

There's no place like home

September 2016 | Second Report of the Expert Panel

Can clinical care in the home alleviate pressure on acute hospitals?

INSIDE

NHS in England could save £120 million

How trusts are saving £1.1 million a year

Extra capacity could be used for thousands of elective surgical procedures



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The NHS must embrace clinical care in the home – at scale

In the health service, we often say patients are at the centre of all that we do. That is absolutely as it should be. So, at the start of any clinical intervention, clinicians will consider what is in the patient's best interests. What is right? What benefit does the intervention provide? And, importantly, is there any way of providing treatment for this patient that better meets his or her needs as an individual, while still achieving the clinical aims?

There is much care that no longer needs to be provided in hospitals. Across the country, health services are responding by increasingly providing care closer to patients' homes. Often, providing care within the home is best for the patient. If clinical care at home is possible, I believe it should be seriously considered.

I have come across services providing clinical care in the home in a number of the NHS roles I have held, and have seen for myself how positive they can be for both patients and the service. I have always believed that they offer the opportunity both to transform services and enhance patients' quality of life, and were worthy of extending further. So I was disappointed at what I believe was the missed opportunity to consider more fully the place of clinical care in the home in both the Carter Review¹ and *Five Year Forward View*.

The expert panel, which I have the privilege of chairing, published its first report in October 2015: *Building the case for clinical care in the home at scale*. In it, we concluded that the evidence proved that clinical care in the home could bring value to patients and potential financial savings to the NHS. But we recognised that more data would be

needed to convince the NHS. There was a lack of research into the economics of providing this kind of care and whether the finances of it would be sufficiently compelling. But now, in this report – the expert panel's second – we have data from more than 9,000 patients who have all been cared for in virtual wards. What these independently validated data show is that the care these patients received in their homes showed no significant difference in numbers of unplanned re-admissions compared to patients who had stayed in hospital. By caring for them at home, the hospitals that remained clinically responsible for them saved thousands of bed days, thus releasing capacity, which could be used in other ways.

“Much care no longer needs to be provided in hospitals”

For those still ambivalent about the potential of clinical care in the home, this report provides, for the first time, evidence that clinical care in the home, at scale, is safe, patients like it, and it actually saves money. The report also recounts the frontline experience of several trusts, clinicians and patients, all with recent experience of clinical care in the home. What the data and these testimonies show is that for certain patients, this type of care should most definitely be considered as a serious option.

I urge the NHS to embrace clinical care in the home as part of the integrated future. It's better for patients if we don't bring them into hospital if there's no need, and it can support them to leave hospital safely. Clinical care at home can definitely offer cost savings. The challenge is how the NHS can and should embrace it.

If the NHS did care for more patients outside of hospital, it would leave hospitals better able to focus their full attention on care that absolutely has to be delivered in an acute setting.

At The Christie NHS Foundation Trust, we have recognised this and this year, following a pilot in 2015, initiated The Christie @ home, offering cancer therapy to certain patients in their homes, where it is possible and suits their needs. The Christie treats 44,000 patients a year, many of whom would prefer to avoid a journey if the treatment can be delivered quickly and safely in their home.

The contents of this report – data and personal testimonies – support the expert panel's enthusiasm for clinical care in the home. I encourage others to explore how such services could help alleviate pressures on acute hospitals in their localities.

Christine Outram

is Chair of The Christie NHS Foundation Trust and chair of the expert panel.

Christine has had a long career in the NHS, with more than 20 years at leadership level. She has held a number of top-level posts including Chief Executive of North Central London SHA, Chief Executive of NHS Leeds, and senior roles at NHS England and the Department of Health, including national work to improve the education and training of professional staff in the health service.

1. Lord Carter of Coles. Operational productivity and performance in English NHS acute hospitals: Unwarranted variations. Department of Health, February 5 2016



Improving quality, efficiency and the patient experience

A ten-day spell in hospital ages the muscles of someone over the age of 80 by ten years.¹ That level of deterioration can determine whether a person is able to stand up unaided or not, which has huge implications on future care needs once the person is discharged from hospital.

While a stay in hospital is often necessary, deconditioning alone drives the need to make the length of time people stay in hospital as short as possible. Once the need for hospital intervention has concluded, all patients, including the elderly, need to be moved quickly into the most appropriate care setting. A patient's home should be the default, but there are other bed-based settings such as step-down facilities, intermediate care beds, and rehabilitation units that can offer a more home-like environment. Their activities support recovery and functional ability to do daily tasks prior to going home, such as eating meals around a table and getting dressed.

Clinical care in the home, therefore, is not about freeing hospital beds and risking unsafe discharges. It is about ensuring the best outcomes for patients. The *Five Year Forward View*, published in 2014, provided a strategy for the NHS in England that has a triple aim: to reduce the health and wellbeing gap, the care and quality gap, and the funding and efficiency gap. Models to provide clinical care in the home have a great potential to meet the triple aim, improving health and wellbeing of patients, transforming quality of care delivery, and all achieved with a more efficient use of resource.

The *Five Year Forward View* also proposed new models of care designed to break down the traditional divides between primary, secondary and community care, mental health, and social care. The integration of health and social care is acknowledged as being fundamental to the future of the NHS, and the integration of these services by 2020 is mandated in the Spending Review of 2015. The Better Care Fund, which launched in 2015, is the beginning of this integration journey, by providing mandated joint funds between health and social care on a local authority footprint.

“All sectors locally need to work together in order to deliver a model for clinical care in the home”

Clinical care in the home is a model that has an opportunity to promote greater integration between multiple health and social care sectors. The model will only work when local organisations work together seamlessly and successfully to deliver the care around a person in their home or place of residence.

The 2020 vision for integration between health and social care creates an opportunity for the clinical care in the home model to bring together health,

social care and housing organisations and professionals. While a hospital can control every aspect of its environment, healthcare providers in the community need the support of social care and housing partners to facilitate a person's journey back to full health. Social care and housing have to ensure the care services a person receives and the environment in which care is delivered support daily living. All sectors locally need to work together in order to deliver a model for clinical care in the home, and this supports the 2020 vision.

As part of the overall drive towards transforming the NHS, clinical care in the home has enormous potential to not only promote integration between health and social care but also to improve patient experience, improve quality of care, and improve cost efficiency. As such, clinical care in the home is a model of care all commissioners should consider in their future plans.

CLINICAL CARE IN THE HOME

Integrated care, treatment and support that take 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.

Victoria Bennett

is Head of Planning Delivery at NHS England, and is writing in a personal capacity.

1. Kortebein P, Symons TB, Ferrando A, et al. Functional impact of 10 days of bed rest in healthy older adults. *J Gerontol A Biol Sci Med Sci.* 2008;63:1076–1081.



The NHS in England could save £120m a year using clinical care in the home

New research shows clinical care in the home can reduce the time spent in a hospital bed and the time patients are under hospital care. These reductions release capacity within hospitals that can then be used in other ways, such as managing waiting lists by performing more elective surgery, or reducing the number of hospital beds in the NHS. The research honed in on one aspect of clinical care in the home – virtual wards.

The independent research is the first of its kind to systematically show that clinical care in the home frees resources in acute trusts because of its ability to both reduce a patient's hospital length of stay, as well as the time actually spent in a hospital bed. Two distinct types of capacity savings were analysed:

- Savings made when a patient spent less time under hospital care, be it physically at home or in the hospital "length of stay".
- As above, plus savings realised in hospital when the patient is at home and beds can be potentially re-used.

The research's key findings are:

- If every acute trust in England introduced clinical care in the home there is the potential for more than 500,000 fewer inpatient bed days per year across the system.
- Widespread adoption of clinical care in the home would release more than £120m of funding back to clinical commissioning groups to help reduce

deficits or spend on other kinds of healthcare.

This real-world study, undertaken by leading global analytics company, MedeAnalytics,¹ and commissioned by Healthcare at Home on behalf of the expert panel, set out to explore:

- Whether clinical care in the home could reduce patients' length of stay in hospital,
- How the quality of clinical care in the home, using unplanned readmissions as the measure, compared to hospital-based care, and
- The financial implications to the NHS of scaling up the use of clinical care in the home.

Experts from MedeAnalytics, led by their chief data scientist Professor Simon Jones, took data from four NHS trusts operating virtual wards and measured how long patients on virtual wards² stayed under hospital care compared with patients with similar characteristics and health problems. The time period examined was October 2012 – May 2016.

Using anonymised data from the national Hospital Episode Statistics (HES),³ they matched patients based on age, sex, deprivation group, admission method and healthcare resource group (HRG, which is a way of categorising diagnoses).⁴ This meant that if an 88-year-old female from a deprived background was admitted in 2015 with an unplanned repair of a broken hip and was transferred to a virtual ward,

VIRTUAL WARDS: SHORTER STAYS AND GREATER PRODUCTIVITY

MedeAnalytics analysis found that being on a virtual ward potentially reduced total length of stay compared with the patients in the control group. Across the four trusts:

5,164

bed days were potentially saved as patients spent less time under hospital care

An estimated

62,040

inpatient bed days were released

This represents a mean saving of

£490

per inpatient spell to the hospital providers

A conservative estimate⁵ is that this equates to cost savings of about

£1.1m

per year⁶ to the four trusts because patients spent less time under the care of the hospitals, whether actually in hospital or at home on a virtual ward

1. Transforming lives through data [Internet]. MedeAnalytics® London: UK; 2016 [cited August 2016]. Available from: <http://medeanalytics.co.uk/>

2. Note the data were from certain hospitals within each of the four trusts and were not necessarily trust-wide data

3. HES data: Health & Social Care Information Centre [Internet]. Leeds, UK: HSCIC c2016. Available from: <http://www.hscic.gov.uk/hesdata>

4. Introduction to Healthcare Resource Groups: Health & Social Care Information Centre [Internet]. Leeds, UK: HSCIC c2016. Available from: <http://www.hscic.gov.uk/hrg>

5. The savings benefits are conservative as the simulated virtual ward also includes patients on bridging care packages (which cost the system less and still create the same benefits in terms of bed days saved)

6. Calculated (in basic terms) as (£excess bed day – £Healthcare at Home cost of care) x bed days saved (or lost). EBD varies by year and HRG, median = £208, minimum = £185 maximum = £396. Healthcare at Home cost of care (supplied and signed off by Healthcare at Home) = £179. For full methodology please see <https://www.hah.co.uk/no-place-like-home>



the researchers identified every other patient with these characteristics in the HES data and measured what happened to them too.⁷

After scanning nearly nine million records in the HES data, 4.2m hospital inpatient stays were found that matched the 9,374 inpatient stays on the virtual wards. These 4.2m records formed the control sample for this research and were the national cohort. Additionally, the researchers calculated that between them, by having patients on virtual wards, the four trusts freed a total of **62,040** inpatient bed days that the trusts could use for other patients.

MedeAnalytics explored how acute trusts could have used this extra capacity over the time period of the study.

If the four trusts wanted to use the extra capacity to carry out elective hip replacements,⁸ and assuming only 80 per cent of the released capacity would be used, they would be able to perform an extra **1,470** procedures and generate an

additional **£7.43m** in annual income. They would likely also reduce waiting times and the NHS is currently in breach of the 18-week target for treating patients referred for non-emergency NHS consultant-led treatment.⁹

But, instead, the trusts could use this extra capacity to reduce the number of beds. Based on the findings, and again assuming 80 per cent would be possible, about 36 beds could be taken out of these hospitals. However, the researchers recognised that this kind of structural change in a hospital may be difficult to achieve, especially if the virtual ward accepts patients from a range of medical specialities rather than targeting specific specialities to maximise impact. As an NHS bed day costs £400,¹⁰ this could potentially avoid more than £5.3m in costs. However, it is noted that an associated decrease in activity would be needed for this to impact the resources available to clinical commissioning groups.

FURTHER RESEARCH

This research has shown that, at scale, virtual wards provide care that releases costs and capacity without making a readmission more likely. The team used unplanned readmissions as a proxy for quality but much more measurement is needed to check the quality and safety of care (it is noted there are many other metrics that could be used, not just unplanned readmissions, e.g. incidence of pressure sores, venous thromboembolisms or blood clots, rates of healthcare acquired infection, better patient reported outcomes, time to re-ablement etc. See the comment by Dr James Featherstone on page 7).

There is more still to be explored, including a better understanding of which conditions benefit most from virtual wards and whether they should, therefore, only be used for a smaller number of higher impact diagnoses.

P10–13: read how eight trusts use clinical care in the home to improve patient flow through the hospital and increase capacity.

VIRTUAL WARDS

A virtual ward works like a hospital ward, using the same systems and daily routines, except that the people being cared for stay in their own homes throughout and the healthcare professionals caring for them are based in the community. It is called "virtual" because the ward does not exist physically and patients remain in their place of residence.

Consultants use technology to monitor patients, such as conducting daily "virtual ward rounds".

7. Please note MedeAnalytics has permission from the Health and Social Care Information Centre to access these data and has passed all security standards. Data do not contain patient identifiable information such as the patient's name.
 8. 2015/16 Enhanced Tariff Option spreadsheet. NHS England. March 23 2016 [cited August 2016]. 20p. Publications Gateway Reference 03237. P4, line 613 Non-Trauma, Category 1, without CC Available from: <https://www.england.nhs.uk/wp-content/uploads/2015/03/2015-16-eto-spreadsheet.xlsx>
 9. Findlay R. It is unlikely the 18 week target will ever be achieved again. HSJ [Internet]. 2016 June 9 [cited August 2016]; Under Quality and Performance [About 9 screens]. Available from: <http://www.hsj.co.uk/topics/quality-and-performance/it-is-unlikely-the-18-week-target-will-ever-be-achieved-again/7005466.article>
 10. NHS hospital stay. Data.gov.uk. May 27 2015 [cited August 2016]. Available from: <https://data.gov.uk/data-request/nhs-hospital-stay>



A powerful model for population management

Attempts to improve quality and contain costs in the NHS have often meant restructuring the delivery of care. Through the new care models programme, a key element within the *Five Year Forward View*, complete redesigns of whole health and care systems are being considered.

These new care model vanguards involve a partnership between numerous NHS organisations. Integrating more services will be key to the success of these new models, which will be delivered via the sustainability and transformation plans. The models are expected to help close the health and wellbeing, care and quality, and finance and efficiency gaps that currently exist.

But these new models have yet to be tested and evaluated before we know if any of them are truly transformational and sustainable. It could be five years before we are able to say which models improve care, contain costs, boost productivity and are acceptable to patients. And yet the NHS needs to do something now to tackle the huge deficits, increase efficiency, and improve health outcomes.

One model that can increase efficiency now and is amassing robust data is clinical care in the home. The independently analysed data that are the focus of this report show how clinical care in the home can deliver high-quality care and release capacity in the acute sector.

By pooling data from four English trusts, gathered over nearly four years, a 9,000-patient virtual ward was created. We can finally see, at scale, how clinical care in the home appropriately shifts care from the more expensive acute setting into a less expensive and, for patients, a more acceptable locus – their homes. These data show that this can be achieved without compromising care, while releasing capacity and making savings.

After years of instinctively knowing that providing clinical care in the home alleviated pressure on the acute sector, this is the first time this volume of data has been made available. For Healthcare at Home, these findings are validation of our claims that, at scale, clinical care in the home can be a powerful model for population management. The findings are further supported by the experiences of trusts detailed elsewhere in this report.

Where the *Five Year Forward View* provided the vision of the future NHS and the more prescriptive Carter Report¹ listed the tactics to create the model hospital, the data from our virtual ward suggest clinical care in the home may be a key tool in transforming services.

The findings also suggest that quality and clinical excellence are assured. With no increase in bounceback to hospital of the patients cared for on the virtual ward, clinicians and patients can begin to see clinical care in the home as an extension of the NHS, a gold standard service.

The data analysed were routinely available and while they provide valuable insights they only measure a small part of what we must understand if clinical care in the home is to help improve patient experience and reduce costs.

At Healthcare at Home, we are committed to using data to be able to measure all aspects of the patient journey. This would begin by double-checking that services are safe by, for example, looking at incidences of pressure sores, surgical site infections or venous thromboembolisms. We would then like to understand how clinical care in the home can activate patients to help them take control of their own health.

For people with long-term conditions we want to be able to understand the wider effects on their health and

wellness: does clinical care in the home lead to re-ablement, increase the likelihood of a return to work, and give them the best opportunity to live a productive and fulfilling life?

“This needs to be scaled up from single trusts”

The question of whether clinical care in the home can reduce deficits and improve efficiency remains. We believe these data show that at scale there is potential for cost savings, increased capacity and, therefore, deficit reduction. But to achieve that, clinical care in the home needs to be scaled up from single trusts to region-wide schemes that get people home faster and prevent them coming into hospital via A&E. To do this the NHS will have to work in partnership with counterparts in local social and community care, as well as with private providers.

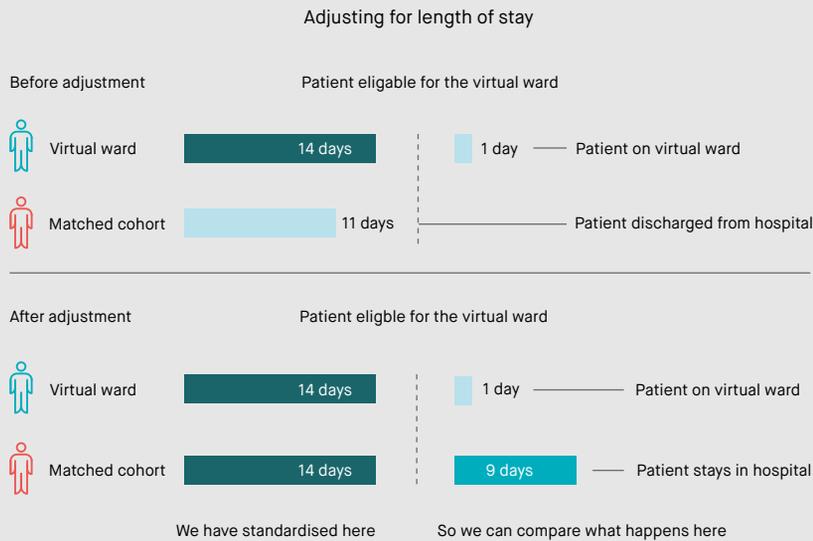
We will have to be bold and manage patients and populations, rather than the service. We need to look at discrete areas of care that have a high impact on A&E. The NHS must make full use of technology, remote care bureaux and telemedicine units to triage patients in the community whose health may be breaking down, catching problems early, thus avoiding unnecessary admissions. This is the way the NHS can avoid admissions at scale, not trust by trust but by region.

Dr James Featherstone is Chief Operating Officer of Healthcare at Home.

1. Lord Carter of Coles. Operational productivity and performance in English NHS acute hospitals: Unwarranted variations. Department of Health, February 5 2016



Research methodology



In order to compare like for like, patients in the matched cohort had to have a minimum length of stay that matched the inpatient length of stay of the patients on the virtual ward.

QUALITY OF CARE

The researchers used unplanned readmissions as a proxy for quality to ensure that any benefit observed in length of stay wasn't contradicted by a detrimental effect on the rate of bouncebacks. They found that while more patients on the virtual ward were readmitted to hospital than patients in the matched national cohort, when they took into account the age, sex, deprivation group, admission method, HRG and original length of stay for each patient, there was no statistically significant difference in the rate of emergency readmissions between the two groups.

MEASURING UNPLANNED READMISSIONS

Patients on the virtual ward had a readmission rate of 15.9 per cent and the readmission rate for the matched cohort was 12.8 per cent. This difference is not statistically significant; that is to say that both fall within the same margin of error.

ADJUSTING FOR LENGTH OF STAY

MedeAnalytics also found that patients on the virtual wards had spent longer time under the care of the hospital, either in a hospital bed or on the virtual ward. The researchers gave four possible reasons for this:

1. The virtual ward patients had complex health conditions so were expected to be in hospital longer than the control group.
2. The longer hospital stays may be a "real effect" e.g. case finders looked for more complex patients to move to the virtual ward or an "artifact" i.e. by chance these patients, in the period measured, happened to be more complex.

3. The intervention and the consequences of it did not affect what happened to the patients for their time in hospital leading up to it e.g. patients on the virtual ward may have, by chance, waited longer than the matched group for in-hospital diagnostics, such as an MRI scans, before being transferred home.
4. Patients in the control group may have also been on some kind of other early supported discharge scheme, but it was not possible to assess this.

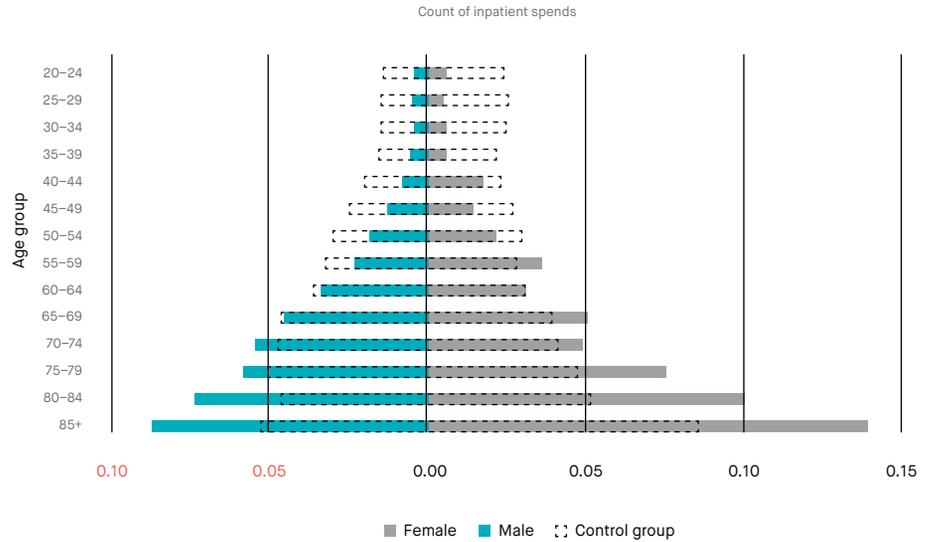
But in order to test the hypothesis – that being on a virtual ward has an effect on length of hospital stay – the researchers needed to account for this difference and therefore adjust for this discrepancy in length of stay.

The graphic above illustrates how the researchers adjusted for the longer stay in hospital. For full methodology please see <https://www.hah.co.uk/no-place-like-home>

CHARACTERISTICS OF PATIENTS ON THE VIRTUAL WARD

As a group, there were more, older patients on the virtual wards than in the national cohort. That is, MedeAnalytics was able to match more patients from the HES data to younger patients on the virtual wards than they could to the eldest patients.

Figure 1. Age/sex profile of patients on the virtual ward compared with the control group

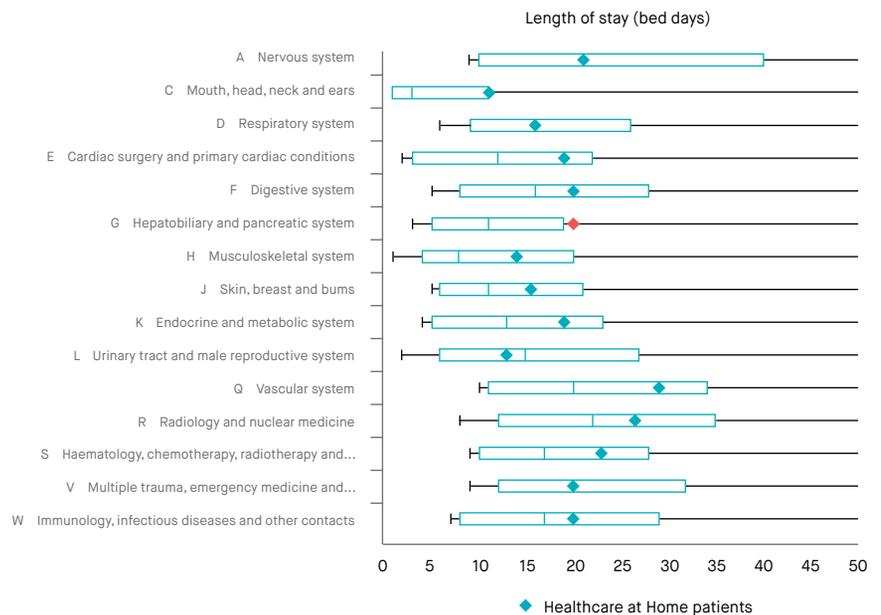


DO VIRTUAL WARDS HAVE A BIGGER IMPACT ON CERTAIN GROUPS OF PATIENTS?

The researchers looked at different disease groups (HRGs) to see if patients in some groups were more likely to benefit than others from being cared for on a virtual ward. Figure 2 shows which groups had shorter length of stays than others using the data from the virtual wards. The rectangles represent the control group data and show the average range of days patients spent in hospital. The bars represent the outliers, either people with a notably short or long length of stay. The diamond is the length of stay for patients on the virtual wards. The closer to the left the diamond is, the more effect the intervention has had.

For the four trusts, being on a virtual ward was particularly effective for respiratory system, urinary tract, and nervous system conditions.

Figure 2. Length of stay on the virtual ward by condition, comparing patients on virtual wards with the control group



Healthcare at Home is currently investigating why there is a longer than expected length of stay for hepatobiliary and pancreatic system patients



Innovative services in the home shift location of care

Patient demand helps to drive the rise in clinical care in the home but trusts recognise other advantages of shifting care out of hospital



USEFUL INFORMATION

COMMON FEATURES OF CLINICAL CARE IN THE HOME SERVICES

- > Patients at home are still the responsibility of the hospital consultant or multidisciplinary team who cared for them while they were an inpatient.
- > Clinical care in the home services often have a 'bed bureau' team at the acute trust, who actively case find and assess patients on the ward who are referred for transfer home.
- > Nurses and therapists providing care in the home update hospital-based colleagues on patients' status in almost real time.
- > Consultants use technology to manage patients via 'virtual ward rounds'.



AT A GLANCE

SOME OF THE SERVICES COMMONLY OFFERED

- > Post-op physiotherapy and occupational therapy
- > At-home chemotherapy
- > IV antibiotics
- > Negative pressure therapy dressings
- > Oesophageal stent
- > Pre-op anticoagulation
- > Pre-chemo bloods
- > Bridging care
- > Discharge to assess
- > Enteral feeding
- > Palliative support/end of life care
- > Catheter management

The Christie is the largest single-site cancer centre in Europe, covering a wide geographical area and treating more than 44,000 patients a year. For some of them, being able to get treatment at this premier cancer centre means a long journey, usually by car, often for care that can be safely delivered in a far more convenient location.

Responding to patients' requests to receive care closer to their homes, The Christie has been moving services into the community. There is a mobile chemotherapy unit that operates on five sites in the north-west; nurse-led and peripheral clinics at other hospitals throughout the region; and in April 2016 it started to offer treatment in patients' homes through The Christie @ home.

Patients all over Greater Manchester and parts of Cheshire can now receive some types of treatments by injection for metastatic breast cancer in their homes. The Christie has plans to expand the service.

"We're flexible, responsive and used to working with multiple providers and commissioners"

While patients are universally enthusiastic about staying out of hospital, patient preference and convenience are not the only

considerations for the many trusts that are exploring the value of clinical care in the home.

A ROUND-THE-CLOCK RESPONSE

In north London, the Central and North West London NHS Foundation Trust, a community trust that cares for about three million people, has introduced a popular and successful rapid access service that aims to keep people out of hospital and help inpatients get home faster.

Graeme Caul, Camden borough director, who oversees the service, says: "There is a place for acute hospitals – we'll always need them for those acutely unwell. But if we can manage demand, trying different models, then that's a positive thing. It is what patients tell us they want."

The team works with University College Hospitals and the Royal Free Hospital in London to provide early discharge support. Members of the rapid response team work with ward teams to ensure prompt referrals to the service. The service also works in the community to avoid admissions, especially those through A&E.

"If a GP has used us they will tell others and through word of mouth people learn about the service and try it," says Caul. The range of services the team can help with is broad and it can manage complex interventions in the community. Support is usually intensive and short-term, up to ten days, but rehab for people who have become deconditioned by long stays in hospital and neurological problems can last for up to six weeks.



The team, which brought together existing rapid response, rapid early discharge and hospital-at-home services, was originally established using winter pressures money to respond to demand in the system. It was so successful it has been mainstreamed. It is now a round-the-clock service, expanded from the original Monday to Friday, 9am to 5pm, service. The service has a capacity to care for more than 40 patients per day depending on case mix.

“It’s what patients tell us they want”

“We’d like to develop the service more; we could do a lot more as a trusted partner of the local hospital by putting our staff in hospital to find cases and navigate,” says Caul.

A CHANGE IN ETHOS

In Cheshire, the Countess of Chester Hospital’s rapid response team has also expanded from what was initially a five-day, 9am–5pm service; it now operates seven days a week from 8am–9pm, supporting patients with increasingly complex needs, offering packages of care up to four times a day. Expansion has been driven by patient feedback, demands placed on the hospital, demands placed on the service, delays in social care packages, and a change in ethos in line with the discharge to assess model.

Graeme Lambert, rapid response therapy team leader at the Countess of Chester, explains that the team adopted the discharge to assess model, cited as best practice by NHS England, to ensure that where possible, patients are moved into the right setting so that ongoing

assessments of their needs can take place.

The team’s goal is to get a patient home with appropriate support and for assessments that would have normally taken place in a hospital setting to now take place at home, in the patients’ normal environment. Lambert says: “This makes assessments more meaningful and specific to the patient, ultimately improving patient outcomes and the patient experience.”

SLOWING EMERGENCY ADMISSIONS

The popularity of these kinds of services rests on many factors. In Leeds the interface geriatrician service has developed services to avoid unnecessary hospital admissions by triaging and assessing patients in A&E and by actively seeking patients at risk of hospital admissions in the community.

The acute trust, Leeds Teaching Hospitals NHS Trust, has noted a slowdown in growth in emergency admissions for older people in Leeds since the interface began. However, this reduction in emergency admissions has not yet translated into financial savings. This is most likely because the interface service has actively looked for frail elderly in the community who would benefit from intervention in their homes and so caseload has increased. Nevertheless, local commissioners have continued to fund the service, recognising the importance of its impact on quality of care.

Dr Eileen Burns, consultant in care of the elderly, says it is the sustainability and transformation plans that should be taking on this model of care. In Birmingham, Andrew McKirgan, director of partnerships at the Queen Elizabeth Hospital Birmingham (QEHB), would like to see virtual wards and clinical care in the home

implemented as part of sustainability and transformation plans.

QEHB’s virtual ward was set up as a pilot three years ago with Healthcare at Home delivering clinical care in patients’ homes while the hospital retains clinical responsibility. The patients are predominantly stable patients referred from medical, neurology, ENT and oncology wards. On an average day, the virtual ward has 26 to 30 patients.

McKirgan says: “The service was set up at a time when it was felt the community trust wasn’t able to deliver the home-based services the trust needed across Birmingham. There was a lack of consistency across the city in the delivery of clinical home healthcare. The Healthcare at Home model was almost a parallel service set up to meet a need but there is an expectation that the sustainability and transformation plan will develop a city-wide service that would remove the need for other services.”

FILLING A GAP

Lack of appropriate community services was also one of the factors which drove the creation of a paediatric Healthcare at Home service for King’s College Hospital NHS Foundation Trust in London. The existing community nursing team could not provide the clinical care the trust wanted, so it turned to Healthcare at Home.

Dr Omowunmi Akindolie, consultant in ambulatory paediatrics at King’s, says: “The initial intention was to expand the existing children’s community nursing team. However, for many reasons, that was not a feasible option, at that time. Healthcare at Home already provided adult clinical care in the home and we were, therefore, able to establish the paediatric service in collaboration with them quite quickly.”

The Countess of Chester Hospital also established its rapid response team partly as a response to inadequacies in community provision, especially social care. Dr Frank Joseph, clinical director for urgent care services at the Countess of Chester Hospital, says: “To make this kind of service work, you need to work in partnership with the clinical commissioning group, social services and community providers.”



Safety, outcomes and the patient experience: governance and regulation

Clinical governance is the responsibility of the organisations commissioning care, providing care and the staff working in them. The national regulator of healthcare services, the Care Quality Commission (CQC), when it inspects a hospital, GP practice or a private provider of care, will consider clinical governance, among other things, when it is deliberating on the service.

In situations where an acute NHS trust works with a private provider to introduce services that offer clinical care in the home, the two organisations will likely co-create protocols and pathways specific to the service being introduced. Usually the organisation providing care in the home will conform to the clinical governance standards of the provider trust as well as applying their own evidenced-based standards as the expert in homecare. It is important to recognise that offering clinical care in the home is a joint endeavour and one in which clinicians have the safety of patients uppermost in their minds, alongside ensuring patients' experience of care is first class and the expected clinical outcomes are achieved.

The NHS trust commissioning the care and the referring clinician retain clinical responsibility for the care that is provided to all of their patients. This applies to patients irrespective of whether that care is provided on NHS trust premises or at an alternative location, for example at the patient's place of residence. Equally, when managers of NHS trusts are considering

the level of care that is provided to patients, these 'remote' patients should be remembered and considered in all decisions that are taken.

Joint working is a hallmark of delivery of clinical care in the home and so is its clinical governance, with regular governance meetings between hospital-based and home-based staff that look at the efficacy, clinical quality, patient experience and patient safety of the service, jointly agreed standards, and clear escalation policies: both the trust and the clinical homecare provider would jointly investigate any complaints or incidents.

When inspected by the CQC, the provision of clinical care in the home will be reviewed as part of the acute trust's inspection but, importantly, the provider of the home service, if not part of the trust, will be inspected in its own right by the CQC.

The CQC is currently developing a set of national standards for acute homecare services that it expects to have ready for discussion early in 2017. In the absence of national standards, best practice for any provider of clinical homecare is to integrate the hospital's clinical governance standards and work towards key performance indicators operational at site level.

The Royal Pharmaceutical Society has already produced and published professional standards for the distribution of medicines to the home, which includes key performance indicators.^{1,2}



IN PRACTICE

HEALTHCARE AT HOME'S CLINICAL GOVERNANCE

Healthcare at Home develops, in partnership with acute trusts, service models that are jointly clinically governed and which are designed to safeguard patient safety. Services are subject to anywhere up to three months integration work, testing that the protocols, pathways, and all clinical processes work in practice, before patients are cared for in their homes. Usually, we start with small numbers of patients, ramping up the numbers we care for slowly.

Over the past two years, we have been working with our NHS partners to develop a set of clinical key performance indicators to understand and demonstrate what a good clinical home care service ought to look like. Our initial approach is to look at what is being measured already against the five Care Quality Commission (CQC) domains – namely, are services safe, effective, caring, responsive to patients' needs and well-led – to assess what would be a meaningful clinical key performance indicator.

There are some challenges in getting these indicators right. For example, using pressure sores as a measure could be sensitive. There may be a worry if the number is too low that incidents are not being reported or if they were too high that there was a problem.

Creating and agreeing a set of clinical performance indicators for clinical care in the home is important to ensure that there is trust and understanding in how the sector is regulated.

Professor Sir Jonathan Asbridge is Clinical Director of Healthcare at Home.

The CQC, the Medicines & Healthcare products Regulatory Agency (MHRA), and the General Pharmaceutical Council (GPhC), and their equivalents in Scotland, Wales and Northern Ireland, regulate Healthcare at Home, which adheres to all clinical standards expected of a healthcare provider.

1. Royal Pharmaceutical Society, Handbook for Homecare Services in England, May 2014. Available from: <http://www.rpharms.com/support-pdfs/homecare-services-handbook.pdf>

2. Royal Pharmaceutical Society, Professional Standards for Homecare Services in England, September 2013. Available from: <http://www.rpharms.com/support-pdfs/homecare-standards-final-sept-13.pdf>



Releasing capacity in acute trusts

Clinical care in the home can increase capacity, enabling the treatment of more patients, and manage increasing demand

Since University Hospital Southampton started using clinical care in the home in 2010, the service has saved 17,793 bed nights. This release of capacity and increased efficiency in patient flow has enabled the hospital to become a major trauma centre.

Consultant medical microbiologist Dr Graeme Jones is responsible for long-term intravenous antibiotic therapy orthopaedic surgery patients receive at home. "For this hospital, the service is a massive advantage," he says. "Beds are very tight in orthopaedics and patients are dotted around the hospital because there aren't enough beds. The clinical homecare service increases our capacity. We have the same footprint but can do more work and it makes us more efficient."

Dr Jones also says that the service makes financial sense: "We buy the services from Healthcare at Home but we are paid to treat the patient's infection and so use that money to pay Healthcare at Home while at the same time using the bed that the patient would have used for another patient, for whom we also get paid. "Most hospitals are struggling and this service improves waiting times, increases our efficiency and enables us to use our capacity to maximum benefit."

At the Countess of Chester Hospital, the home care service takes care of 50 patients on an average day, two-thirds of whom need a package of care that includes personal care, medicines and therapy, and all are on a virtual ward with the hospital. Dr Frank Joseph, director of urgent care at the hospital, says: "By working on both admissions avoidance and early discharge, we have improved patient flow, which creates capacity and means we have beds available for the right patients."

"Over winter everywhere struggles. The good news for us is that if you

compare us to local acute trusts, while we don't always meet our targets, we do better than others locally and our patient flow is better."

Not all acute trusts have been able to quantify the financial or capacity advantages of clinical care in the home, although they are convinced it is beneficial. Andrew McKirgan, director of partnerships at the Queen Elizabeth Hospital Birmingham, says it has been difficult to assess if a clinical care in the home service saves money:

"For this hospital, the service is a massive advantage"

"We've tried to quantify the system but the numbers are too small. Against our overall activity, the figure is tiny and if you look nationally, it's very hard to find a clear evidence base. But intuitively we know it's the right thing to do."

For The Christie, the Manchester-based specialist cancer centre, moving services closer to patients' homes is part of planning for the future. Jackie Wrench, head of systemic anti-cancer therapy services, says: "As a hospital, The Christie knows demand on its services will grow and we've looked at how to accommodate it, especially for patients who cannot be treated at home."

The Christie @ Home has not, as yet, increased capacity. Some patients on the scheme had been receiving clinical care in the home through another provider; others were attending either the Christie, peripheral clinics or nurse-led clinics, so currently the at-home service is

£837,000
saved from
January to May
2016 by the
Countess of
Chester Hospital

about improving the patient experience and pathway.

Like The Christie, King's College Hospital provides tertiary services but it is also a local hospital for its neighbourhood in south London, providing typical district general hospital services. Megan Beardsmore-Rust, service manager at King's, says the ambulatory paediatric service, which includes a Healthcare at Home service, increases capacity, enabling the trust to treat local patients and tertiary referrals. Clinical care in the home has also alleviated pressure and improved flow throughout the service, including A&E. King's has managed to reduce by 97 per cent the number of children being 'treated and transferred' to another hospital due to lack of capacity.

Dr Omowunmi Akindolie, consultant in ambulatory paediatrics, says King's is "a busy acute hospital and virtual capacity enables us to undertake more inpatient work whilst optimising efficiency."

Ms Beardsmore-Rust adds: "It enables us to treat specialist patients without compromising the care of local patients. It works clinically, too, because we're not exposing patients to risks inherent in a hospital stay."

KING'S COLLEGE HOSPITAL: FIRST YEAR OF SERVICE, APRIL 2014 TO APRIL 2015

- > 97 per cent reduction in children being 'treated and transferred' to another hospital due to lack of capacity, compared with the same period the preceding year
- > 33 per cent reduction in paediatric emergency department four-hour target breaches
- > 37 per cent reduction in paediatric elective surgery cancellations



Transfers home delight hospital patients

Being in hospital is hard work if you're a patient. That's why more and more patients are happy to receive high-quality care in their homes while still being under the supervision of their hospital consultants

Describing his experience, Ewen Steel, says: "In the first week I was in hospital, I had about six hours sleep." The 57-year-old train driver from Nether Wallop, says: "It's impossible to sleep on a ward. New patients can arrive at any time of day or night."

Samuel Johnston says: "Last time I was in hospital I was in there for six weeks. I couldn't handle it. I was going crazy."

Barry Roberts agrees: "They keep you awake through the night in hospital, marching up and down. Those nurses have a lot to do, God bless them, but I'm much better off at home."

These three patients were all transferred from busy hospital wards to a virtual ward, where they continued to receive treatment under the care of their hospitals, but in the familiar surroundings of home. Johnston and Roberts received care for serious wounds; Steel received a long-term course of intravenous antibiotics.

All three men's delight at being home to complete their care is typical of patients who receive clinical care in the home. From being able to sleep in their own bed to getting back to a more normal routine, they prefer being in their own environment, with nurses or therapists visiting regularly and their hospital consultant watching over them from a distance.

Beyond the gratitude of simply being out of hospital, many patients say being with their family is very important. Roberts was glad to be home to be able to support his wife of 60 years. Another patient, Ron Baynham from Sutton Coldfield, says: "Being at home means your family can easily see you. I have five grown-up children and they can visit whenever they like."



The reasons why patients need care vary. In Steel's case, his health problems began with a hip replacement in 2013 that was troublesome from the start. By mid-2015, his problems had increased and exploratory surgery in Southampton uncovered infection in the joint. His artificial hip was removed and an antibiotic-impregnated spacer inserted. This is standard procedure when artificial joints are being revised, with intravenous antibiotic therapy to treat the infection.

Because of the availability of a clinical care at home service, Steel was able to go home and complete his course of antibiotics there. He says, "I was thrilled to get home. As soon as I got home I slept and ate better."

NURSES AND PATIENTS: POSITIVE RELATIONSHIPS

For many patients, the continuity and one-to-one nature of the relationship between them and the nurses who visit them is critical. Natalie Webster says the nurses who cared for her baby, Arthur Fliegner, when he had meningitis took the trouble to include his older brother, Claude, who was a toddler at the time. Arthur was two weeks old when he was transferred back home from King's College to finish his course of antibiotics, and Webster says the nurses' interactions with the whole family made the treatment process relaxed.

Johnston agrees: "I like the one-to-one. And they are all so professional. You can't knock them – they know their job!" Steel reports that the nurses who attend him every day have offered both clinical and emotional support: "I'm pretty useless at the moment – just the one leg and two crutches," he jokes, highlighting the importance of high-quality therapeutic interventions.





From 0 to 80: clinical care in the home for all ages

From newborn baby Arthur to 80-year-old former plumber Ron, these stories show that clinical homecare packages can suit every generation's needs

Clinical care in the home can work whatever age the patient is. From babies to octogenarians, services can be delivered that give patients the convenience and comfort of being at home, while still under the watchful eye of their hospital.

Ron Baynham, an 80-year-old former plumber from Four Oaks, Sutton Coldfield, fell ill three years ago during his diamond wedding anniversary celebrations. He was eventually diagnosed with restrictions in his bile duct, causing liver problems that have led to jaundice and repeated infections. The infections have needed repeated long stays in hospital for antibiotic treatment.

In the spring of 2016, he was referred to Queen Elizabeth Hospital Birmingham's Healthcare at Home service. He says: "I'd been in hospital for five weeks receiving antibiotics. When they suggested I could go home and be cared for there, I was relieved. I'd had enough."

"The quality of the care I receive is exceptional, superb"

Barry Roberts, patient, North Middlesex

The homecare nurses visited him three times a day and he describes them as "wonderful". Baynham, who ran his own business for 65 years until he retired 16 years ago, says that while three visits a day may seem restrictive he's been able to get on with his life around the nurses' appointments. Plus, he says, "You've got your own bed."

ARTHUR'S STORY

At the other end of the age spectrum, Arthur Fliegner's referral to King's College Hospital's Healthcare at Home service occurred when he was two weeks old. At eight days old, he had developed bacterial meningitis caused by a group B streptococcal infection and was admitted to King's via A&E. From there he was rushed to the high dependency unit.

Despite being very ill, Arthur responded well to treatment. So well, in fact, that his consultant suggested he be taken home and receive his three

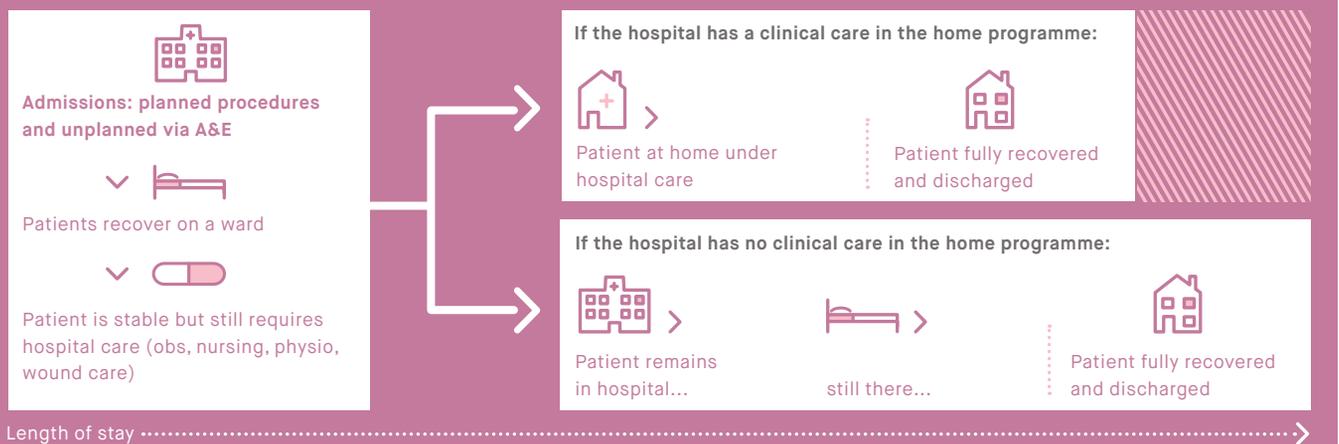
daily doses of IV antibiotic there. Mum Natalie Webster and dad Simon were delighted with the idea because even though they only live ten minutes from the hospital, Arthur's older brother, Claude, was a toddler at the time and family life was becoming complicated.

"It was a difficult time for us and not easy to manage," says Webster. "We wanted to be at home to get used to having a new baby and making our family situation work."

Being back home made the experience of having a sick baby much less stressful for her.

"For us the service was fantastic. I had no fears in terms of how Arthur was recovering and definitely felt like he was being fully monitored," says Webster, also praising the nurses and saying they "could not have been better", with Claude as well as Arthur. Arthur was discharged from follow-up at King's at 14 months with no evidence of any long-lasting effects from his meningitis.

PATIENT PATHWAY





New ways of working for clinical staff

Clinicians have embraced the opportunity to transfer medically stable patients to their own homes, recognising the benefits to patients and their own clinical practice

Dr Omowunmi Akindolie, a consultant in ambulatory paediatrics, took on her job at King's College Hospital NHS Foundation Trust specifically to realise the vision of delivering an ambulatory paediatric health service. She was convinced of the value of moving care out of hospital and closer to home, even for the very young.

Dr Akindolie, a consultant in ambulatory paediatrics, says: "Children can demonstrate remarkable resilience in terms of how they recover from illness. In hospital, a significant cohort are clinically stable but have some aspects of



their treatment which traditional models of care deem necessary to be delivered in a hospital setting. With redesign of the service, a significant proportion of these children can now safely have their care delivered at home or in their school. This has numerous, remarkable benefits for them in terms of restoring normality to family life and facilitating parents' returning to work. The Trust benefits from the increased efficiency of use of inpatient beds for children who can only be cared for in a hospital setting."

In April 2014, working with Healthcare at Home, King's introduced the first children's service of its kind; a consultant-led, nurse-delivered model of acute paediatric care in patients' homes. Dr Akindolie says: "We work to ensure there is parity between inpatients and those at home in terms of clinical input. All patients in the service are part of the ward round, albeit virtually, and the Healthcare at Home nurses maintain a highly visible presence on the inpatient wards. The service has overwhelmingly

positive feedback and that's the ultimate aim."

A key feature of successful clinical care in the home services is the integration between the service and the acute hospital teams. Typically, patients on a virtual ward are discussed in the daily multidisciplinary team meeting in the hospital and the hospital team is updated almost in real time by staff in the field.

"Overwhelmingly positive feedback"

In London, the North Middlesex University Hospital began working with Healthcare at Home in the winter of 2015 to offer a virtual ward service, with the goal of reducing the time patients stayed in the hospital. The service operates a fully integrated patient management model, in which Healthcare at Home nurses attend the RAG (Red Amber Green) handover meetings on the wards and together both teams identify who could potentially benefit from the service.

As experience with and news about the service has spread, more and more wards are using it to get patients home sooner than has been possible before. But originally, both patients and consultants had to be convinced about the service. Matron Sarah Mitchell says: "The consultants had to be happy as they are still responsible for the patient. And patients think, 'I'm unwell, I should be in hospital'. But once the physicians took on board the benefits they were able to reassure the patients."

As use of the service has increased, more and more patients are being referred from a range of wards including care of the elderly, surgery, and general medical.

At King's College Hospital in London a lot of work has been done to instil confidence in clinicians around the ambulatory paediatric service.

"It can be difficult to convince a doctor that, until recently, a patient receiving 24-hour care on a ward is able to go home. You have to reassure them that the patient will be safe at home and of the skills of the nurses who will be providing care," says Megan Beardsmore-Rust, service manager at King's. Despite a 100 per cent patient satisfaction rate, not all departments will refer and Ms Beardsmore-Rust says that for some complex paediatric patients under the care of multidisciplinary teams, the logistics of involving all members in the virtual ward round preclude patient referral. There is steady change noted in this pattern, though. As the service is becoming more embedded, the referral criteria are being reviewed and expanded on a regular basis.

The Countess of Chester Hospital's at-home services have been running longer than either King's or North Middlesex's. They have expanded considerably due to both demand and popularity with patients and clinicians. Dr Frank Joseph, clinical director for urgent care services at the hospital, says that when the service began four years ago, it started with the easiest patients. But this has radically changed. Now patients often have more than one issue to address.

Graeme Lambert, rapid response therapy team leader, says: "There may be both acute and chronic medical issues, which can impact on the way in which a patient presents functionally at home. In response to this, the team has expanded to cater for more complex patients and this has been possible because of the knowledge, skills and adaptability within the team that truly allows us to manage complex patients."

The team handles everything but end of life care and in the spring of 2016 it took on the respiratory early supported

97%

reduction in King's College Hospital's children being 'treated and transferred' to another hospital due to lack of capacity, compared with the same period the preceding year.





discharge team. Dr Joseph gives pneumonia as a good example of the expansion and maturity of the service.

"We know an elderly person needs more support and so we combine care and medical services in the rapid response care package," he says.

In Leeds, Dr Eileen Burns, consultant in care of the elderly, has been working



with colleagues at both the Leeds Teaching Hospitals NHS Trust and Leeds Community Healthcare NHS

Trust since 2012 to provide services beyond core acute work. This has involved geriatricians working across secondary, primary and community care settings and the goal of the Leeds interface geriatrician service is to keep elderly patients out of hospital.

Dr Burns says: "The challenge is to identify who in the community needs the support. Once these patients are identified they are then seen by geriatricians in their homes. This bit is new and is different work for a geriatrician.

"In hospital the focus is given to symptoms but in the home we have to interpret the care record and find out what the patient wants. This is a change from the usual way of working where the patient presents and the complaint is clear; at home it's not so obvious and that needs another mindset."

Dr Joseph agrees that clinical care in the home has changed the way clinicians think. "We used to wait until a patient was well enough to get up and walk out of the door, but that's changed. With older patients, the longer we keep them the less likely they will be to walk. Now we work to stabilise them and then send them home, where they are better off. It's a change in mindset."

Dr Joseph found that at the start of the project there was some rigidity among team members from different professions and the work they did. But the nature of a rapid response service means team members have to respond to the demand where it's located, and demand for the Countess of Chester Hospital's service is high. His colleague Maria Woodward, who is the rapid response nursing team leader, adds that the team created a skills and competency framework based on core assessment

33%

reduction in King's College Hospital's paediatric emergency department four-hour target breaches

skills, and this has helped to ensure that all members of staff are equipped to provide a holistic assessment of a patient's needs, both in an inpatient and community setting.

Woodward says: "There is still the need for the more specialist interventions specific to each specialty, which the team still provides, with staff movement being fluid throughout the team to ensure optimum use of resources."

"We don't shoehorn staff into a particular role. It's about cross fertilisation of skills; never just about the job but the skills and competencies of the individual," says Dr Joseph.

Dr Burns adds: "The biggest challenges are cultural. People are used to working in the way they've always worked and it's challenging to work in a different way.

"The other challenge was that although our clinical managers in the CCGs understood the need for secondary care physicians to work in the community, some people who were interested in how the money flows struggled to understand how the financial flows could support that way of working. We are stretching across boundaries as well as doing the traditional geriatrician role in hospital."

In Chester, members of the rapid response team are based both in A&E and on wards. In A&E they assess and treat the walking wounded, frail elderly, and chronic obstructive pulmonary disease patients having an exacerbation who are referred to them by A&E clinicians. They screen them and if medically suitable the goal is to return them home within 48 hours, avoiding admission to an acute ward.

On the wards, members of the team, usually the nurses, work with ward-based multidisciplinary teams actively looking for medically stable patients who can be sent home with the support of the rapid response team.

"It's medicine plus therapy plus care. Trying to have a team that offers all three is what makes you effective," says Dr Joseph. "The hospital setting is not necessarily the best for a patient. Getting them home and supporting their normal routine means they flourish."

For some clinicians the opportunity to provide care in a patient's home, without the pressures associated with

a busy ward, makes the work attractive. Laura Cox, one of The Christie @ home chemotherapy nurses, says: "It's a privilege to go into someone's home. Patients are more relaxed and you see the bigger picture of their life. You can listen to your patient with no distractions. You may also pick up on what other services they might need."

Dr Burns agrees: "We're really able to identify a person's wishes and record it in their plan so that other professionals know them too."

Dr Graeme Jones, consultant medical microbiologist at University Hospital Southampton, oversees long-term antibiotic treatment of orthopaedic surgery patients in their home delivered by Healthcare at Home nurses. He notes the emotional as well as medical support the service offers.

"People are used to working in the way they've always worked and it's challenging"

"Depression is associated with recovery from major orthopaedic surgery but the Healthcare at Home nurses go in daily and build up a rapport with patients," he says. "Giving people the ability to go home is so much better all round." Previously, they would have had to stay in hospital for up to three months, something Dr Jones describes as "purgatory."

The quality of care offered at home does not differ from that in hospital. Analysis of the paediatric ambulatory service at King's shows that while it is still a new service, it has delivered "exemplary clinical care" according to an analysis published in the peer-reviewed journal, Archives of Diseases in Childhood in 2015. Cox says when working off-site she is still in contact with her colleagues and the hospital team: "You have to use your clinical judgement and if you aren't 100 per cent sure about something you check with your colleagues."



Transformation and sustainability for the NHS

Clinical homecare is about transforming the way we care for patients, moving beyond traditional models and pathways to give patients a choice, as well as an improved experience.

The potential of clinical homecare to release savings and capacity within an overburdened system must no longer be overlooked. The research on pages 5–9 shows that virtual wards could yield 62,040 bed days or £120m a year, which is 21 per cent of the of the provider deficit predicted for 2016/17 for the NHS in England. And this is just the tip of the iceberg. If the health system adopted clinical homecare at scale, as part of its plans to transform the NHS to make it more sustainable, then the system-wide savings would be significant.

In this report, we have heard of a trust that discharges the equivalent of almost 2.5 wards a week, thanks to its use of clinical homecare; and another that has reduced its 'treat and transfer' rate by 97 per cent.

Until now, it has been hard to find (or produce) the data to build and support the case for clinical care at home, when anyone who provides such care in patients' homes knows instinctively the difference it makes to patients and the NHS.

People with experience of clinical care provided on a virtual ward or in a patient's home know it is clinically equal to that provided in hospital. However, it is only now, thanks to the 24 clinicians and patients interviewed, the 12 members of the expert panel (who have been with this project for 18 months), the four trusts who provided the raw data, the eight trusts who shared their lived experiences, the analyst team at MedeAnalytics, and the 9,000-plus patients who were benchmarked against

4.2 million NHS records, that we can move beyond anecdote, and start to see the transformative power clinical homecare could have.

What the evidence tells us is this: if high-quality care and a high-quality patient experience is achieved, then so too will strong clinical and financial outcomes. To scale these kinds of services requires greater integration between health and social care, greater cooperation between providers and commissioners, and greater support and trust between local and national NHS than currently exists. Data now show categorically that significant savings can be made by using clinical homecare across the system.

If the NHS is to derive the full benefits of clinical homecare, it is vital that all of us who strive to provide the best possible care and outcomes for patients, consider how the evidence in this report can be used to kickstart local, regional and national plans to increase the use of clinical homecare.

To my colleagues in this sector, I would say this: as an industry, we need to provide more evidence like this, and we have an obligation to make this available to commissioners, providers and researchers so that we can demonstrate to everyone – from payers to patients – the value that the clinical homecare industry can offer.

“If high-quality care and a high-quality patient experience is achieved, then so too will strong clinical and financial outcomes”

Natalie Douglas is Chief Executive Officer of Healthcare at Home.

Acknowledgments

The trusts who kindly shared their stories with the expert panel for this report are: Central and North West London NHS Foundation Trust, The Christie NHS Foundation Trust, The Countess of Chester Hospital NHS Foundation Trust, King's College Hospital NHS Foundation Trust, Leeds Teaching Hospitals NHS Trust, North Middlesex University Hospital NHS Trust, Queen Elizabeth Hospital Birmingham, University Hospital Southampton NHS Foundation Trust.

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Paul Molyneux,
 Head of Analytics, EMEA
Professor Simon Jones,
 Chief Data Scientist
Mark Davies,
 Medical Director

MedeAnalytics is a population health analytics platform, designed to look at care across an entire local health economy. Its unique approach allows the relationship between different services to be understood at the patient level. Care providers and planners are able to generate their own insights and use self-service analytics to target care where it will be most effective, resulting in better outcomes for patients and better use of resources. MedeAnalytics' cloud-based tools analyse 21 billion patient encounters, providing better care to more than 30 million patients.

The expert panel was convened by Healthcare at Home to create a broad consensus across the clinical care in the home market and to provide expertise, insight and evidence. The expert panel has already reported on building the case for clinical care in the home at scale and will consider patient adherence in the future. The expert panel is sponsored by Healthcare at Home but it is an independent group.

THE EXPERT PANEL MEMBERS

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 and chair of the expert panel

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Victoria Bennett,
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 Black Country Alliance

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

HEALTHCARE AT HOME TEAM

Natalie Douglas, Dr James Featherstone,
 Professor Sir Jonathan Asbridge,
 Angela Norton, Edel McCaffrey,
 David Anderson and the Healthcare
 at Home team.

ZPB TEAM

Alex Kafetz
 Maya Anaokar
 Gail Hackston
 Sophie Jenkins
 Gita Mendis

DESIGN

Design to Communicate



healthcare at home

it's where you want to be

About Healthcare at Home

We care for people in the place they most want to be. As a leading provider of clinical home healthcare in Europe, we support more than 150,000 patients a year across 49 different therapy areas. That's one in 500 patients in the UK. We oversee 11,000 interactions a day and have cared for more than four million patients since we started in the 1990s. In the UK we are working with more than 650 healthcare establishments including NHS Trusts, independent providers and private medical insurance companies. Every member of the team, from specialist clinician to driver, lives by the same simple philosophy: the patient comes first.

For more information about our services and reports please visit our website:

www.hah.co.uk

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