare have enabled people to receive more of their treatment and care outside of the hospital. The internet has also played its part in creating better informed patients who want to be more involved in their own treatment and social trends mean people have higher expectations of a personalised service. The spiralling cost of healthcare and the prospect of an ageing population make finding more cost-effective ways of caring for patients imperative. By 2033, 23 per cent of the population will be pensioners, compared with 16 per cent in 2008[7], and 4.5 million people will be over the age of 85 within 15 years[8], making it the fastest-growing age group.

Addressing the future

Across the NHS, any number of initiatives and pilots are underway, designed to redraw patient pathways, improve care and deliver efficiencies. It is clear, however, that many such initiatives have not reached the mainstream. The crisis facing the economy and the state of public finances is now creating added pressure on the NHS to take bolder 'game-changing' action.

NHS patients treated in hospital 2004-2008

Source: Dr Foster Intelligence, Secondary Uses Service (SUS), FY 08/09



Turning theory into reality

Successive policy initiatives have focused on the potential to achieve this kind of development in specific areas of care. Shifting Care Closer to Home (2007) established opportunities in six specialties, while The End of Life Care Strategy (2008) sought to provide greater choice for the terminally ill. The additional cost of providing improved care in the community and in care homes would be offset by reductions in hospital admissions and length of stay.

A range of integrated care pilots was embarked on in 2009, designed to improve the coordination of care, reduce unnecessary hospital admissions and enhance the patient experience, particularly for older people and those with long-term ACS conditions.

And yet GP services have become harder to access in the past five years, while access to accident and emergency has become easier. Targets such as 18 Weeks serve to increase the perception and reality of hospitals being a convenient place to receive treatment, particularly for those suffering from long-term conditions. Dr Foster Intelligence's latest analysis shows a steady increase in A&E admission costs for ACS conditions, rising from 451,000 patients at a cost of £898 million in 2007/8 to 491,000 patients at a cost of £1 billion in 2008/09.

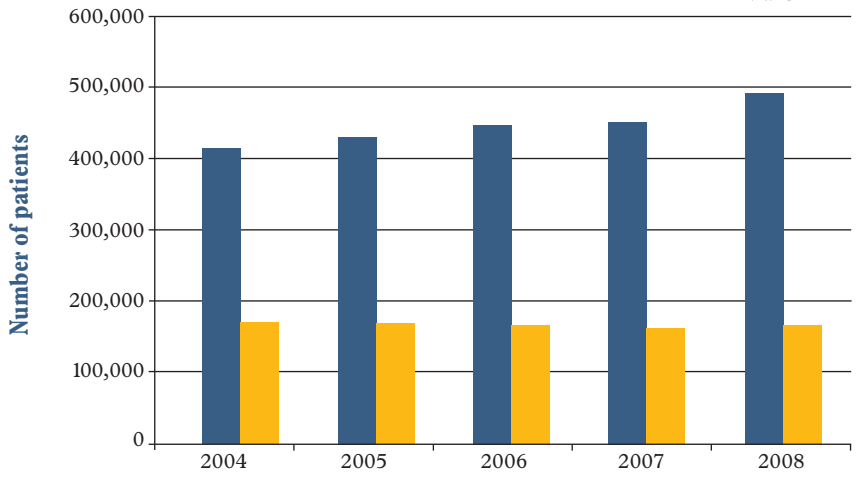
There are also notable obstacles in the current infrastructure of community services, raising questions as to whether the system has appropriate resources to handle a substantial change in patient-referral patterns. In 2008 there were 795,000 emergency readmissions at a cost of £1.5 billion to the NHS.

In 2008, there were 795,000 emergency readmissions[9] costing the NHS

£1.5bn

Number of patients with emergency admissions for ACS conditions 2004-2008

Source: Dr Foster Intelligence, Secondary Uses Service (SUS), FY 08/09



"The urgency of the challenge we face means we will need to go further, faster in many ways."

SIR DAVID NICHOLSON, NHS Chief Executive, August 2009

Not only is there significant disparity in the resources available for community-based versus hospital-based healthcare, hospitals have had much longer to create the management capacity and systems necessary to organise their services. Hospital occupancy figures indicate that beds are too often blocked by patients who should be treated in the community. Dementia patients are a key group, occupying 25 per cent of all hospital beds[10]. McKinsey recently found that four hospital patients in ten are there unnecessarily, of which, 25 per cent are waiting for community care services; 21 per cent could be discharged, provided skilled care is available, and 25 per cent are there due to delays in getting tests and therapies[11].

It is perhaps unsurprising, therefore, that the Audit Commission recently noted that in 2008/09 the number of inpatient and day cases grew by over four per cent (an increase on 2007/08) and outpatients by nearly eight per cent. Tellingly, it also found that this growth was being driven by increases in less costly treatments, rather than by an increased number of complex cases.

"The national figures for 2008/09 suggest that there was no shift from hospitals to care closer to home in the community; either in terms of investment or activity"
Are productivity and efficiency improving in the NHS?,
Audit Commission, November 2009

The big freeze

Few expect anything other than a squeeze on healthcare spending beyond 2011, regardless of any change in government. The introduction of the Quality, Innovation, Productivity, Prevention (QIPP) programme came hard on the heels of warnings from the chief executive of the NHS regarding the need for savings of the order of £15 billion to £20 billion in the period 2011 to 2014, to be achieved while maintaining quality as the organising principle of the NHS.

In this context, a number of sharper messages to commissioners are emerging in the second year of World Class Commissioning guidance, QIPP and the Transforming Community Services programme. These urge a focus on the 'big gains', especially the hospital/community interface, and encourage moves towards shifting care to the most clinically and economically effective settings, while decommissioning inappropriate or surplus capacity.

FOOTNOTES
[6] Department of Health, 2008
[7] Office of National Statistics, 2009
[8] International Longevity Centre, 2008
[9] Tariff cost of 28-day emergency readmissions, SUS 08/09, analysed by Dr Foster Intelligence
[10] *Counting the cost*, The Alzheimer's Society, November 2009
[11] InterQual (McKesson) data, cited in McKinsey report on NHS cost savings, September 2009; source *Health Service Journal*

2. Supporting patients at home

As the debate dwells ever longer on public spending and cuts in services, there is growing anxiety among patient groups and the public. Ward and bed closures are often perceived negatively; they are seen as a result of poor financial management rather than improved clinical effectiveness.

Yet there is a growing body of evidence linking clinical effectiveness to value for money. The provision of home-based healthcare is one such area of development, improving the convenience and acceptability of treatment for particular patient groups, while freeing up bed days and diverting resources to develop better services.

Mark Hackett is chief executive at Southampton University Hospitals NHS Trust, where a home-based service is being developed that allows patients to be discharged back to their homes more quickly and with greater support. He explains, "Our trust needs to constantly improve the service we offer to the customer, reduce its cost base and offer leading-edge treatments as a university teaching hospital.

"Home-based care offers the very essence of what we are trying to achieve. By working with trusted professional partners who see their services as integral to our total clinical delivery, we are able to offer services and products which are new and innovative to our primary care trusts and our customers, at a reduced cost.

"We are now able to reduce length of stay, reduce follow-up services and deliver a service in patients' homes. We are working with Healthcare at Home to deliver domiciliary chemotherapy, rapid orthopaedic rehabilitation for elective and emergency work and early discharge schemes for acute medicine and elderly care. We anticipate this will save many hundreds of thousands of pounds by releasing our facilities and services, enabling us to free up our current expensive resources which we can use to attract regional and complex referred work which our PCTs wish us to do more of."

"Home-based care offers the very essence of what we are trying to achieve. We are able to offer services and products which are new and innovative to our primary care trusts and our customers, at a reduced cost."

MARK HACKETT,
Chief Executive, Southampton University Hospitals NHS Trust

Improving patient experience and outcomes

A recent study in Northern Ireland[12] ran a retrospective analysis of the costs of delivering out-of-hospital care to 275 patients over an entire year. The conclusion was that, on average, this care model was around 80 per cent less expensive than comparable in-hospital treatment, i.e. five times as many patients could be treated for the same price as treating one patient in hospital.

The study also examined patient preferences and satisfaction in relation to home-based healthcare and discovered that both patients and consultants were highly receptive to this model of care. The study found that:

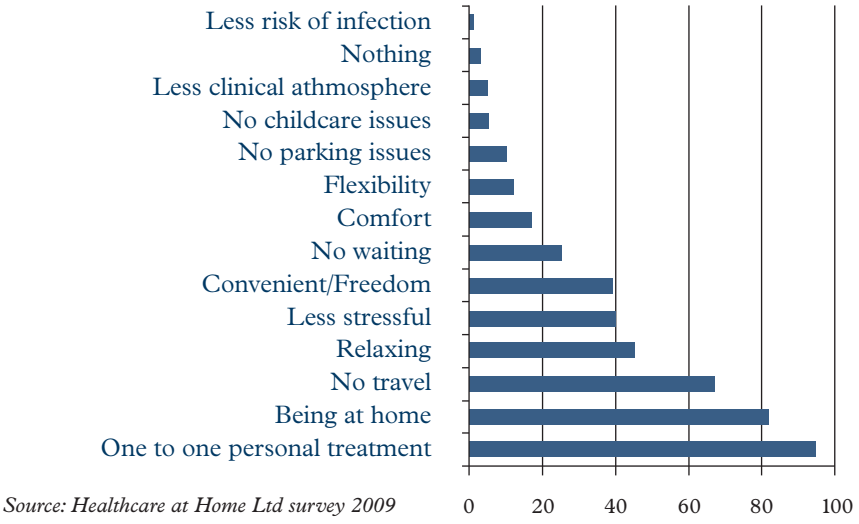
"It's an immense advantage being treated at home. My hospital is almost an hour's drive away and the appointment would take up to four and a half hours. Imagine that every three weeks for an indefinite period. It's so valuable in terms of quality of life to have everything done in 90 minutes at home. It means a whole day isn't spent travelling or being treated and I can get on with everyday things such as paperwork or my voluntary work. I can even go out in the morning of the day I have IV therapy. If treatment at home was more generally available it would take the pressure off hospitals, where people are sitting around for hours either waiting for treatment, being treated or recovering."

EILEEN NORMAN,
cancer patient

THE PATIENT'S VIEW

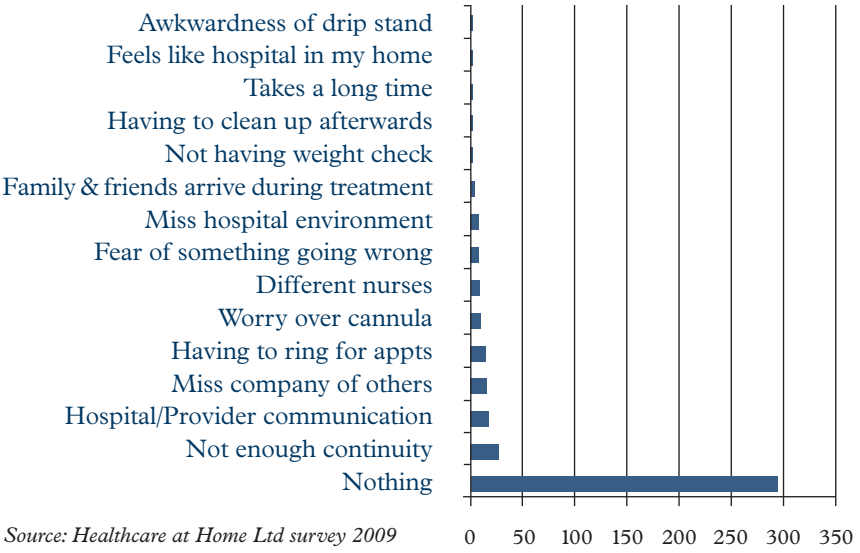
- 66 per cent of patients receiving home-based healthcare believed that their symptoms had improved, relative to receiving care in a hospital setting
- 86 per cent felt that their overall quality of life was better
- No patients felt that their quality of life had deteriorated versus in-hospital care
- 100 per cent of consultants surveyed said they would continue to refer appropriate patients to the scheme

These results are mirrored elsewhere. In a separate survey, 525 patients receiving home-based healthcare were asked what they most liked about it[13]:



Source: Healthcare at Home Ltd survey 2009

The same respondents were also asked what they liked least about receiving home-based healthcare, with the following findings:



Source: Healthcare at Home Ltd survey 2009

Clinical effectiveness, safety and patient experience

The Health Services Management Centre (HSMC) at the University of Birmingham recently undertook a rapid evidence review to support the Transforming Community Services programme, focusing on interventions that are not yet widespread within the NHS. In over 1,000 studies, it found useful evidence both of what works and what does not, but also noted the relative paucity of literature on this topic to date.

"Acute hospitals continue to have an important role, but organisations are examining how services that may previously have been offered in hospital can now be offered closer to home."
Evidence for transforming community services,
University of Birmingham, 2009

The report looked at examples of enhanced supported discharge and home-based healthcare services designed to help avoid hospital admission and reduce length of stay. It noted that patients welcome receiving hospital services at home, but emphasised the importance of a system-wide approach, rather than simply changing the location of care. Key opportunities and lessons identified in the report include:

- Providing 'hospital' services in a home environment
- Offering IV therapy in the community
- Considering anticoagulant therapy in the community
- Not relying solely on local appointments with specialists
- Not relying solely on adding specialists to community teams
- Not relying solely on sharing care with hospitals

A review of 27 studies from seven different countries[14] concluded that home-based healthcare was as effective as hospital care as long as patients were carefully selected. For older people, who are more likely to experience adverse events in hospital, it noted that home-based healthcare has the potential to avoid exposure to infection and have the benefit of offering care in familiar surroundings.

A study of 455 older patients in the US[15] found that patient satisfaction was higher with home-based healthcare and that secondary care services were accessed for a shorter period of time. The quality of care was found to be on a par with hospital care.

A randomised controlled trial in Australia[16] compared home-based healthcare with hospitalisation for people with chronic obstructive pulmonary disease. The home-based group had better knowledge of their condition, improved quality of life and greater satisfaction.

"There appears to be clear evidence that home healthcare can achieve outcomes comparable to acute care delivered in a hospital environment. There also appears to be clear evidence that home healthcare generally gives rise to greater patient satisfaction."

PROFESSOR CIARAN O'NEILL,
School of Medicine and Dentistry,
Queen's University Belfast[17]

FOOTNOTES

[12] *Home Healthcare – an economic choice for the health service*, Northern Ireland Health Economic Group, 2008

[13] 525 patients treated by Healthcare at Home Ltd were surveyed between January and November 2009

[14] *Hospital at home; a review of the literature on the effects of a form of transmural care*, Berendsen AJ, Schuling J, Meyboom-De Jong B. Nederlands Tijdschrift Voor Geneeskunde 2002; 146(48): 2302-8

[15] *Hospital at home: feasibility and outcomes of a program to provide hospital-level care at home for acutely ill older patients*, Leff B, Burton L, Mader SL et al. Annals of Internal Medicine 2005; 143(11):798-808

[16] *Randomised controlled trial of home based care of patients with chronic obstructive pulmonary disease*, Hermiz O, Comino E, Marks G, Daffurn K, Wilson S, Harris, M

[17] *Home Healthcare – an economic choice for the health service*, Northern Ireland Health Economic Group, 2008

3. Building a model for home-based care

Healthcare at Home Ltd worked with Dr Foster Intelligence to identify the potential savings and benefits to be derived from delivering a range of specific care and treatment services in a home environment, rather than in hospital.

The brief

- To identify patient activity applicable to each of four services where home-based healthcare represents an alternative to hospital care

- To calculate the current costs of inpatient and outpatient episodes of hospital care for each service, using 2008/09 data from the Secondary Uses Service (SUS)

- To estimate the costs of providing home-based healthcare services to those populations, based on existing service models and assumptions

- To identify potential savings in one illustrative PCT by comparing these figures and to extrapolate savings at a national level

The approach

Detailed costings, figures and assumptions have been drawn from NHS BEN's home-based healthcare programme, which the PCT is delivering in partnership with Healthcare at Home Ltd. The four services in question are:

1. Care for people with selected long-term and other ACS conditions
2. Enhanced supported discharge
3. Specialised cancer services (chemotherapy)
4. End-of-life healthcare

For each of the above, the relevant diagnoses, procedures and healthcare resource groups (HRGs) were used to track the corresponding number of individual episodes of hospital care, both inpatient and outpatient. Using this activity data derived from SUS for 2008/09, together with tariff information, the cost to the NHS of hospital-based patient care was calculated in relation to each service.

The costs of providing home-based healthcare services have been estimated using current business models and assumptions provided by Healthcare at Home Ltd. Some of the services apply to all of the patients identified in the stage above, others to only a certain percentage (visit www.hah.co.uk/hospitalcareathome for the full methodology). Net savings are represented by the difference between the cost of providing hospital-based patient care and the estimated cost of home-based healthcare (including the cost of hospitals providing care to those patients not captured by the home-based healthcare service).

The assumptions provided by Healthcare at Home Ltd have been tested with the PCT's clinical services team. Net savings have been modelled for NHS BEN before being scaled to an England-wide level using national activity data. For the end-of-life healthcare service, the activity has been scaled up to the national level using relevant demographic information.

There has been no phased introduction of the services built into the model: the figures presented assume services are operating at full capacity for a whole year. For each of the four areas of care, the analysis applied to current or planned services within the PCT represents a baseline net savings model. For three of the areas there is an extended net savings model: this estimates the potential net savings if the analysis is applied to an extended list of applicable services, or if further savings are considered. All data is for the 2008/09 financial year.

Detailed methodologies, assumptions and data sources can be found online at www.hah.co.uk/hospitalcareathome

3.1 Avoiding preventable admissions: long-term conditions

Key findings

- 3,100 emergency admissions could have been avoided in NHS BEN in 2008/09 through home-based healthcare for people with selected conditions
- Net savings from this service would amount to £1.7 million per annum for NHS BEN
- Taking additional savings associated with A&E attendance into account, these savings could rise to £2 million
- England-wide, 345,000 emergency admissions could be avoided through better access to home-based healthcare
- Savings could be between £180 million and £210 million on a national level

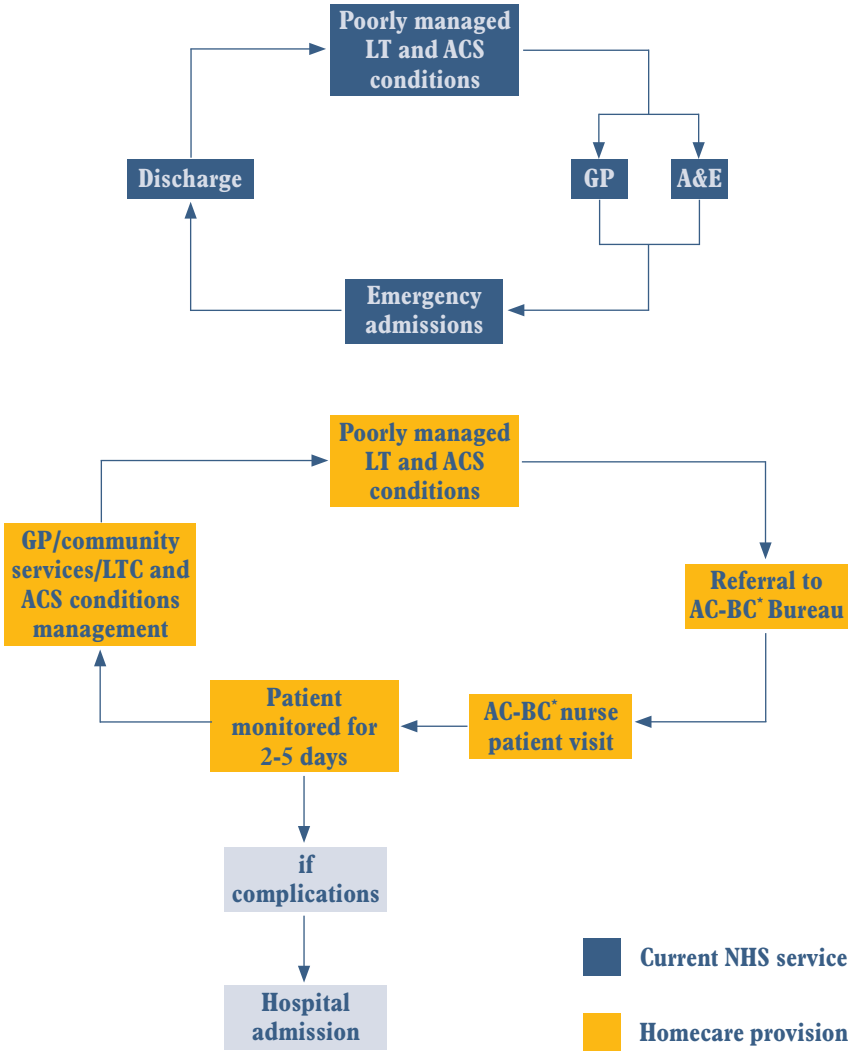
Scope

A wide range of literature indicates that the timely and effective management of ACS conditions in a community setting can reduce or eliminate unnecessary hospitalisation. For the purposes of this analysis, home-based healthcare services for people with the following ACS conditions were selected:

- Chronic obstructive pulmonary disease (COPD)
- Diabetes complications
- Dehydration and gastroenteritis
- Influenza and pneumonia
- Cellulitis
- Asthma
- Angina
- Hypertension
- Iron deficiency anaemia

How home-based healthcare works

Patients are referred to the home-based healthcare service by primary or secondary care, and a nurse-led service visits them in their home. Having obtained consent and provided a clinical assessment, the nurse plans the patient's treatment in liaison with the prescribing lead. A time-limited, high-intensity intervention is delivered over a number of days, with progress monitored in line with clinical governance. As can been seen from the two scenarios below, the service helps patients avoid visits to A&E, plus the related ambulance trips, as well as subsequent admissions to hospital (whether through A&E or via a GP).



**AC-BC stands for 'acute community-based care'*

"The NHS knows it has to deliver services in a radically different way if we are to meet demands for improved quality in straightened economic circumstances. Creating NHS services that fit the personal circumstances of everyone in north-east Birmingham, but particularly those from disadvantaged communities, is our objective. Many people – some who stay in hospital too long, others who need not be treated in hospital at all – will benefit from home-based care. The creation of the world's first 24-hour service for those people approaching the end of their lives who do not need, or wish, to go in and out of hospitals, demonstrates how we can improve safety, the quality of clinical outcomes and quality of people's experience, while saving cash."

ANDREW DONALD, Chief Operating Officer, NHS Birmingham East and North

THE COMMISSIONER'S VIEW

CASE STUDY

Between September 2004 and April 2008, Imperial College Healthcare NHS Trust administered intravenous antibiotics to patients with chronic conditions at home, rather than admitting them to hospital.

As a result, the trust saved 7,394 inpatient bed days, the equivalent of more than 20 bed years.

Findings

In NHS BEN in 2008/09, patients experienced 4,400 emergency admissions for the nine ACS conditions in question, at a tariff cost of £8.9 million. Given the assumptions set out below, an alternative home-based healthcare service would cater for 3,100 of these episodes at a cost of £4.5 million. 1,300 admissions would still take place, at a tariff cost to the PCT of £2.7 million, giving baseline net savings to the PCT of £1.7 million. Applying the extended model, which takes into account other costs associated with A&E attendances[18], would give additional potential savings to the PCT of £390,000, i.e. more than £2 million in total.

Table 1: Comparative costs and potential baseline savings in NHS BEN

Current situation		Alternative homecare service				
Emergency admissions	Tariff	Homecare patients	Costs	Remaining emergency admissions	Tariff	NET SAVINGS
4,400	£8,850,000	3,100	£4,520,000	1,300	£2,660,000	£1,670,000

Applying the model at a national, England-wide level indicates savings of £180 million, with additional potential savings of £32 million.

Table 2: Comparative costs and potential baseline savings England-wide

Current situation		Alternative homecare service				
Emergency admissions	Tariff	Homecare patients	Costs	Remaining emergency admissions	Tariff	NET SAVINGS
494,200	£899,910,000	345,900	£450,280,000	148,300	£269,970,000	£179,660,000

Approach and assumptions

This PCT-level analysis of hospital activity and costs focused on emergency admissions experienced by patients with the selected conditions in 2008/09. The number of emergency admissions via both A&E and GP referral were analysed by condition (using ICD-10 codes), building up a monthly activity roster and the associated tariff costs of the admissions. The service costs are based on the assumptions that effective home-based healthcare can eliminate 70 per cent of emergency admissions that come via GP referral and 70 per cent of emergency admissions that come through A&E. These assumptions are drawn from the service model adopted in NHS BEN and previous experience of Healthcare at Home Ltd in providing similar services.

This reflects the reality that some cases will be so severe and time-critical that an admission from A&E is required. The fee per patient will be 50 per cent higher than those for GP referrals, reflecting the 24-hour nature of A&E visits and the potential severity of the episode.

An extended model was developed to analyse additional potential savings associated with A&E visits, including ambulance travel costs for a proportion of patients. These were estimated by applying the average cost of an A&E attendance[19], for those patients identified using the assumptions above, and applying high-level assumptions on both the proportion of A&E patients arriving by ambulance[20] and the cost of that journey[21].

The potential net savings at national level have been calculated by analysing the activity levels and tariff cost for the nine ACS conditions for England as a whole, and applying the above assumptions to that activity. The extended model applies the same assumptions.

FOOTNOTES

[18] Visit www.hah.co.uk/hospitalcareathome for full details of the methodology, including the other A&E costs accounted for

[19] Source: NHS Reference Costs 2007/08

[20] Source: West Midlands A&E Surveillance Centre

[21] Source: University Hospital North Staffordshire

3.2 Returning home: enhanced supported discharge

Key findings

- Enhanced supported discharge services in NHS BEN could have generated savings of £1.9 million in 2008/09
- 640 patients would have spent less time in hospital
- Extending the service to people undergoing a wider range of procedures could generate savings of £7 million to the PCT
- England-wide, savings could amount to £217 million, benefiting 77,000 patients
- Extending enhanced supported discharge services could generate savings of £837 million nationally

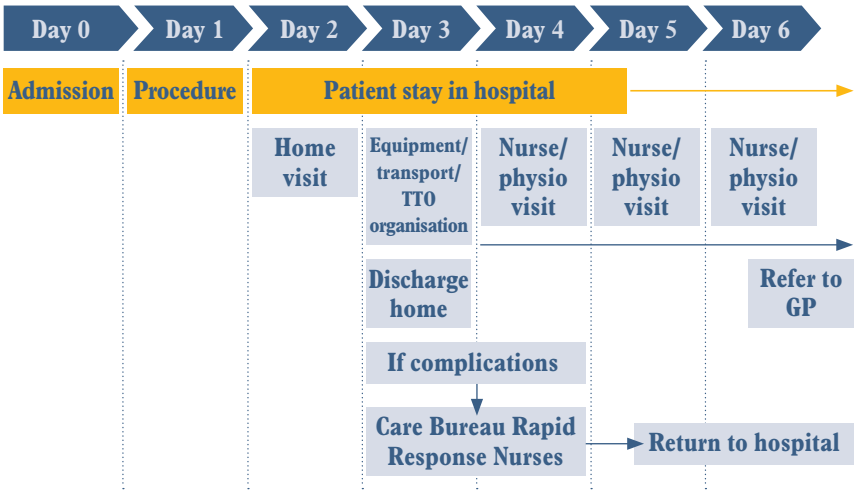
Scope

This analysis has focused on enhanced supported discharge services for patients in the following HRG classification categories:

- Infections of bones or joints (H30)
- Closed upper limb fractures or dislocations >69 or with complications (H39)
- Closed upper limb fractures or dislocations <70 without complications (H40)
- Revisional procedures to hips (H71)
- Primary hip replacement un/cemented (H80-81)
- Extracapsular neck of femur fracture with fixation with or without complications (H82-83)
- Intracapsular neck of femur fracture with fixation with or without complications (H84-85)
- Neck of femur fracture with hip replacement with or without complications (H86-87)
- Other neck of femur fracture with or without complications (H88-89)

How enhanced supported discharge works

A community-based team providing care in the patient's home allows discharge from hospital usually between days two and seven of the hospital stay. In contrast, patients remaining in hospital for these conditions stay up to 40 days on average[22]. Lack of available support is believed to be a contributory factor to the delay in discharge. The multidisciplinary care team consists of orthopaedic nurses, physiotherapists, occupational therapists and assistants with dedicated medical support. As shown below, patients follow a plan of care, with daily visits as required. At the end of the pathway, the patient is discharged back to their GP.



Findings

In NHS BEN, 1,330 patients underwent these procedures in 2008/09 at a cost of £6.6 million. This includes excess bed days, i.e. those who stayed in hospital for longer than assumed within the standard HRG tariff. Given the assumptions described below, an enhanced supported discharge service could cater for 640 of these patients, representing baseline savings of £1.9 million. Applying an extended savings model, based on offering enhanced supported discharge to patients undergoing a far wider range of procedures, gives potential savings of £7 million[23].

Table 3: Comparative costs and potential savings in NHS BEN

Current situation		Alternative homecare service				
Patients in hospital	Tariff	Homecare patients	Costs	Remaining in hospital	Tariff	NET SAVINGS
1,330	£6,600,000	640	£740,000	690	£3,930,000	£1,930,000

CASE STUDY

For Paul[24], celebrating the birth of his daughter in June 2007 should have been a happy occasion. Instead he remembers it as the beginning of a traumatic period that involved him having five surgical procedures, a serious infection and months of treatment.

As Paul was able to be treated at home, however, he could leave hospital almost a month early and continue his treatment in the comfort of familiar surroundings.

"Having treatment at home meant I could be discharged from hospital after a fortnight and continue being cared for by nurses at home," says Paul.

"I had to be given antibiotics intravenously four times a day for four weeks, which was a bit disruptive to family life, but that was nothing compared to how disruptive my being in hospital five miles away would have been for my partner, with a new baby to care for."

TARIFFS EXPLAINED

Each patient stay in hospital is assigned an HRG (based on the ICD-10 condition code and OPCS4 procedure code) and the associated costs are charged back to the PCT through a tariff attributable to that HRG. The PCT will pay the tariff regardless of the patient's length of stay, unless that patient stays beyond an upper limit, known as a trimpoint. The PCT then pays an additional daily rate (or excess bed-day rate) for each day spent in hospital beyond that trimpoint. For a stay that ends before the trimpoint, regardless of whether it is two days or eight, the charge is the same. The only exception is if the length of stay is particularly short (0-2 days) for a non-elective admission, in which case a reduced short-stay tariff is charged (up to 60 per cent less). Due to the nature of tariffs, shortening a patient's length of stay will yield only the excess bed days as realisable savings for the PCT (if indeed there are any). The PCT must pay the same rate for a patient who stays for a couple of days as a patient who stays until the trimpoint. Consequently, a renegotiation of the tariff mechanism will be required for commissioners to realise savings for reduced lengths of stay below the trimpoint.

At a national, England-wide level, net baseline savings are £217 million, with 77,000 patients receiving the enhanced supported discharge service. The extended savings model indicates potential savings of £837 million.

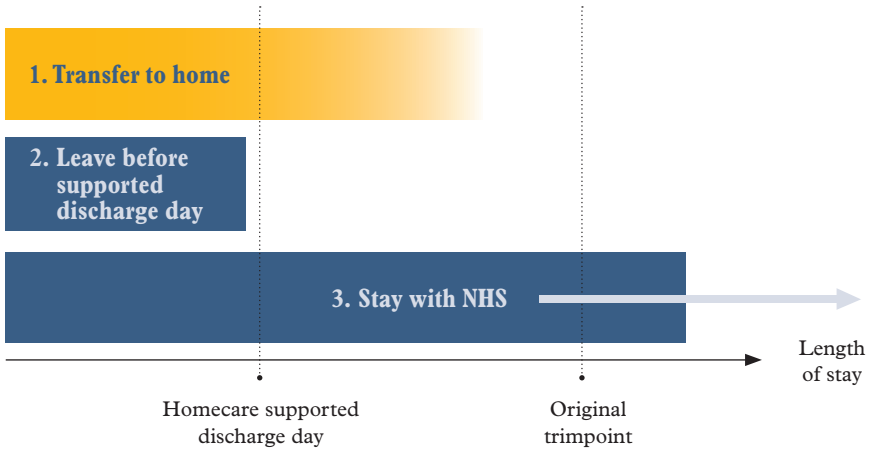
Table 4: Comparative costs and potential savings England-wide

Current situation		Alternative homecare service				
Patients in hospital	Tariff	Homecare patients	Costs	Remaining in hospital	Tariff	NET SAVINGS
168,000	£777,160,000	76,900	£88,230,000	91,100	£471,620,000	£217,310,000

Approach and assumptions

Using SUS, the number of admissions was calculated by HRG, length of stay and total tariff (split by spell and excess bed-day tariff). The baseline savings model used here assumes that a 50 per cent tariff reduction can be negotiated for stays below the HRG trimpoint (see left). Patients have been split into three groups:

1. **Patients transferred to Healthcare at Home Ltd on the supported discharge day.** A reduced tariff has been applied, with home-based healthcare costs thereafter.
2. **Patients with short lengths of stay who leave before the supported discharge day.** A reduced tariff has been applied, recognising the hospital's reduced role.
3. **Patients who stay in hospital as normal.** The standard tariff has been applied, plus an average of the excess bed-day charge for the HRG, where appropriate.



In estimating the home-based healthcare costs, patients in group 2 have been excluded and it is assumed that 70 per cent of the remaining patients will receive the enhanced supported discharge service (group 1), with 30 per cent left in group 3 and staying in hospital. Home-based healthcare costs are calculated on the

basis of a monthly standard charge covering up to 30 patients, with an additional monthly fee for every additional patient. The baseline net savings are calculated as the difference between the home-based healthcare costs for group 1 patients, together with the tariff costs for patients in groups 2 and 3, and the total tariff paid for care in hospitals in 2008/09. The same methodology, using England-wide activity data, has been used to calculate the net savings at a national level.

The extended savings case looks at the implications of expanding the service to just over 360 HRGs[25]. The extended analysis does not apply the same methodology of grouping patients, but aims to estimate the savings obtainable if length of stay were reduced for each HRG. Potential savings have been estimated for reducing length of stay by one, three or five days (using the appropriate excess bed-day tariff) for all lengths of stay above two, four or six days respectively (i.e. taking into account patients who would already have been discharged by that point).

Table 5: Potential savings from extending enhanced supported discharge to other procedures in NHS BEN

	1 day saving	3 day saving	5 day saving
los > 2	£3,366,000	-	-
los > 4	£2,331,000	£6,992,000	-
los > 6	£1,701,000	£5,102,000	£8,503,000

Taking the middle assumptions (three-day savings, for lengths of stay above four days), the savings for the PCT could total £7 million in the extended case. Although this case uses high-level assumptions on a long list of HRGs, a sense check can be applied: this level of savings represents just eight per cent of total PCT spend on these HRGs (£90 million in 2008/09). The baseline model indicates savings of £1.9 million against spend of £6.6 million or 29 per cent of total spend. This suggests that the extended case would be achievable.

Table 6: Potential savings from extending enhanced supported discharge to other procedures England-wide

	1 day saving	3 day saving	5 day saving
los > 2	£400,605,000	-	-
los > 4	£278,898,000	£836,694,000	-
los > 6	£202,207,000	£606,619,000	£1,011,031,000

The same methodology is used for the extended national net savings model. The extended savings model identifies that £837 million could be saved nationally if these services were adopted across the board.

FOOTNOTES

[22]Source: Dr Foster analysis, average length of stay for H88 other neck of femur fracture with complications 40.4 days, April 2008-March 2009, NHS BEN

[23]Visit www.hah.co.uk/hospitalcareathome for the full methodology, including which other procedures were accounted for

[24]A false name has been used in order to protect the identity of this patient of Healthcare at Home Ltd

[25]Source: Healthcare at Home Ltd, 2009

3.3 Chemotherapy at home: specialised cancer services

Key findings

- By delivering chemotherapy and trastuzumab (Herceptin) to breast cancer patients at home rather than in hospital, NHS BEN could achieve savings of £420,000 while improving treatment for 380 patients
- Providing home-based chemotherapy for all cancers indicates savings of up to £740,000 in the PCT
- England-wide, home-based healthcare for breast cancer patients could generate savings of £46 million for the NHS while benefiting 45,000 patients, which equates to approximately 15 per cent of all cancer patients undergoing chemotherapy
- Extending home-based healthcare services to all cancer patients indicates potential savings of £73 million nationally

Scope

This analysis focuses on the opportunity to move the delivery of chemotherapy and trastuzumab for breast cancer patients out of hospitals and into a home setting. The extended analysis considers the potential savings from extending home-based healthcare to all cancer patients.

How home-based chemotherapy works

Having attended an oncology clinic, a breast cancer patient is presented with a choice: hospital or home for chemotherapy delivery. Should the patient choose the latter option, a nurse will arrange a home assessment to ascertain suitability for drug treatment. A blood sample is taken 24 to 48 hours before the first treatment date and analysed by pathology: if the results are within the allowed parameters, treatment in the home can begin. Clinical evaluation takes place at every stage, with each patient needing to take a 12-weekly cardiac / MUGA assessment.

Findings

In NHS BEN, there were 2,700 procurements and subsequent deliveries of breast cancer chemotherapy drugs in 2008/09, at a cost of £2.9 million; this covered 380 patients. Assuming all patients would have been able to receive this treatment at home, the baseline savings model indicates potential savings to the PCT of £420,000. Applying the extended savings model, which estimates the savings represented by providing home-based chemotherapy for all cancers, indicates potential savings of £740,000[26].

Table 7: Comparative costs and potential savings in NHS BEN

Current situation			Alternative homecare service			
Breast cancer chemotherapy deliveries	No. of patients	Ref costs	No. of Spells	No. of Patients	Costs	NET SAVINGS
2,700	380	£2,870,000	2,700	380	£2,450,000	£420,000

Extrapolating this to the national, England-wide level, the baseline net savings would be £46 million, with 184,000 drug procurements and deliveries covered by the home-based healthcare service for 45,000 patients. The extended savings model indicates potential savings of £73 million.

Table 8: Comparative costs and potential savings England-wide

Current situation			Alternative homecare service			
Breast cancer chemotherapy deliveries	No. of patients	Ref costs	No. of Spells	No.of Patients	Costs	NET SAVINGS
183,600	45,000	£293,910,000	183,600	45,000	£248,240,000	£45,670,000

THE PATIENT'S VIEW

"I opted for home treatment because I believed I would feel more comfortable and, more importantly, my children could see chemotherapy in action... It sounds like common sense, I know, but understanding dissipates fear and I believe that being able to watch me having cups of tea, chatting to my wonderful nurse, Elaine, and generally being relaxed during each session was an enormous relief to everyone."

Cancer patient, treated by Healthcare at Home Ltd

CASE STUDY

"One patient was needle-phobic. Being treated at home meant he could stay out of the way until the last minute, then lie on his chaise longue, have his treatment and go straight to bed afterwards – something we simply can't offer at the unit.

"It does increase paperwork slightly, but the advantage of freeing up capacity is immense. We can see the waiting list come down, which is very rewarding. We are still very busy but are able to run a few more pre-assessment clinics and see more staff access training for new services."

TRACEY WHEETMAN, Macmillan lead cancer nurse and matron, Haematology and Oncology Unit, Mid Staffordshire NHS Foundation Trust

Approach and assumptions

The SUS data gives an insight into the delivery of chemotherapy in both inpatient and outpatient clinics, allowing analysis of the annual activity both in an individual PCT and nationally. The baseline net savings look at chemotherapy only for breast cancer, taking into account both procurement of the chemotherapy drugs and subsequent delivery.

The costs for the PCT have been built up using the ten costing bands for procuring chemotherapy drugs and the six bands for their subsequent delivery. SUS does not provide the costs behind the procurement and delivery of these drugs, so NHS Reference Costs have been applied. Approximately a fifth of breast cancer operations require trastuzumab treatment[27], with each patient receiving on average 17 cycles per year[28]. The cost of trastuzumab delivery has been estimated by the NHS BEN Specialised Commissioning Group.

No VAT is applied to the procurement of the drugs for chemotherapy delivered in the home, meaning the procurement cost to the NHS can be reduced by 17.5 per cent. A home-delivery cost for the drugs has been estimated by Healthcare at Home Ltd, based on existing business models.

The extended model applies the methodology to chemotherapy treatment for all cancers (removing the trastuzumab element from the analysis as this only applies to breast cancer). As with the other analyses, the SUS dataset can be used to scale the savings for both the baseline and extended savings model to a national level.

The extended savings model for providing home-based chemotherapy for all cancers suggests savings of £740,000 at PCT level and £73 million at the extended, national level.

Table 9: Calculating the costs to the PCT of breast cancer chemotherapy and trastuzumab

Treatment	Drug costs	Treatment	Activity	Other delivery
Band 1 Chemotherapy	£36,652		Deliver complex chemotherapy including prolonged infusional treatment at first attendance	£146,640
Band 2 Chemotherapy	£94,804		Deliver more complex parenteral chemotherapy at first attendance	£5,850
Band 3 Chemotherapy	£137,238		Deliver simple parenteral chemotherapy at first attendance	£53,091
Band 4 Chemotherapy	£3,834		Deliver subsequent elements of a chemotherapy cycle	£61,600
Band 5 Chemotherapy	£34,408		Other specified delivery of chemotherapy for neoplasm	£0
Band 6 Chemotherapy	£7,840		Unspecified delivery of chemotherapy for neoplasm	£160
Band 7 Chemotherapy	£22,330			
Band 8 Chemotherapy	£320,087			
Band 9 Chemotherapy	£1,985			
Band 10 Chemotherapy	£350,960			
Herceptin treatment	£1,319,263	£270,300		
Sub-total	£2,329,401	£270,300		£267,341
TOTAL				£2,867,041

FOOTNOTES

[26]Visit www.hah.co.uk/hospitalcareathome for the full methodology

[27]Section 2.4 of NICE Technology Appraisal Guidance No.34 – *Guidance on the use of trastuzumab for the treatment of advanced breast cancer* (March 2002)

[28]Derived from Healthcare at Home Ltd's current working practice

3.4 Supporting end-of-life healthcare

Key findings

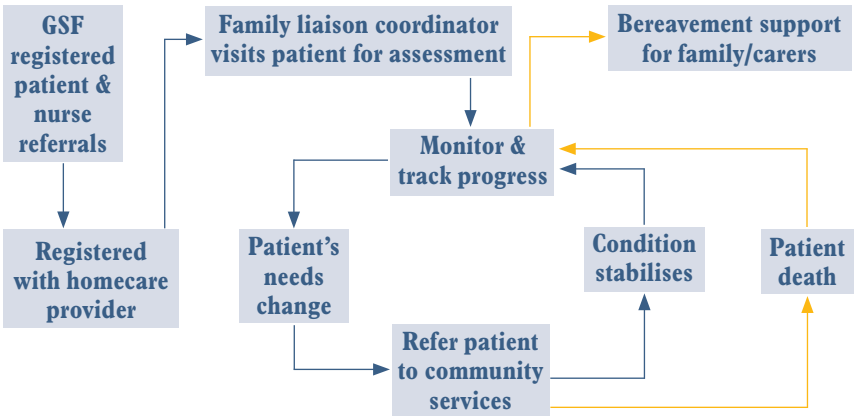
- Providing home-based end-of-life healthcare for 604 people could generate savings of £1.2 million in NHS BEN
- England-wide, the savings from providing home-based healthcare for 88,000 such patients could be £160 million

Scope

This analysis focuses on end of life in hospital, when patients could be cared for at home. Since SUS data does not identify such patients, Healthcare at Home Ltd and NHS BEN identified HRG D99, complex elderly with a respiratory system primary diagnosis, as the HRG which closest matches the cost of the final hospital admission.

How home-based end-of-life healthcare works

Home-based end-of-life healthcare seeks to ensure patients and their carers receive family support and coordination, 24-hour nursing triage and a rapid response service and drug access support. Patients are referred to the service either through the Gold Standards Framework for end-of-life healthcare or through nurse referrals. Patients are assigned a family liaison coordinator who organises the care package to suit the patient's needs. The aim is to improve coordination and response of services so that unnecessary hospital admissions can be prevented. The rapid response service provides nursing and emotional support, when the alternative may be to ring an ambulance. The service ensures clear communication between key stakeholders and ensures a smooth transfer of care between providers.



Findings

In NHS BEN in 2008/09, 604 patients were identified as appropriate for this service, at a cost of £1.9 million, using HRG D99 as an indicator of the cost of their last admission. Providing these patients with end-of-life healthcare at home could have generated savings of £1.2 million for the PCT[29].

Table 10: Comparative costs and potential savings in NHS BEN

Current situation		Alternative homecare service		
Identified patients	Indicative cost	Homecare patients	Costs	NET SAVINGS
604	£1,940,000	604	£730,000	£1,210,000

Table 11: Comparative costs and potential savings England-wide

Current situation		Alternative homecare service		
Identified patients	Indicative cost	Homecare patients	Costs	NET SAVINGS
88,400	£266,290,000	88,400	£106,660,000	£159,630,000

Assumptions and approach

The net savings were calculated by comparing the average tariff for a D99 death admission for the 604 patients with the cost of providing a home-based healthcare service, estimated using existing business models.

Demographic information has been used to scale the net savings to a national level. The D99 HRG applies to the over-60s only and, as there are 78,000 people in this age group in the PCT, 604 patients represent 0.8 per cent of this population segment. With just over 11 million over-60s nationally, applying the same 0.8 per cent rate provides approximately 88,000 patients who may be eligible for end-of-life home-based healthcare.

The average national cost of a D99 admission resulting in death has been calculated using SUS, then applied to generate the total cost to the NHS in providing final admissions (£266 million). The net savings are derived by calculating the difference between this and the cost of the provision of home-based healthcare.

56-74%
of people would prefer to be cared for and to die at home[30]

18%
of deaths occur at home

17%
of deaths occur in care homes[30]

1 in 7
hospitals do not provide any facilities to support relatives and carers who wish to stay in hospital with a patient during their final days[31]

FOOTNOTES

[29] Visit www.hah.co.uk/hospitalcareathome for full details of the methodology

[30] *Delivering Care Closer to Home*, Department of Health, July 2008

[31] *The Hospital Guide 2009*, Dr Foster Intelligence, November 2009

3.5 The bottom line

Calculating the overall savings: NHS BEN

There is an overhead cost that must be incorporated before the total savings can be calculated: £1.2 million a year will be spent on a call centre to cover the four service areas in the PCT. This function also features a medic and IT support.

For the four services analysed in NHS BEN, transferring hospital care into patients' homes would amount to total potential baseline savings of £4 million, using 2008/09 figures. In this scenario 5,000 patients would avoid hospital.

Table 12: Baseline comparative costs and potential savings in NHS BEN

	Current situation		Alternative homecare service				
Area of care	Patients in hospital	Cost	Homecare patients	Homecare costs	Remaining hospital patients	Remaining hospital costs	NET SAVINGS
LTC	4,400	£8,850,000	3,100	£4,520,000	1,300	£2,660,000	£1,670,000
ESD	1,330	£6,600,000	640	£740,000	690	£3,930,000	£1,930,000
Specialised cancer	380	£2,870,000	380	£2,450,000	-	-	£420,000
End of life healthcare	604	£1,940,000	604	£730,000	-	-	£1,210,000
Sub-total	6,714	£20,260,000	4,724	£8,440,000	1,990	£6,590,000	£5,230,000
Central Care Bureau cost				£1,200,000			
TOTAL	6,714	£20,260,000	4,724	£9,640,000	1,990	£6,590,000	£4,030,000

The baseline savings of £4 million represent 20 per cent of all tariffs spent on the conditions in question, and two per cent of total hospital expenditure[32]. Adopting the extended net saving models, the trust's savings could rise to £10 million. This represents four per cent of hospital expenditure before applying any further related savings: reduced incidences of acquired healthcare infections, capital gains through estate realisation and reduced overheads.

Table 13: Extended potential savings in NHS BEN

Extended analysis	NET SAVING
All cancer	£740,000
ESD expanded HRG 3 day saving where patient los > 4	£6,990,000
LTC A&E attendance/Ambulance potential savings	£390,000
NET TOTAL (including baseline)	£11,000,000
Central Care Bureau cost	£1,200,000
TOTAL	£9,800,000

Calculating the overall savings: England

Nationally, moving care out of hospital in the four areas identified could generate baseline savings of £540 million, benefiting 550,000 patients.

The overhead costs would increase relatively and a larger, centralised call centre (or central care bureau) would be needed to cover services across the country. Patient numbers have been used to scale the size of the centre, scaling it up to an estimated cost of £61 million.

Table 14: Baseline comparative costs and potential savings England-wide

	Current situation		Alternative homecare service				
Area of care	Patients in hospital	Cost	Homecare patients	Homecare costs	Remaining hospital patients	Remaining hospital costs	NET SAVINGS
LTC	494,200	£899,910,000	345,900	£450,280,000	148,300	£269,970,000	£179,660,000
ESD	168,000	£777,160,000	76,900	£88,230,000	91,000	£471,620,000	£217,310,000
Specialised cancer	45,000	£293,910,000	45,000	£248,240,000	-	-	£45,670,000
End of life healthcare	88,400	£266,290,000	88,400	£106,660,000	-	-	£159,630,000
Sub-total	795,600	£2,237,270,000	556,200	£893,410,000	239,400	£741,590,000	£602,270,000
Central Care Bureau cost				£60,900,000			
TOTAL	795,600	£2,237,270,000	556,200	£954,310,000	239,400	£741,590,000	£541,370,000

Adopting the extended net saving models, the savings could rise to £1.2 billion nationally.

Table 15: Extended potential savings England-wide

Extended analysis	NET SAVING
All cancer	£72,610,000
ESD expanded HRG 3 day saving where patient los > 4	£836,690,000
LTC A&E attendance/Ambulance potential savings	£32,160,000
NET TOTAL (including baseline)	£1,280,750,000
Central Care Bureau cost	£60,900,000
TOTAL	£1,219,850,000

FOOTNOTES

[32]Net savings compared with the PCT's 2008/09 annual budget for acute services

Conclusions

"What sets successful initiatives apart is not the substantive content or process, but a focus on leadership, ongoing training, providing support and mentorship to staff, resources, space and time to test changes, and a transformation in mindset to use service users, carers, social care, housing, education and others as equal partners in care."

Evidence for transforming community services,
University of Birmingham 2009

The NHS has until now been geared for growth with the focus on increasing hospital capacity and reducing waiting times. Current tariff structures and commissioning arrangements continue to incentivise hospital-based activity and, while demand management initiatives may be succeeding, they do so only as the margins and overall inpatient and outpatient activity continue to grow. The vision of an NHS that is less confined to hospitals and more available in people's homes has been slow to materialise, but increasing budgetary pressures mean that real re-engineering of the system is no longer optional. The current crisis offers the opportunity for commissioners to take bolder action.

The analysis here suggests that a shift to home-based healthcare offers just such a bold opportunity and is a viable alternative to short-term fire-fighting measures, which may cut costs in the short term but fail to address the underlying symptoms of an increasingly unaffordable healthcare system. Tough decisions on disinvestment will be required and commissioners will need supporting in taking such decisions. Creativity will be required, for example, in exploring benefit-sharing mechanisms to incentivise key stakeholders. The temptation to introduce incremental change at the margins through pilots and small initiatives will need to be overcome if mainstream change is to be achieved, and real savings realised.

It is not just about cost savings, however. Patient experience is no longer on the fringes of healthcare policy. Improving the patient experience is today a policy requirement and one against which PCTs and acute trusts are measured.

This report has used a PCT commissioning programme on which to base its analysis, but the argument is equally compelling for acute care. Hospitals cannot afford to be complacent in this area: the 2010/11 CQUIN schemes are worth 1.5 per cent of provider contract value, and one of the national priority areas specified in the scheme is improving responsiveness to the personal needs of patients. Moving care from hospitals to the home may also help address the QIPP challenge, and four per cent of acute spend presents a good starting point. With an overwhelming majority of patients rating home-based healthcare more highly than in-hospital care, there is a strong case for enabling more of it to happen.

The findings here should supply commissioners and providers with the impetus they need to consider service redesign in this way. Home-based healthcare is no longer a 'nice-to-have' option, it is an increasingly attainable solution for all health and social care organisations. The debate now needs to move away from budgetary obstacles and into an arena where longer-term investments can deliver better outcomes and patient experience.

Postscript

Change necessitates strong leadership and common sense

Charles Walsh, Chair,
Healthcare at Home Ltd

All of these developments point in a single direction, the direction of home-based healthcare. But, in the vast majority of cases, hospital continues to be the default option. For ever-increasing numbers of patients, we should be asking: are they in hospital for the wrong reasons?

Reasons such as the failure to develop safe, appropriate and accessible community-based services where they live.

Reasons like inertia, resistance to change and a lack of incentives to create more patient-focused care services.

Reasons like weak commissioning in the face of more powerful acute sector interests.

Reasons like a lack of conviction and vision at the top of government.

These obstacles have not been enough to stop the advance of home-based healthcare, but they have limited its progress. Many thousands of patients are currently benefiting from home treatments that would formerly have been provided in hospital. Yet many more patients with exactly the same healthcare needs are still having to go into hospital for treatment: at greater cost to the healthcare system and at the risk of less positive experiences of care. I am confident that home-based healthcare will continue to grow, simply because it makes sense.

Acknowledgements

We would like to thank the following for their contribution to this report:

Tara Athanasiou, *Head of Marketing and Communications*, Dr Foster Intelligence

Sally Brooks, *Head of Marketing and Communications*, NHS Birmingham East and North

Ruth Carnall, *Chief Executive*, NHS London

Sir Ian Carruthers, *Chief Executive*, NHS South West

Sophia Christie, *Chief Executive*, NHS Birmingham East and North

Steve Davis, *Head of Marketing*, Healthcare at Home Ltd

Andrew Donald, *Chief Operating Officer*, NHS Birmingham East and North

Mark Hackett, *Chief Executive*, Southampton University Hospitals NHS Trust

Professor Alistair McGuire, *Head of Social Policy*, London School of Economics

Jo Phillips, *Group Financial Controller*, Healthcare at Home Ltd

Claire Taylor, *Marketing Manager*, Dr Foster Intelligence

Sir William Wells

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Photographs by Getty Images

About Healthcare at Home Ltd

Healthcare at Home Ltd is the UK's leading provider of hi-tech, home-based healthcare. It also delivers innovative on-site services throughout the NHS and independent sector.

Established in 1992, the company has grown rapidly and now employs almost 1,000 staff, approximately half of whom are highly skilled and experienced clinicians.

Operating from locations throughout the UK, Healthcare at Home Ltd provides nationwide services, delivered locally to over 100,000 patients each year. A broad range of care options is offered across many disease areas to patients of almost every NHS trust in the country. While the NHS is the biggest customer of Healthcare at Home Ltd, private medical insurers, pharmaceutical companies, charities and self-funding patients also employ its services.

These services are highly rated by patients, relieve capacity for the referring centres and represent an extremely cost-effective care model for funders. At all times, patients remain under the overall care of their referring clinician, with whom Healthcare at Home Ltd maintains close contact.

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About Dr Foster Intelligence

Dr Foster Intelligence aims to help bridge the gap between data and knowledge. It is a joint venture between The NHS Information Centre for health and social care and Dr Foster Holdings LLP, and provides a unique, innovative public service.

One of Dr Foster Intelligence's key objectives is to promote the development of an information culture in the NHS by providing appropriate information and analysis to clinicians and managers in order to help them deliver the best quality healthcare.

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February 2010

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