

TAKING THE PRESSURE OFF

METHODOLOGY STATEMENT



Bupa
Home Healthcare



INTRODUCTION

The data that supports this report was drawn from 2 principal areas; the Hospital Episodes Statistics from 2010 and, in order to build the costings case around Chemotherapy, data from the National Schedule of Reference Costs 2009-10 for NHS Trusts.

The information on the suitability of particular cohorts of patients for discharge into home care was made by our team of doctors and nurses, lead by our Medical Director, based on research and their experience in the field.

All of the data has been created using 10/11 tariffs and market forces factors have not been applied.

GETTING PEOPLE HOME AT THE RIGHT TIME

1) Analysing the areas to which early discharge into the home could be applied

Our clinical experts analysed the list of admitted patient Health Resource Groups (HRGs) version 4 to identify those which could benefit from the utilisation of some degree of home healthcare.

Each of these HRGs was then assigned to a proposition area:

- Long Term Conditions
- Wound Care
- Continuing Care (at 3 different levels of severity)
- Home Infusions

Each of these proposition areas was then assigned a day rate cost for treating the patient in their own home.

All readmissions were removed from the calculation in order to avoid double counting with the readmissions section later in the report.

2) Assessing the proportion of patients that could be safely transferred back to their homes.

We are keenly aware that not all patients are suitable for transfer back into the community at an early stage. Against each of the HRGs identified, our team of clinicians assessed the proportion of spells that were likely to be suitable for home healthcare to arrive at an **impactable proportion**.

3) Applying a Home Healthcare Trimpont

Our clinicians looked at the average length of stay for each of the HRGs and the NHS Long Stay Trimpont in order to define a **home healthcare long stay trimpont** - a length of stay after which it was felt that most patients would be able to be transferred safely into their own homes. This was undertaken for both emergency and elective care.

4) Calculating the NHS cost of care for the patients identified

In order to understand the total cost of treating patients over the **home healthcare trimpont**, the total number of bed days for the **impactable proportion** of spells over the **home healthcare trimpont** was calculated and multiplied by the NHS Long Stay Tariff. This is the day rate tariff that is applied to all activity over the NHS Long Stay trimpont and is perhaps the best proxy available to the health economy of a patient staying in a hospital bed for a day. This calculation left us with a **total cost for NHS care provision (over the home healthcare long stay trim)**. All spells with a length of stay shorter than the home healthcare trimpont were removed from the calculation.

5) Calculating the cost of Bupa providing home healthcare for the patients identified

In order to calculate the cost of providing home healthcare for the patients identified, the total number of bed days for the **impactable proportion of spells** over the **home healthcare trimpont** was calculated and multiplied by the relevant home healthcare tariff (Continuing Care, Home Infusions etc.) to arrive at a **total cost for home healthcare provision**. All spells with a length of stay shorter than the **home healthcare trimpont** were removed from the calculation.

6) Calculating the net saving for NHS organisations

The net saving is arrived at by subtracting the **total cost of home healthcare provision** from the **total cost for NHS care provision (over the home healthcare long stay trim)**.

7) Making the data more meaningful

In order to aid interpretation, the spells were then grouped into similar areas by our clinicians. Where the HRG referred to an infection, the data was further grouped to allow a more detailed understand of where savings could be made.

“Assessing the potential financial impact of any changes in healthcare provision is difficult. Nevertheless, this report presents a methodology that is clear, straightforward and based on clinical expertise in the field”

Professor Simon Jones - Visiting Professor, University of Surrey

HELPING AVOID UNNECESSARY RETURN VISITS



This section of the report shows that many readmissions could be avoided if there were post-discharge care packages in place and patients were monitored for complications or deterioration. It is important to note that these savings are not achievable without an early discharge scheme and attendant home nursing infrastructure being in place.

We started by looking at the same group of HRGs outlined in the previous section as these were the areas for which it was felt that home healthcare was appropriate.

1) Outlining readmissions that are avoidable

There is a wide variety of research that has been undertaken on what constitutes an avoidable readmission. Clearly, not all of them could be avoided through the use of home healthcare. Our clinicians worked to put together a list of circumstances where a readmission would have been avoided had proper home healthcare provision been in place.

- a. A list of HRG codes that made up 80% of the impactable readmissions cost was obtained from the analyst.
- b. Primary procedures within this list were reviewed and highlighted if impactable e.g.
 - i. Infusions
 - ii. Immunotherapy
 - iii. Other disease modulating therapy – infusion, injections etc
 - iv. Care procedures – dressings, wound debridement etc)
 - v. Rehabilitation or physiotherapy related procedures

2) Ensuring that tariffs are properly assigned

All Readmissions are grouped into 4 categories:

1. Emergency readmissions following an emergency admission
2. Emergency readmission following an elective admission
3. Elective readmission following an emergency admission
4. Elective readmission following an elective admission

Since emergency readmissions within 30 days following the discharge from an elective admission no longer carry a tariff payment, they have been separated from the rest of the analysis, since they constitute a saving to the trust, but not the NHS as a whole.

Likewise, where an emergency readmission has followed an emergency admission, there is a 25% reduction in tariff and this has also been separated from the rest of the analysis. Both of these elements have been added to the section on tariff penalties which is summarised in table 14.

3) A proportion of patients who might reasonably be impacted was assigned

4) Calculating the total cost of the avoidable admissions identified

For those spells identified as within scope, the total tariff was calculated and moderated for the percentage of impactable spells. The totals for tariff penalties outlined above were also totalled.

5) Making the data more meaningful

In order to aid interpretation, the spells were then grouped into similar areas by our clinicians. Where the HRG referred to an infection, the data was further grouped to allow a more detailed understand of where savings could be made.

CANCER

In order to understand the likely savings available through home dispensing of chemotherapy drugs, the NHS reference costs for 2009 were consulted. It has to be acknowledged that this data source does not constitute the full extent of activity that has occurred for chemotherapy within the year, but it is the fullest record of activity available.

1) Outlining the dataset

We took chemotherapy procurement costs for Inpatient, Outpatient, Day case and Other from the 2009 reference costs as our dataset. Reference costs break down different chemotherapy drugs into different cost bandings.

2) Assigning activity that could be undertaken in the home

A conservative estimate was taken due to patient eligibility and preference that 75% of patients are eligible to receive chemotherapy at home. To reflect this, we have taken 75% of the activity reported in the dataset in order to build our case.

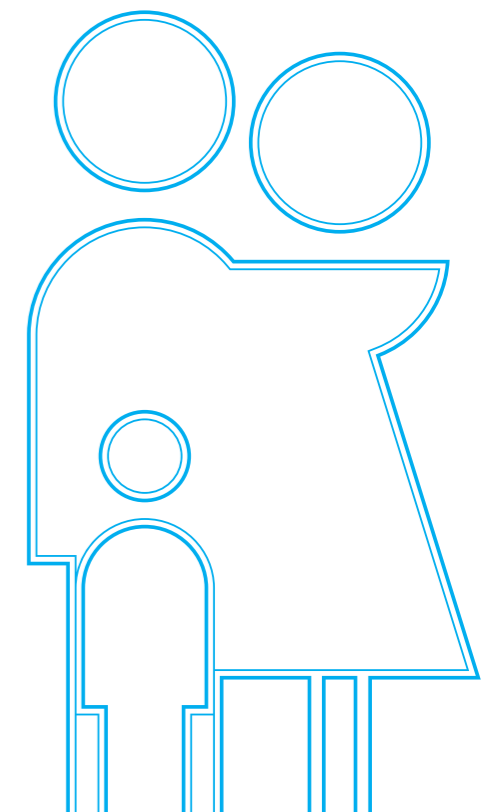
3) Calculating the VAT saving

In order to calculate the VAT saving we have taken the new activity level (75% of the total) and multiplied it by the national average unit cost in order to arrive at a total procurement cost for the drugs. We then calculated the value of the 20% VAT saving that would have been made on that total.

The costs for each are broken down as follows:

Currency Description

Procure Chemotherapy drugs for regimens in Band 1
Procure Chemotherapy drugs for regimens in Band 2
Procure Chemotherapy drugs for regimens in Band 3
Procure Chemotherapy drugs for regimens in Band 4
Procure Chemotherapy drugs for regimens in Band 5
Procure Chemotherapy drugs for regimens in Band 6
Procure Chemotherapy drugs for regimens in Band 7
Procure Chemotherapy drugs for regimens in Band 8
Procure Chemotherapy drugs for regimens in Band 9
Procure Chemotherapy drugs for regimens in Band 10
Procure Chemotherapy drugs for regimens not on the national list

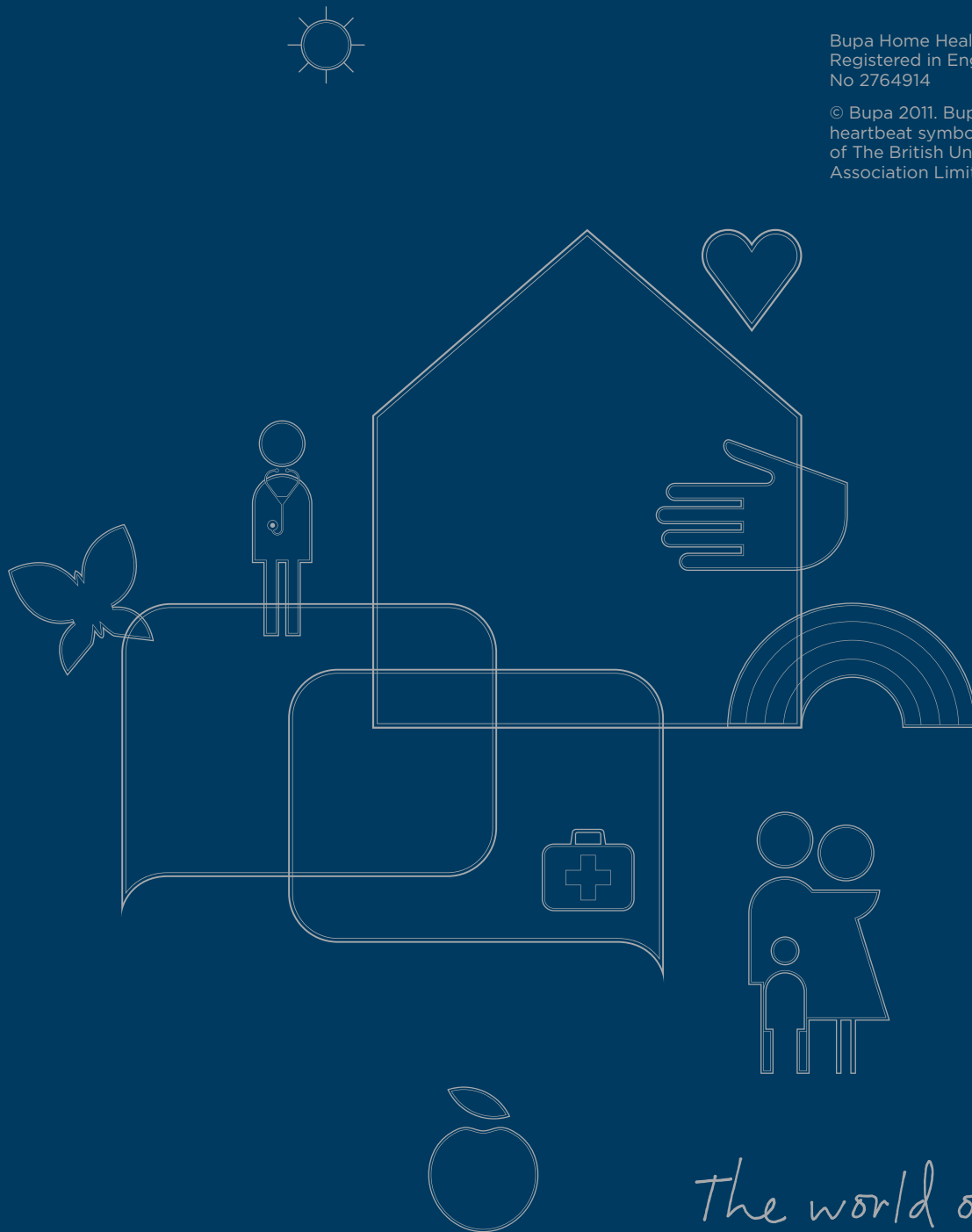


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