

TAKING THE PRESSURE OFF

# THE OPPORTUNITY FOR HOME HEALTHCARE IN TODAY'S NHS



**Bupa**  
Home Healthcare



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# 1. FOREWORD

I find it hard to question the benefits of the care closer to home agenda. Patients prefer the option of home treatment rather than the often daunting experience of going into hospital and the benefits to the wider health economy are evident. With the Nicholson Challenge firmly upon us, solutions which offer both patient and financial benefit should be grasped with both hands.

The levels of hospitalisation we currently see, both in terms of length of stay and readmissions, drain resources from our already stretched health and social care systems. Whilst work is taking place in every Trust in the country to enact change and realise financial savings, we need to question 'are we moving far or fast enough?' – and are we keeping the patient at the centre of what we are trying to do?

No-one should either be admitted to or stay in hospital unless absolutely necessary. We can no longer accept hospitals as just the bricks and mortar of the old district generals, acting not only as a central location for providing care but too often as a place where people with no other option are staying for weeks on end or readmitted to post discharge.

Instead, we need to see hospitals evolve into local hubs that provide services to improve the overall health of the community, with capacity and facilities that meet local need, from the hospital itself, to step-down care right into people's homes.

I believe this report highlights a real problem for our health system but also a tangible solution. We have known for too long that too many people are being admitted to or staying in hospital unnecessarily but we have never succeeded in putting in place the infrastructure and services to stop it happening.

I believe that with the right focus and leadership, particularly at a local level, real savings to the health economy can be realised without undermining patient care.



**Rt Hon Lord Warner**

## 2. PREFACE

As new and existing service providers seek out differentiation in the marketplace, new business models evolve, offering improved value to customers and in the case of healthcare - patients. Home healthcare is one such innovation and here we have demonstrated the added value it can create for both the NHS and patients.

This report is the culmination of several months of analysis by a team of clinicians with experience of hospital, primary and community care. We have made a careful and thorough analysis of Hospital Episode Statistics (HES) data to determine where home healthcare can impact upon acute care and the extent of that impact. We have also made realistic estimates of the costs involved in the delivery of home healthcare derived from our own experience and used this to arrive at the considerable net savings reported here. Any of the assumptions made in this report have been conservative and therefore the real cost saving to the NHS of full home healthcare implementation is likely to be even higher than that stated in this report.

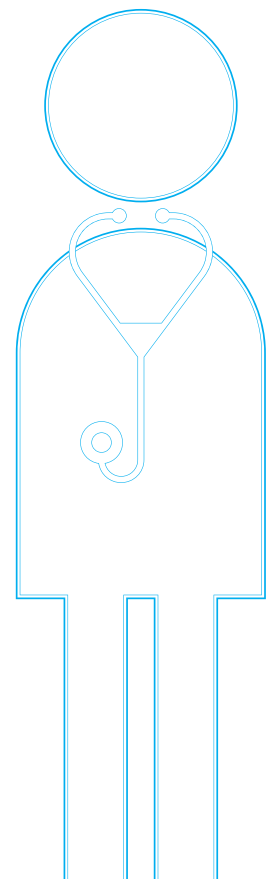
The case for home healthcare, both in terms of benefits to patients and NHS budget holders is clear. What is required now is the willingness of senior leaders to take on the changes necessary to implement home healthcare in a systematic manner. We have outlined here the steps we believe would be necessary both at Trust and government level but the real difference will be made by individual leaders willing to challenge the status quo and constantly strive for better patient care.



**Dr Mehmoood Syed**  
**Medical Director**  
**Bupa Home Healthcare**

“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



# 3. EXECUTIVE SUMMARY

This report demonstrates the benefits of home healthcare both in terms of large financial savings and improved patient experience and satisfaction. Analysis has identified that large savings can be made through the earlier discharge of patients to their own homes as well as reductions in the number of readmissions that occur after discharge.

The analysis in the report of the NHS' Hospital Episode Statistics (HES) dataset, which contains detailed information on all hospital use in the NHS, has identified the opportunity to save a total of £1.3-£1.7bn through more care being delivered in the home.

This figure, whilst a significant financial saving, also equates to over 14.5 million bed days, or patients spending over 2 million unnecessary weeks in hospital. To give some illustration of the size of the saving that can be made, each patient who is discharged early into home healthcare would save the NHS an average of around £860 per year. Within the analysis, the management of infections and reducing readmissions within the elderly population have been identified as key areas where home healthcare can be especially cost effective.

To concentrate solely on the financial benefits of home healthcare is to ignore the individual benefits to patients that home healthcare brings. Contained throughout the report are real-life case studies of individual patients whose treatment and care on the NHS has been transformed through the use of home healthcare.

Whilst these latter benefits are more difficult to measure, the advantages to patients of being treated in the privacy of their own home, without the inconvenience of lengthy travel and waiting times are important, especially at times of major illness.

The report also makes a number of recommendations for the Government, the NHS and the medical community that will help increase the uptake and availability of home healthcare across the health service:

- 1) The Department of Health and the newly formed NHS Commissioning Board should use the Any Qualified Provider framework to encourage the roll-out of home healthcare.
- 2) The Department of Health should investigate the effectiveness of incentives and penalties for reducing length of stay and readmissions for both providers and commissioners.
- 3) The NHS should routinely include home healthcare as part of recommended care pathways and ensure that patients and clinicians are aware of it.
- 4) Hospital Trusts should put in place the appropriate infrastructure, services and partnerships to enable their patients to get treated in the home.
- 5) Additional emphasis should be placed on out of hospital care in medical training and education.

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## PATIENT BENEFITS

- Allowing patients to live as a normal life as possible, without the need to travel into or stay in hospital
  - Treatment in a private, comfortable environment surrounded by family and friends
  - Reduction in the possibility of contracting a hospital acquired infection
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## FINANCIAL HIGHLIGHTS

- Analysis of the NHS dataset has identified the opportunity for the health economy to save **£1.3-£1.7bn** through the greater utilisation of home healthcare
  - **14.5m** bed days and between **£1.1bn** and **£1.3bn** could be saved by moving patients into the home when clinically safe to do so
  - Home healthcare could save the NHS **£300 - £390m** nationally by reducing avoidable hospital readmissions
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# 4. INTRODUCTION



The purpose of this report is to help NHS decision-makers identify and implement changes in how and where NHS patients can get the drugs, treatment and care they need.

This report is not a theoretical discussion of patients in the health system. It is a call to action for NHS commissioners, providers, clinicians and policy-makers to focus on the people treated week-in, week-out in the NHS. It is aimed at encouraging decision-makers to think about new ways to deliver the care they need, in a location of the patient's choosing.

As we all look to deliver more for less in the health service, it is the patient who must remain front and centre of our thinking. In that context, this report demonstrates that increasing the use of home healthcare fits well with a truly patient-centred approach. It also highlights how home healthcare can be delivered in a way that does not place additional burdens on an already financially strained system, but frees-up limited resources for use elsewhere.

Our analysis has focused on three areas of healthcare where we believe there can be most patient benefit from higher levels of home healthcare. These are:


- The number of people currently in hospital who could be discharged into their home;
- Readmissions to hospital soon after discharge that could be avoided through treatment being provided in the home; and
- The number of people with cancer who could receive chemotherapy in the home.

Through thorough analysis of NHS data, in each of these areas we have identified the total number of people able to receive the medication, treatment and care they need in their home, as well as highlighted the potential efficiency savings the NHS could generate by implementing this approach.

We hope this report will begin an important broader discussion in the NHS about changing how and where healthcare can be provided to patients, who too often end up having to stay in potentially very costly hospital facilities that might better focus their own resources elsewhere.

We need to fashion a vibrant, creative NHS that really fizzes with ideas of how to improve quality and how to reduce costs..... So, instead of relying on ever more funds flowing from the Treasury, we must look to ourselves to make savings.

**Earl Howe, Minister for QIPP - July 2010**



## FIGURE 1: WHAT HOME HEALTHCARE MEANS TO A PATIENT'S QUALITY OF LIFE

Sophie was born prematurely at just 25 weeks and developed breathing difficulties due to scarring of her vocal cords from ventilator tubing, as well as chronic lung disease. She was given a tracheostomy at four months old.

For her parents it was an incredibly difficult time. On top of numerous trips back and forth to the hospital, there was continual stress and worry. The constant need for suctioning and a vulnerability to infections meant mum and daughter felt isolated and homebound, while her dad spent many nights in hospital before working the whole day. The pressure was unbearable.

Following a formal Continuing Care assessment, NHS Ealing offered support at home, which was gladly welcomed. They arranged for Bupa Home Healthcare, as one of the approved providers, to provide regular, weekly support from a trained clinical support worker. Highly trained and experienced carers helped with feeding, suctioning and general care for the tracheostomy providing much needed relief. Mum received regular rest from the mental and physical strain and exhaustion of caring for a poorly child.

It also meant that when Sophie's little sister was born, Mum was able to spend more time with her too. "I've been able to trust the people from Bupa Home Healthcare enough to leave Sophie with them" said Mum. "You can tell [the carers] really care, and it's been a big help from the exhaustion and strain we all felt."

# 5. THE CHALLENGE FOR TODAY'S NHS

## Key points:

- The NHS faces unprecedented budgetary challenges
- These challenges will grow due to an ageing society, rising medical costs and increases in chronic diseases
- Our health system is not designed to meet the health challenges we face today

Everyone involved with the NHS today is aware of the significant funding challenges it faces. With admission rates rising by 30% since 2000<sup>1</sup> and a population forecast to grow by 15% over the next 20 years (43% growth in those aged 75 or over)<sup>2</sup> the NHS funding gap is due to grow to crisis point. The King's Fund has suggested that an ageing population will on its own add £1-1.4bn a year to NHS costs.<sup>3</sup> With rates of chronic disease, such as diabetes and heart disease predicted to increase by 25% by 2050, ever increasing pressures will be placed on the health system.<sup>4</sup>

Unless the health system can adapt and respond to these challenges, health spending will become unsustainable.

The Department of Health's Quality, Innovation, Productivity and Prevention (QIPP) programme is designed to help the NHS respond to these challenges, at least in the shorter term. It aims to generate the 4% year on year efficiency savings - equating to £15 - £20bn - it needs to find between 2010/11 and 2014/15 to meet the funding settlement it received from the government's 2010 Spending Review.

One of the main challenges for delivering these efficiency savings is that large parts of the UK's healthcare system, were designed to provide healthcare according to individual episodes of care delivered to the patient within large, generalist hospitals. Today we are in a very different situation in terms of what health conditions people face and where they can receive the most appropriate treatment for them.

To keep delivering high quality patient care, the NHS, in particular its hospitals, will need to respond to these changes. Achieving this aim will not be easy. Today, hospitals face major challenges around tackling hospital acquired infections. They also face increasingly tough waiting list targets, a requirement to play a major role in generating the efficiency savings, as well as the expectation to continually do more for patients with comparably less.

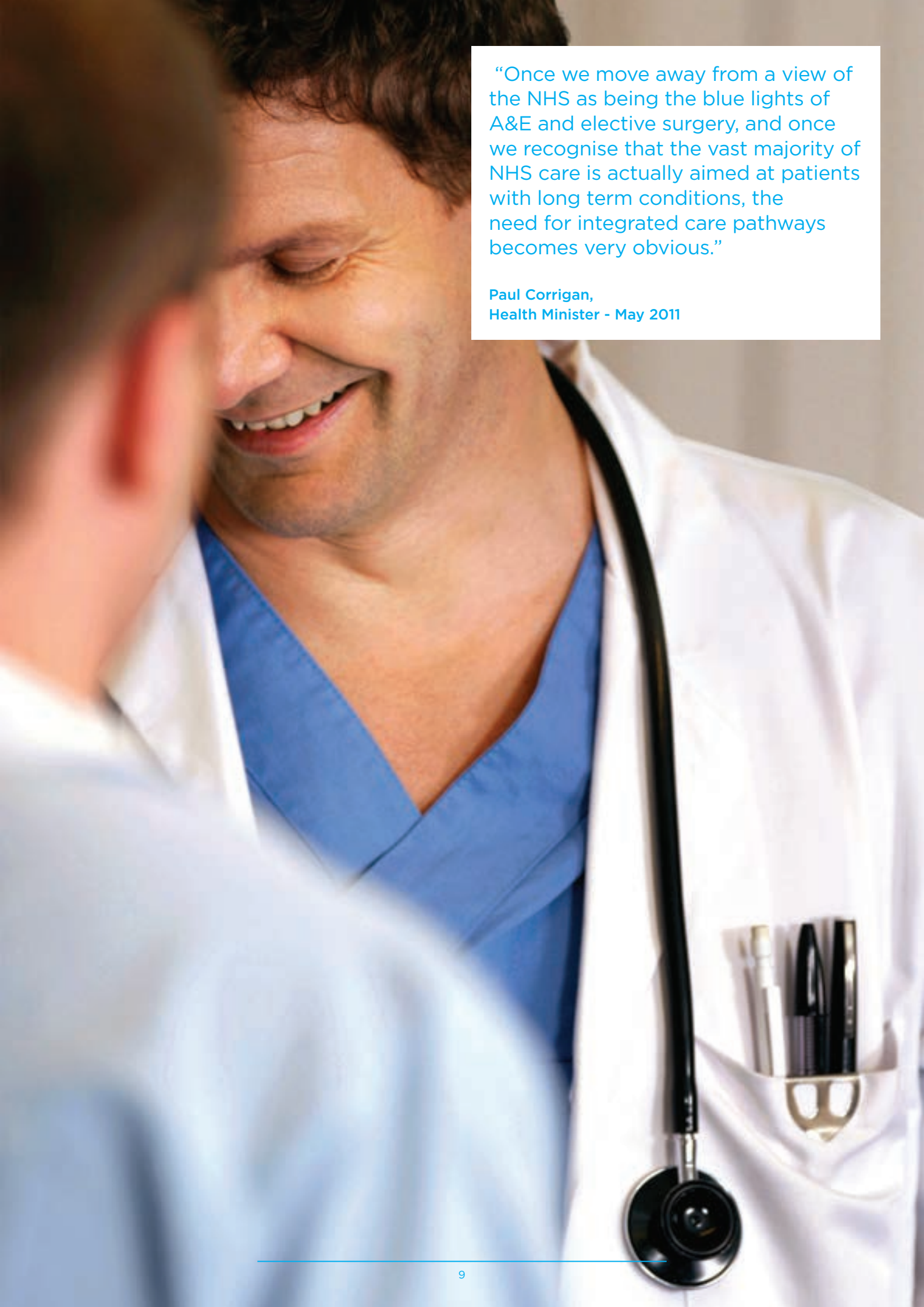
There is no one solution to these challenges. However, what is clear is that change is needed to continue achieving the high standards currently set by the NHS both nationally and locally. We believe the role home healthcare can play in helping create a sustainable healthcare system has been underestimated, and should therefore be re-examined.

<sup>1</sup>Hospital Episode Statistics Online, Available online at: <http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=451>, date accessed: 28th October 2011

<sup>2</sup>Office of National Statistics: "National Population Projections, 2010-based projections." 2011

<sup>3</sup>King's Fund - "How cold will it be? Prospects for NHS funding: 2011-2017", 2011

<sup>4</sup>Guardian (2011) 'Why long term conditions need healthcare in the community'



“Once we move away from a view of the NHS as being the blue lights of A&E and elective surgery, and once we recognise that the vast majority of NHS care is actually aimed at patients with long term conditions, the need for integrated care pathways becomes very obvious.”

Paul Corrigan,  
Health Minister - May 2011



## FIGURE 2: HOME HEALTHCARE IN PRACTICE

### Providing care for children with complex care requirements

Bupa Home Healthcare provides care for 17 patients who have complex and continuing care needs for NHS Cornwall and Isles of Scilly. Here, Leah Parker, Associate Director Women and Children's Commissioning, discusses the healthcare environment and the background to the 10 year relationship.

"For us, I think that choice and care closer to home are high on the agenda; choice particularly in terms of palliative care.

Homecare is certainly something that's grown over the years... we've used Bupa Home Healthcare for the past 10 years. When I came into post we had one young person who required 24 hour care and with medical and technical advances we have seen an upward trajectory of patients.

Our patients include children with long term ventilation, either invasive or non-invasive therapy, children with life limiting conditions in palliative end of life phase and children with challenging behaviour.

The reality is that if Bupa weren't there, many of those children would be in a care environment. If those children were accommodated in a specialist school for example with a package of healthcare, that would be in the region of £150,000 per child. We would be charged £328,500 a year if that child was in an acute sector hospital bed."

**17** PATIENTS

**£2.55m** ESTIMATED COST TO THE PCT FOR CHILDREN'S CONTINUING CARE

**£1.8m** ANNUAL SAVING TO THE PCT

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"Other than the financial aspects, patient care is the main benefit for us. To know that parents are supported to continue to care for their child in their own home is the ethos that we've come from."

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"Home healthcare enables the child to remain in their community; living with their family and going to school, so you certainly get better outcomes than a child lying in an acute hospital bed."

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# 6. THE OPPORTUNITY FOR HOME HEALTHCARE IN TODAY'S NHS

## Definition of home healthcare

“The provision of medicines, supplies and supporting clinical services directly to patients at times and places most convenient to them”

National Clinical Homecare Association, 2011

99% of patients are happy receiving their treatment at home<sup>5</sup>

Historically, home healthcare has been perceived as a distribution activity - a ‘man in a van’ delivering medication across the UK to patients’ homes. This has progressed significantly and evolved into both a service and a market which offer opportunity and development for the NHS, independent sector and charity providers.

As shown in Figure 3, the sector covers a wide range of therapy areas as well as home nursing provided by healthcare professionals. It offers a patient-centred approach for high and low acuity care ranging from the home delivery of medication to medical administration services such as for chemotherapy infusions, intravenous antibiotics and many other therapy lines.

Putting patients at the centre of their own care has always been a priority for the NHS and the government alike. However, hospitals can be impersonal places and not conducive to the patient having simple things like privacy. Spending private time with a family member, at what can be among the most difficult moments in someone’s life, is often not a readily available possibility.

Along with increased patient satisfaction and improved quality of life, there are additional benefits to providing patient care in the home. Not least among these is the avoidance of hospital acquired infections which can cause unnecessary morbidity and mortality. Although bacteria such as MRSA and *C. difficile* are undoubtedly present in the community, their concentration in hospital settings raises the likelihood of exposure to individual patients. Discharging patients more quickly into their own home helps to reduce the risk.

Given the pressures faced by the NHS to deliver more for less for patients, we have focused the analysis of this report on three important areas of care for both the health service and the people that use it. These are:

1. Getting people home at the right time
2. Reducing avoidable readmissions
3. Providing chemotherapy in the home

## FIGURE 3: EXAMPLE SERVICE AND THERAPY LINES:

Continuing Care  
Cystic Fibrosis  
Dermatology  
Erythropoietin-Stimulating Agents (ESAs)  
End of Life Care  
Fertility – Assisted conception  
Growth Hormone  
HAART (for HIV)  
Haemophilia  
Hepatitis B and C  
IV Antibiotics  
IV Chemotherapy for cancer  
IV Immunoglobulin - Immunology  
Management of Long Term Conditions e.g. COPD  
Multiple Sclerosis  
Oral Oncology  
Parenteral Nutrition  
Parkinson’s Disease  
Post Transplant - Immunosuppressants  
Pulmonary Arterial Hypertension  
Rheumatoid arthritis  
Schizophrenia  
Thalassaemia

<sup>5</sup>Bupa Home Healthcare patient satisfaction survey 2011

# 7. ANALYSIS AND COMMENTARY

## 7.1 GETTING PEOPLE HOME AT THE RIGHT TIME

### Key points:

- Ward capacity is a growing issue across the NHS with increasing waiting lists exacerbated by the drive for cost savings
- 14.5m bed days and £1.1 - £1.3bn could be saved by moving patients into the home when clinically safe to do so
- The treatment of infections is one of the key areas where bed days and cost efficiencies could be most significantly realised

On any given day in the NHS, there are tens of thousands of patients sitting in beds who could be cared for more effectively in their own homes. Getting people home at the right time is all about safe discharge into the right care at the right time, which of course then utilises capacity in the most effective way. This report shows that a real change in the way in which the NHS operates could produce much better results for patients and their families, as well as help to reduce pressures on NHS budget holders.

As detailed further in the appendix (methodology and approach), through our analysis of the NHS dataset on hospital usage and spending, we have identified a range of conditions and treatments where patients are remaining in hospital longer than would otherwise be necessary if a home healthcare service was available.

There are many conditions and treatments that require patients to receive follow-up support and care from a healthcare professional (see table 1). For instance, the care needed to support recuperation following an acute operation or the fracture of a bone or joint, or a period of hospitalisation after the flare-up of a chronic condition.

By analysing how long patients with these conditions in the English NHS remained in hospital in 2010 and determining the point at which they could have been discharged into home healthcare, we have calculated that the NHS could save between **£1.1bn and £1.3bn**. This figure includes the cost of providing the home healthcare service.

This equates to over **14.5m bed days** that could be saved. These patients are unnecessarily remaining in hospital after receiving a treatment when they could be discharged into their home, if the appropriate support service and infrastructure were in place to do so.

**£1.1 - £1.3 billion**

The amount the NHS could save by discharging all eligible patients earlier into home based health care

### The clinical drivers of extended lengths of stay

The savings that can be achieved through home healthcare could make an enormous difference to resource allocation in the NHS. The £1.1bn to £1.3bn savings per annum that we have identified are inclusive of the cost of delivery. This represents between 4 and 5.5% of total tariff spend in the acute sector for the last year, and would make a significant dent in the quest for £20bn in savings across the NHS by 2014.

Our analysis has shown that a fully implemented early discharge scheme could benefit 1.3m people who are admitted to hospital per year. This figure represents 11% of all admissions into secondary care last year.

**Table 1: Savings potentials for early discharge**

Conditions	Savings (£m)	Bed days saved (000's)
Musculoskeletal	235	2120
Infections	223	2804
General Medicine	204	3050
Neurology	177	1776
General Surgery	164	1362
Gastroenterology	149	1949
Plastic Surgery	101	611
ENT	343	165
Urology	315	283
Cardiothoracic	283	276
Gynaecology	117	146
Total	1,360	14,500

The financial benefits for the NHS are also considerable. The tariff cost of treating the conditions we have identified is £12bn. The £1.3bn savings that we have identified represent an 11.5% reduction in the total cost of caring for these patients per annum.

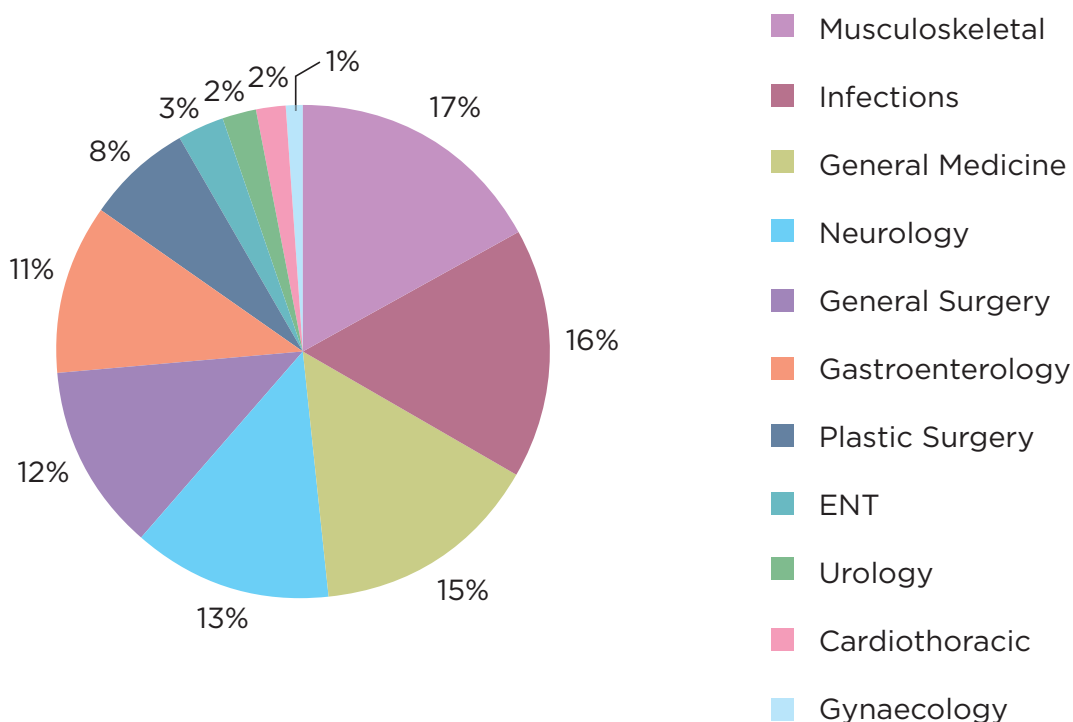
Often, numbers of this magnitude can be difficult to interpret and make real. To give some illustration of the size of the saving that can be made, each patient who is discharged early into home healthcare saves the NHS an average of around £860 per year.

Were a home healthcare service in place for every admission that could have been impacted last year, the patient would have spent nine days less in hospital.

**14.5 million**

The number of bed days that could be saved

**Figure 3: Savings by clinical area**



## Managing infections

The analysis shows that one of the biggest areas of clinical and cost pressure for the NHS are infections. It also highlights how home healthcare can be especially cost-effective in dealing with infections, as it shows that infections account for 11% of the admissions that we have identified as potentially suitable for early discharge and they account for more than 16% of potential savings. Infections and their treatment are a significant burden on primary and secondary care resources. Frequently, patients are admitted to hospital or have their hospital stay prolonged solely to receive intravenous drugs. Home healthcare can provide home nurse support and intravenous drug delivery while decreasing the risk of hospital acquired infection and alleviating the NHS bed crisis.

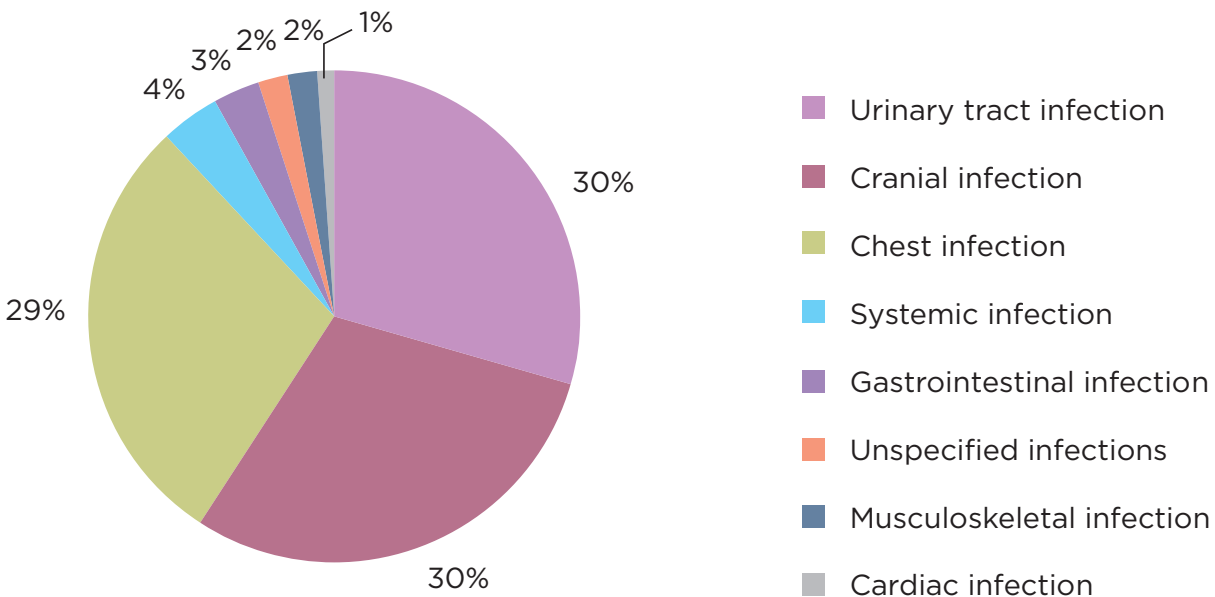
**Table 2: Savings by Infection type**

Type of Infection	Affected number of admissions (000's)	Total saving (£m)
Urinary tract infection	52	67
Cranial infection	30	66
Chest infection	79	64
Systemic infection	6	10
Gastrointestinal infection	6	7
Unspecified infections	4	4
Musculoskeletal infection	1	3
Cardiac infection	1	2
<b>Total</b>	<b>179</b>	<b>223</b>

Almost 60% of the achievable savings, around £130m, can be achieved here by concentrating on ensuring that patients suffering from urinary tract infections and chest infections are discharged back to the home earlier. This represents an opportunity for Trusts to achieve some of the benefits of home healthcare over a short timescale, by putting in place processes for ensuring that patients who are likely to be on a ward for these conditions have a care pathway in place that allows them to receive infusions at home.

**£223 million**  
 The amount that could be saved by managing infections in the community

**Figure 4: Savings by type of infection**



## FIGURE 5: BARRY'S STORY

**Barry, 63, would have been in hospital for 3 months without the option of treatment at home.**

"I had a very bad infection after a knee replacement operation in March 2010. It all seemed fine at first but two weeks later I was back in hospital as the infection was so bad it had damaged my knee joint and it had to be removed and a temporary joint inserted.

This was the start of 18 months of hospital treatment for me - over that period I must have spent 10 to 12 weeks in hospital to treat the infection with antibiotics, remove damaged tissue and have a new replacement joint inserted.

After the third operation I was stuck on a ward connected to an intravenous drip of very strong antibiotics. It wasn't much fun, plus the longer I stayed in hospital the more concerned I was about picking up another infection - so when the hospital told me I could have my treatment at home I breathed a big sigh of relief.

Although I'd needed a 10 week course of antibiotics, after two weeks I was allowed to go home and have the remainder of my treatment there. My antibiotics

were delivered by Bupa Home Healthcare - they always arrived on time and if ever I was running low I could phone and arrange a delivery within 24 hours.

I have a line inserted in the top of my arm so that it's easy to hook myself up to the antibiotic infusion. I'd have to have them twice a day for two and a half hours each time - the drugs made me feel tired and so it was great that I was at home where I could rest in peace and quiet.

I'd also had enough of being stuck in hospital with people who were very unwell - I found it quite depressing seeing other people suffer and if I hadn't been able to have my drugs at home I would have had to stay in there for another three months."

"Having my drugs delivered to my home may seem like a small thing but it had a big impact on the course of my treatment and my quality of life."

## 7.2 HELPING AVOID UNNECESSARY READMISSIONS

### Key points:

- Readmissions currently cost the NHS £2bn per annum with approximately 14% of patients readmitted within one month of discharge
- Home healthcare could save the NHS £300 - £390m nationally by reducing avoidable hospital readmissions
- Elderly patients could especially realise benefit from home healthcare as readmission for this patient group is disproportionately high
- The tariff penalties on Acute Trusts from readmissions that could have been avoided through home healthcare could reach £80m

Large numbers of patients (14%) need to return to hospital within a month of their original procedure because complications have arisen.<sup>6</sup>

Typical reasons for readmission are a failure to manage a long term condition such as diabetes properly, a failure to properly exercise after surgery, contracting a hospital borne infection, a patient having nowhere to report issues that they experience post-discharge or a failure of medical staff to pick up the early warning signs of post-surgical complications.

To conduct our analysis we have defined avoidable readmissions by picking out those where the primary procedure fell under one of the following categories:

- Infusions;
- Immunotherapy or chemotherapy;
- Other disease modulating therapy - infusion, injections etc;
- Care procedures - (dressings, wound debridement etc); and
- Rehabilitation or physiotherapy related procedure.

Our analysis has looked only at avoidable admissions - those that could have been avoided had proper steps been taken in terms of health planning, assessment and ongoing monitoring.

The data shows that, in areas where home healthcare could have an impact on readmission rates, the NHS could have saved **£390m** last year. A breakdown of some of the areas of largest potential can be found below, with the largest potential saving within infection management.

**Table 3: Savings potential for readmission avoidance**

Clinical area	Savings (£m)	Number of readmissions (000's)
Infections	130	50
General Medicine	116	107
Gastroenterology	49	51
Musculoskeletal	32	39
Neurosurgery	31	24
Plastic Surgery	21	8
General Surgery	8	7
<b>Total</b>	<b>390</b>	<b>289</b>

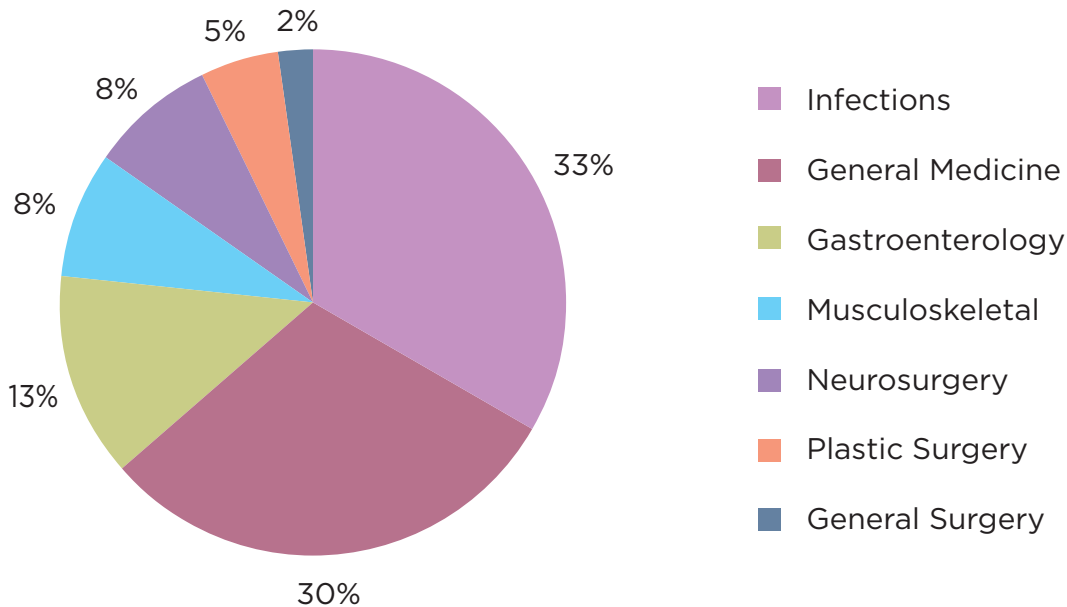
### £300 - £390 million

The amount that could have been saved by the NHS had home healthcare been used in all applicable cases.

<sup>6</sup>NHS Institute for Innovation and Improvement, [http://www.institute.nhs.uk/scenariogenerator/tools/reduce\\_readmissions.html](http://www.institute.nhs.uk/scenariogenerator/tools/reduce_readmissions.html), retrieved 7/11/2011

Clearly, the presence of complications creates some obstacles to care outside of the hospital. However, frequently these complications take the form of long term conditions such as chronic obstructive pulmonary disease (COPD) or congestive heart disease (CHD) which, if managed correctly in the home, can prevent the need for further readmissions.

Figure 6: Potential savings by clinical area



The largest opportunity for Trusts to make quick progress lies in the treatment of infections. Avoidable readmissions for infections account for approximately 17% of the total cost of readmissions, yet are responsible for a third of the cost of avoidable readmissions. This echoes the opportunity for savings to be made through early discharge and there would appear to be a very strong business case for Trusts to look at infection management as an initial focus for extending the utilisation of home healthcare across the care continuum.

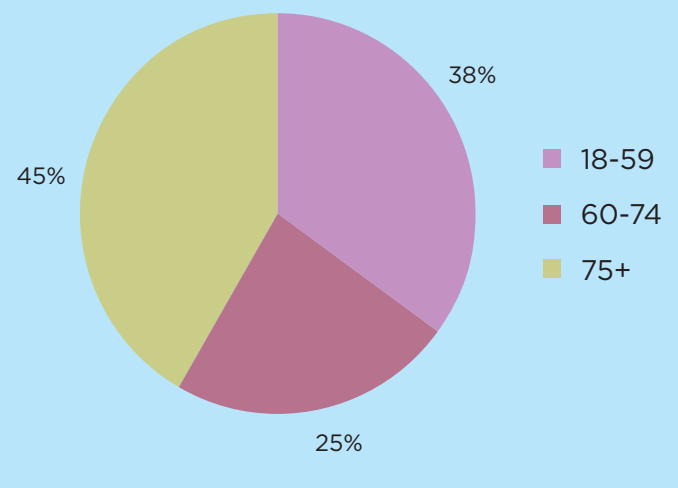
The research shows home healthcare can help to free up capacity in the system. Avoidable readmissions where home healthcare might have been utilised after the first admission accounted for 290,000 readmissions last year.

The utilisation of home healthcare could therefore have ensured that the above capacity was used to treat those most in need of care.

**290,000**  
The number of readmissions that could be avoided.

The proportion of patients from the elderly community who could be treated using home healthcare is disproportionately high, providing further evidence for the case of bolstering social care provision to reduce NHS spend. Local authorities, Primary Care Organisations, Acute Trusts and home healthcare providers need to work closely together to ensure that elderly patients can stay at home. If patients cannot be cared for safely at home, comparatively small complications are likely to result in readmissions.

Figure 7: Proportion of readmissions by age



## Reducing tariff penalties

The Department of Health is acutely aware of the unnecessary burden that avoidable readmissions place on the system. In order to incentivise the correct behaviours from Acute Trusts, a system of penalties has been put in place when patients are forced to return to hospital for reasons which could have been avoided.

Hospitals will not receive payment for emergency readmissions within 30 days of discharge following a planned admission, and all other readmissions within 30 days of discharge will be subject to locally agreed thresholds. This is to ensure that, wherever possible, hospitals have good discharge arrangements in place to avoid readmissions. Primary Care Trusts must work with providers, GPs and local authorities to reinvest the savings in re-ablement and post discharge support.

Our analysis of 2010 data has shown that the likely impact of tariff penalties on Acute Trusts from avoidable readmissions that could have been dealt with equally well via home healthcare was £79m.

Table 4: Tariff penalties for avoidable readmissions in 2010

Condition	Penalty (£m)
Infections	22
General medicine	24
Gastroenterology	16
Musculoskeletal	6
Neurology	2
Plastic surgery	5
General surgery	2
<b>Total</b>	<b>79</b>

## FIGURE 8: ELEANOR'S STORY

### Eleanor Stewart, 15, has Cystic Fibrosis and receives IV antibiotic treatment at home

"I was born with cystic fibrosis, a genetic condition which leads to the build up of sticky mucus in my lungs and makes me more prone to lung infections. If I catch a cold it can be difficult to shift and can lead to chest infections, so two to three times a year I need intravenous infusions of antibiotics for around seven days each time to get rid of persistent infections and protect me against more bugs.

Fortunately I've always been able to have this treatment at home without the need for a lengthy hospital stay. I have had a PICC line under my right arm where the line can be hooked up since I was five and to me it's just normal.

The drugs are delivered by Bupa Home Healthcare and then I set up the infusion myself. I can either do

it at home or I can set it up in a bum bag and go out with it - it really doesn't stop me doing anything at all and is so much more convenient than having to stay in hospital for the treatment.

Having the treatment at home has just meant that I can be a normal teenager. I'm able to do normal things like go to a club called LIFE, a youth club, and go out with my friends. I'm studying for my GCSEs now and have lots of work to do and it would have been very disruptive for me if I'd had to have time off for treatment in hospital."

"Sadly we lost Eleanor's brother Ashley, who died 12 years ago aged just 11 to cystic fibrosis - so I'm very nervous about Eleanor going to hospital and being exposed to infections. It's so much better that she can have her treatment at home."

**Valerie, Eleanor's mother**

# ZERO-RATED VAT

Traditionally, home healthcare has been thought of as a means to achieve VAT savings through the dispensing of drugs within the home. Through this report we have shown wider financial and service benefits that home healthcare can bring however it would be remiss not to address the potential for cost savings to be made in this manner.

Currently, approximately £1bn worth of drugs are dispensed within the home, yielding a saving of £200m to the NHS. However, we believe the opportunity is far greater. For example, of the top ten medicines issued in acute care in 2009, nine of these can be issued in the home, with the sole exception of Ranibizumab. The VAT savings on these top ten drugs alone could reach over £150 million

**Table 5: Top 10 medicines by cost for medicines issued in hospital in 2009 Hospital issues**

	Cost (£m)
Etanercept	158
Adalimumab	150
Trastuzumab	96
Ranibizumab	94
Infliximab	90
Rituximab	79
Imatinib	54
Docetaxel	49
Oxaliplatin	39
Paclitaxel	34
Total spend on top 9 drugs (excluding Ranibizumab, which cannot be administered in the home)	749
<b>VAT saving</b>	<b>150</b>

Hospital Prescribing, England: 2009 NHS Information Centre

## 7.3 FOCUS ON CANCER

### Key points:

- By providing chemotherapy at home, Trusts see capacity eased on busy wards and outpatient units allowing them to focus on those most in need of in-hospital care.
- Evidence suggest that home chemotherapy is a clinically safe alternative to hospital care.
- Financial benefits of £66m can be realised through procurement of drugs with zero-rated VAT.

Every person is likely to be touched by cancer at some point in their lives – whether it be through family, friends or themselves. Each year around 250,000 people in England are diagnosed with cancer. Chemotherapy forms a key component of treatment in many cases and data from 2009 shows that 757,000<sup>7</sup> cycles of chemotherapy were administered to patients in England in that year alone.<sup>8</sup> The vast majority of this was done in a hospital setting.

With patient choice and awareness becoming increasingly important, the opportunity for patients to receive chemotherapy in the comfort of their home is becoming more widely available. The benefits to the patient are clear, allowing the patient and their families to carry on with day-to-day activities at home, removing the need to travel to and from hospital and moreover receiving the one-to-one nursing support which truly puts the patient at the centre of their care. The response in relation to this level of nursing care from a patient experience perspective is exceptionally positive.

During the NHS's first quarter of the year (April to June) the 62 day urgent GP referral to first treatment target for all cancers was only achieved for 86.5% of patients nationally.<sup>9</sup> Delivering treatment to patients at home or in the community, where possible, will help ease capacity and help to reduce waiting times.

As well as easing capacity pressures and reducing waiting times there are also financial benefits that can be achieved. The ability to deliver many chemotherapy drugs in the home gives the NHS the opportunity to qualify for zero-rated procurement of these high cost drugs. In this area alone, the NHS could save £66m per annum based on a 20% VAT saving for the activity seen during 2009/10. Additional savings can be made by reducing and even eliminating the cost of drug wastage in hospital pharmacy departments by outsourcing the compounding of chemotherapy drugs.

### At least £66 million

The amount the NHS could save by administering chemotherapy in the home.

<sup>7</sup>Cancer research UK, Cancer Incidence for all cancers combined, <http://info.cancerresearchuk.org/cancerstats/incidence/all-cancers-combined/>; Retrieved 8 November 2011.

<sup>8</sup>Data calculated using the NHS Reference Costs . [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_123459](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123459). More detailed information can be found in the methodology appendix available online.

<sup>9</sup>Department of Health, Cancer Waiting Times, <http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomedataandstatistics/HospitalWaitingTimesandListStatistics/CancerWaitingTimes/index.htm>).

## FIGURE 9: DONNA'S STORY

**Donna, 43, received treatment for breast cancer at home.**

"I was diagnosed with breast cancer in June 2010. I was told I'd have to have six months of chemotherapy to shrink the tumour, before I could have a mastectomy. I went to the Velindre Cancer Hospital in Cardiff every three weeks to have my treatment. The staff there were very kind and I received good treatment, but the chemotherapy itself was gruelling and really took its toll on me. My hair fell out, I suffered mouth ulcers and some sickness – but by far the worst problem I had to cope with was my depression. Some days I just didn't want to get up in the mornings and wanted to hide away from the world.

In December 2010 after my chemotherapy finished I had the mastectomy and reconstruction with a temporary implant. By this stage I was relieved that most of my treatment was over – I didn't want to be sick anymore and just wanted to get on with my life and stop being a patient and be a person again.

The hospital had told me I would then need an intravenous infusion of the drug Herceptin® every three weeks for a year. I wanted to have the treatment but the thought of going back to hospital filled me with dread – I just didn't want to sit in

another waiting room surrounded by other people like myself – I just found it too depressing.

Luckily though, my hospital was able to offer treatment at home via Bupa Home Healthcare. A nurse would come once every three weeks, set up a drip and stay with me until the treatment had finished.

Not having to go to hospital has actually made me feel more like a person again rather than a cancer patient."

"When I told my friends and family, they were amazed that I could get such a personal service, arranged at my convenience on the NHS and that it was totally free."

"The care I've received has actually made a horrific situation – having cancer – bearable. It also meant that my husband didn't have to have time off to take me to hospital every three weeks."

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## FIGURE 10: FOCUS ON HERCEPTIN®

As a further illustration for the savings that can be made in the provision of cancer care, we have looked at the financial case for the delivery of Herceptin® treatment in the home

- Approximately 8,000 patients are suitable for Herceptin® treatment in England<sup>10</sup>
- 17 infusions (16 can be delivered at home) required for treatment
- £407.40 cost per vial<sup>11</sup> (3 vials per patient, per infusion)
- £19,536 cost of treatment per patient
- Saving of almost £4,000 per patient through zero-rated VAT

**Potential NHS saving: £31.2m**

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<sup>10</sup> Total breast cancer cases in 2009: 40,260. Approximately 15 to 20% of women with metastatic breast cancer over express HER2 at the 3+ level.

<sup>11</sup> Herceptin Intravenous Infusion, 150mg vial British National Formulary 61, March 2011, BMJ Group and the Royal Pharmaceutical Society

# 8. MAKING THIS HAPPEN

## IN YOUR LOCAL HEALTH ECONOMY

Putting forward a case for financial and patient experience benefits of home healthcare can be seen as the easy part. Making this a reality across the local health economy is the far greater challenge and clearly barriers exist to making this happen whilst appreciating home healthcare is not a panacea. The situation and extent of home healthcare usage differs from trust to trust and is dependent on a range of factors; financial, historical, geographical and the capability and capacity of trust personnel. Some trusts embark on an integrated home healthcare strategy, with a team in place to implement home healthcare services for a full range of therapy areas. Conversely, many trusts utilise home delivery services in a piecemeal manner with limited knowledge of the full spectrum of services in operation and the financial benefits possible.

To help drive an integrated home healthcare strategy, every trust board should be aware of the home healthcare services operating in their Trust to achieve engagement, transparency and realise the full patient and financial benefit.

In addition to ensuring all key stakeholders are bought into the process, Trusts need to ensure the appropriate procedures are in place.

### Identifying patients suitable for home healthcare

Home healthcare is not suitable for every patient and for many home is neither the safest nor best place to be. Patients are selected through an assessment process and only discharged home when medically stable and with the provision of ongoing support. This is a partnership approach between the hospital clinicians and home healthcare providers.

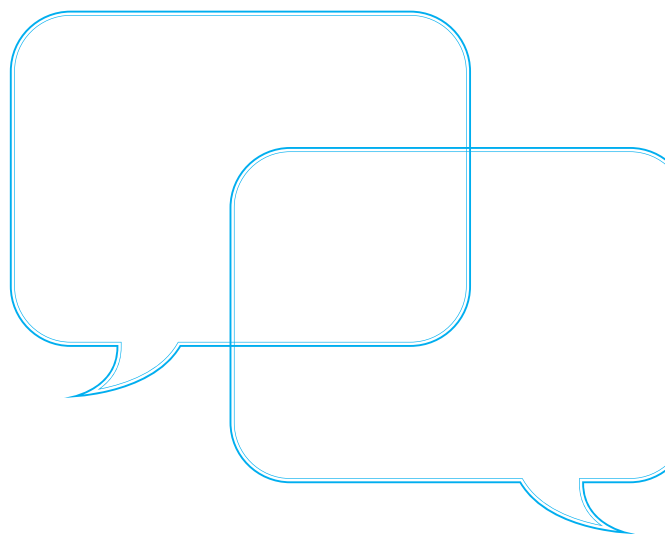
### Working in partnership

There are a number of organisations that play a part in the whole system including social services and home healthcare providers. Having the right partnerships in place is vital to ensure the service is effectively co-ordinated and managed.

### Monitoring home healthcare services

In order to support the adoption of home healthcare services, there are a number of mechanisms to monitor the effectiveness of home healthcare available in areas such as:

- Patient experience
- Patient Reported Outcome Measures
- Clinical measures
- Readmission rates
- Mortality
- Hospital acquired infections
- Costs



### Questions a Board should consider:

- Which home healthcare services are currently utilised across the Trust or PCT and by which providers?
- What is the financial benefit realised in terms of VAT savings and bed days saved from using these services?
- Which therapy lines are not using home healthcare services and what potential savings could be realised from these?
- What are the organisational barriers to change within the Trust?
- Are the commissioners and local authority integrated with a cross-service process in place to support system change and who manages this approach?
- What value can increased capacity bring to the Trust as a result of faster throughput?
- What governance procedures are currently in place for home healthcare services and which need to be established?
- Does the internal resource and capability exist to build and support a business case?



## A STRATEGIC NATIONAL APPROACH

To drive a strategic approach to home healthcare nationally, we also suggest the following policy recommendations:

### **POLICY RECOMMENDATIONS**

#### **1) The Department of Health and the newly formed NHS Commissioning Board should use the Any Qualified Provider (AQP) framework to encourage the roll-out of home healthcare**

One promising area for increasing the uptake of home healthcare will be the roll-out of the new AQP policy.<sup>12</sup> When fully implemented, this policy will enable the NHS to more easily access all types of provider of home healthcare services. As highlighted in the recent Department of Health note on the AQP process, home chemotherapy services would make a logical initial focus for the roll-out of AQP.<sup>13</sup>

#### **2) The Department of Health should investigate the effectiveness of incentives and penalties for reducing length of stay and readmissions for both providers and commissioners**

While efforts have been made to incentivise reductions in readmissions, there are conflicting financial incentives at play. Acute Trusts who discharge too early, are liable to receive a reduced tariff figure under the short stay tariff scheme. If the patient stays in a hospital bed, the Trust receives both the tariff plus a long stay tariff for every day that they stay longer than the average. The shortest possible stay is not necessarily the optimal financial outcome for an Acute Trust.

#### **3) The NHS should routinely include home healthcare as part of recommended care pathways and ensure that patients and clinicians are aware of the options available**

The Department of Health should make clear recommendations about the utilisation of home healthcare in clinically appropriate circumstances. It should be made clear to both patients and clinicians that, where appropriate, access to home healthcare is a choice available to them. Furthermore, the emphasis in care pathways should be on having patients in hospitals for the shortest possible time. One potential mechanism to help focus activity would be via existing cancer networks, which could be given a role to monitor and report back on progress made in offering chemotherapy at home to patients.

#### **4) Hospital Trusts should put in place the appropriate infrastructure, services and partnerships to enable their patients to get treated in the home**

The effective redesign of care pathways, including the implementation of home healthcare requires the involvement of primary care, acute care and social care teams. Hospital Trusts will need to engage with their local Health and Wellbeing Boards, as well as other new ways for engaging local stakeholders such as clinical senates and clinical networks.

#### **5) Additional emphasis should be placed on out of hospital care in medical training and education**

Perhaps the biggest enabler to the greater adoption of home healthcare is the buy-in and support of healthcare professionals. Clinicians need the confidence that patients can be discharged into an environment that is safe and in which patients will receive the everyday support that they need until they are ready to manage care for themselves again. Greater focus should therefore be placed on incorporating care outside of the hospital setting in medical training and education.

<sup>12</sup>See <http://healthandcare.dh.gov.uk/aqp-answers/> for further details

<sup>13</sup>See [http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH\\_128538](http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_128538)

# 9. CONCLUSION



In this report we have sought to reshape notions of how home healthcare can deliver benefits to the NHS and to illustrate that the major benefits to both patients and the health economy are to be made through the reshaping of care pathways and post-discharge care.

The well documented economic issues faced by the country show little sign of improvement in the medium term and the pressure for reform and cost savings is being felt most severely in the health economy. The NHS stands at a crossroads - either it reforms and starts to economise of its own accord, or it has reforms thrust upon it from outside. The ambitious £20 billion savings target for 2011-14 will not be achieved through small scale efficiency programmes, it will require real reform in the way that healthcare is delivered in this country.

Our analysis has shown that home healthcare, if fully implemented, could have saved the NHS £1.3 - £1.7bn last year. If similar returns could be made into the future, the NHS could make substantial strides towards its savings target.

The report has also highlights the 14.5 million bed days which could be saved by moving patients into the home when clinically safe to do so, resulting in easing capacity pressures and in turn tackling the increasing issue of waiting times.

As such, home healthcare ought to be a win-win for both NHS budget-holders and patients. Patient surveys repeatedly show that patients prefer home healthcare to hospital based care. Simple experiences, like the opportunity to be treated in a private, safe environment, without the need for lengthy travel or waiting, or to exercise a new hip replacement away from the gaze of other patients and their visitors should not be underestimated.

Ultimately, the culture of the NHS must evolve to ensure patients are only be admitted into hospitals as a last resort. Once there, every effort should be made to allow them to return home as soon as it is safe to do so. Once at home, patients should be supported by a range of services that allow them to recover in comfort, safe in the knowledge that their progress is being monitored on behalf of the hospital clinicians by professionals experienced in home healthcare.

<sup>14</sup>Bupa Home Healthcare patient satisfaction surveys 2007 - 2011

# 10. APPENDIX: METHODOLOGY AND APPROACH

Notwithstanding the multiple benefits of home healthcare for patients and their families, there remains a key challenge of whether there is also potential financial benefit to the health economy. The basic premise that reducing readmission and length of stay in acute care will result in financial efficiencies appears a sound one, however limited evidence exists as proof of this point.<sup>15</sup> This report looks at three key areas and takes the approach of defining the size of this financial benefit should the NHS grasp the opportunity presented. It is acknowledged that these savings cannot be made overnight but those who take the opportunity seriously will be preparing themselves for what could prove to be a challenging future.

The market has been split for this purpose into three key opportunities; they can be briefly described as:

- Selecting those in hospital who can be safely supported at home
- Supporting those that might unnecessarily return to hospital
- Treating cancer in the home

The savings calculations are based on the way in which the NHS is currently funded (known as Payment by Results tariff). Every time a patient attends hospital they are assigned to a costing model known as a Health Resource Group (HRG).<sup>16</sup> This is based on the combination of conditions that the consultant records the patient as having (coded as an ICD-10 condition code) and where relevant, the procedures that are required to treat the patient (coded as an OPCS4 procedure code).

The associated costs of the hospital attendance, are charged back to the local commissioner. The variance in this charge is then dependent upon the length of time that a patient spends in hospital. A standard charge exists for this time, unless the patient is admitted as an emergency and is in hospital for a particularly short amount of time (usually up to a couple of days). In this situation, the commissioner will then pay less than the standard rate (up to 60% less). Where this report focuses is on those that stay beyond the length of time agreed (trimpoint) within the tariff, this is where the commissioner incurs additional cost (known as excess bed days).

Our approach has been to look at 2010 inpatient data, identify patient groups that are appropriate for home healthcare and look at opportunities for costs savings within these groups in terms of early discharge, differences in cost between the NHS and home healthcare and the opportunity for trusts to avoid readmissions. All of the potential savings mentioned here are net savings, which is to say that they encompass the costs of providing alternative care arrangements within the home.

The financial argument made in the report is that, based on medical evidence and best practice, patients could, in many cases, recuperate safely at home earlier in the process, and therefore the trimpoint should be considered to be earlier in the tariff. The shorter length of stay should yield savings to the NHS. The financial case is furthered by penalties that have been introduced for hospitals that receive readmissions of patients within a period of 30 days of discharge. It is estimated that this penalty will cost NHS hospitals an additional £600m per year. The avoidance of these penalties through proactive nursing, condition management and service signposting is also visited in the financial incentives for home care.

“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

<sup>15</sup>Making progress on efficiency in the NHS in England: options for System reform, Jennifer Dixon, The Nuffield Trust, June 2010 [http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/making\\_progress\\_on\\_efficiency\\_in\\_the\\_nhs\\_in\\_england.pdf](http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/making_progress_on_efficiency_in_the_nhs_in_england.pdf)

<sup>16</sup>Full methodology document is available at [www.bupa.co.uk/home-healthcare](http://www.bupa.co.uk/home-healthcare)

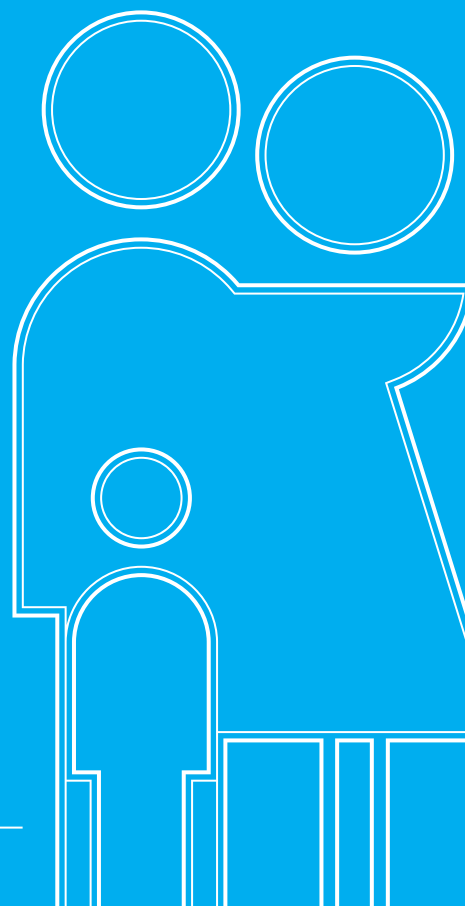
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- <sup>9</sup> Department of Health, Cancer Waiting Times, <http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomancedataandstatistics/HospitalWaitingTimesandListStatistics/CancerWaitingTimes/index.htm>). Retrieved 2 November 2011.
- <sup>10</sup> Total breast cancer cases in 2009: 40,260. Approximately 15 to 20% of women with metastatic breast cancer over express HER2 at the 3+ level.
- <sup>11</sup> Herceptin Intravenous Infusion, 150mg vial British National Formulary 61, March 2011, BMJ Group and the Royal Pharmaceutical Society
- <sup>12</sup> See <http://healthandcare.dh.gov.uk/aqp-answers/> for further details
- <sup>13</sup> See [http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH\\_128538](http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_128538)
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- <sup>16</sup> Full methodology document is available at [www.bupa.co.uk/home-healthcare](http://www.bupa.co.uk/home-healthcare)

## ACKNOWLEDGEMENTS

### Thank you to the following contributors:

Lord Norman Warner  
Professor Simon Jones, Visiting Professor, University of Surrey  
Dr Mehmood Syed, Medical Director, Bupa Home Healthcare  
Claire Taylor-Harris, Head of Marketing, Bupa Home Healthcare  
Beverley Wilson, Marketing Lead, Bupa Home Healthcare  
William Brocklehurst, Corporate Affairs Manager, Bupa  
James Thompson, Public Relations Manager, Bupa  
Innovation 1st  
Bupa Health Dialog  
Unigraph Design

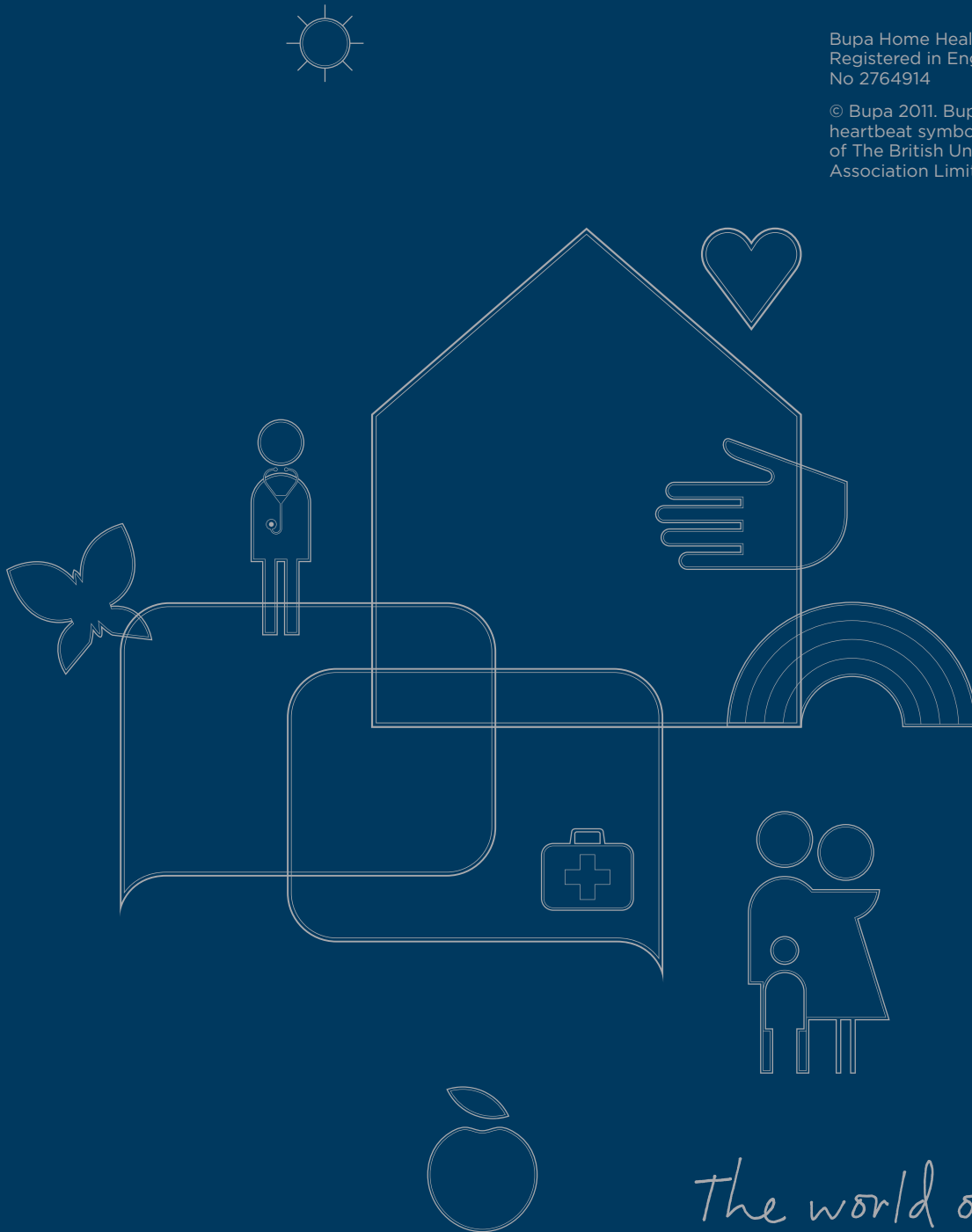


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