FOR HEALTHCARE LEADERS
HSJ

CARE CLOSER TO HOME

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IN ASSOCIATION WITH BUPA

HOMING INSTINCT

WHY OUT OF HOSPITAL CARE MAKES SENSE FOR PATIENTS AND THE NHS

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FOREWORD

IN ASSOCIATION WITH BUPA

Bupa

CARE IN THE MOST APPROPRIATE A HELPI

CARE IN APPROPRIATE SETTINGS

Why care out of hospital needs to be made more robust if the problems of bed blocking and delayed discharge are to be prevented from getting much worse. We also look at Bupa's risk stratification tool that can help to identify those most likely to be admitted.
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EARLY DISCHARGE

Moving patient care out of the clinical setting and into the community can improve patient experience and reap financial rewards for healthcare organisations.
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"As the challenges facing the NHS become more acute, and with the winter pressure season upon us, the opportunity for the NHS and the third and private sectors to work together is clear.

The goal is to develop longer term solutions for patient-centred preventative care, but we should also focus on practical steps which can be taken today.

Understanding the needs of the community at the local level is key. A recent audit Bupa conducted at a typical NHS district general hospital showed that within a single two-week period, 87 patients could have been discharged to an appropriate out of hospital care solution, saving nearly 600 bed days.

Patients could have been cared for in their own homes, or in an intermediate care setting such as a care home to support the transition from hospital to home.

Practical steps such as providing short-term IV antibiotics in the home can release beds and free up valuable hospital resources, while exploring the provision of more systematic care in the home and community for those patients who are clinically stable.

Importantly, short term tactical solutions can go hand-in-hand with pursuing longer term 'out of hospital' care solutions.

New models of care are essential as part of the longer term solution, and this may encompass care in a variety of settings most appropriate to the individual, including the home, care home or community clinic. It's well documented that patients prefer to be treated in a familiar setting where they feel more comfortable, and satisfaction with home healthcare is around 99 per cent.

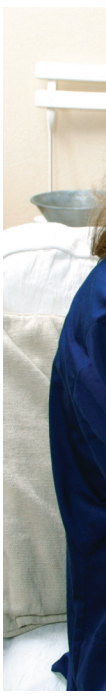
'To achieve the cultural change, we must think big while appreciating the complexities and work together in partnership to make our vision come to life'

Technology is also an integral part of this and it is important we understand the benefits it can bring to the commissioner and the patient.

Although the benefits are clear, integrated out of hospital care is still limited to a few pilot areas and has not spread more widely. To achieve the cultural change necessary for an increase in the provision of out of hospital care, we must think big while appreciating the complexities, be committed to breaking down barriers, and work together in partnership to make our shared vision come to life.

Tiffany Hall is managing director, Bupa Home Healthcare."

Unnecessary hospital admissions and bed blocking are set to increase unless community support is ramped up



When commissioning adviser Jacqui Lyttle was asked to carry out an audit of patients in a district general hospital she found that over a quarter of them had no medical need to be there.

Many could have been treated in a community setting – a step-down environment or at home – and some had been unnecessarily admitted in the first place. The problem is that there was a lack of sufficient community-based services.

"I think what we identified was typical across the UK," she suggests. "The problem is delayed discharge, which means that patients [who need to be treated in hospital] can't be admitted because of bed pressures."

Ms Lyttle, an independent consultant asked by Bupa to carry out the audit, says that the 336 patients the audit looked at (paediatrics and areas such as intensive care were excluded) over two weeks in May accounted for 590 unnecessary bed days.

Two hundred and fifty seven of these could have been saved if services were available to support patients at home, and 230 more if they had access to a step-down service. Of the remaining days, 63 could have been saved if patients received IV antibiotics. In total, 87 patients would not have needed to be in hospital if the right service was available elsewhere.

The audit gives some indication of the scale of the problem for the NHS, but also the opportunities. Sir Stephen Bubb, chief executive of the Association of Chief Executives of Voluntary Organisations (ACEVO), sums it up: "Too many people receive care in acute settings when they could be cared for at home or in the community."

If the acute sector is to cope with the predicted surge in emergency admissions this winter, having good alternatives will be vital. Research by the Nuffield Trust and Health Foundation has shown that preventable admissions have risen by 26 per cent in a decade – and halting this rise will

CONTINUES PLUS CASE STUDIES OVERLEAF ▶

SETTINGS

NG HAND FOR THE NHS

GETTY

WINTER PRESSURES

To support the NHS in the short term, the government has made an extra £250m funding available to 53 NHS trusts this winter. Of this:

- £51m is for improving urgent care services – eg for patients with long term conditions.
- £25m is for primary care services such as providing care for patients in their home and admissions avoidance.
- £16 million is for social care – eg integrating health and social care teams to help discharge elderly patients earlier and prevent readmission.
- The Department of Health has also announced an additional £150m winter pressures fund for emergency departments that are not receiving a share of the £250m unveiled in September.

be a priority for providers and commissioners.

While avoiding unnecessary admissions is important, the bigger savings are likely to be in discharging medically fit patients earlier. This will require good organisation within hospitals and also the right mix of services in the community to support early discharge.

NHS Confederation policy director Johnny Marshall says out of hospital care "is taking on a new significance as resources are stable, demand is growing and vulnerable older people are coming into A&E with more complex problems".

And Jeremy Taylor, chief executive of National Voices, says: "We are spending too much at the crisis end of the spectrum. We don't have a systematic approach to supporting people to self manage. We don't have well-funded social care. And we have GP services that are a cottage industry."

'We are spending too much at the crisis end. We don't have a systematic approach to supporting people to self manage'

At the Dudley Group of Hospitals the development of out of hospital services has been crucial in ensuring the trust is ready for the coming winter. This has included an out of hospital antibiotic service and a team delivering a virtual community ward.

Without these sorts of measures, chief executive Paula Clark says there could be "protracted trolley waits, ambulance turnaround and having to regularly cancel surgical patients. That would affect our 18-week target but it is also about the quality of patient care."

But her trust is in an unusual position of running both acute and community services – others will need to work with other providers and commissioners to ensure those services are available.

Out of hospital care can be more cost effective than hospital care. Sir Stephen Bubb has warned that "a reactive approach to treatment is financially unsustainable". But looking after people closer to home also has other advantages.

"Patients prefer to receive their care in a setting where they feel most comfortable, and for many this is the home environment," says Tiffany Hall, managing director of Bupa Home Healthcare.

It can also propel them towards independence and mean they are less likely to be exposed to infections. So what could be a game changer this year? There is intense pressure on hospitals to prepare for and cope well with the inevitable increase in emergency admissions over the winter period and to maintain quality – which is infinitely harder if emergency departments are overflowing with patients who can't move into beds.

The answer could be in a new approach to providing care – one that follows the particular needs of a patient rather than assuming that hospital is the best place for all patients.

"Commissioners need to look at who is out there as providers and put together a package of support from whoever has the talent," says Mr Taylor. "But we still need a service which wraps around the individual's needs."

There is a key role for the NHS to play in providing these much-needed services. However, given the scale of the demand and existing pressures on the NHS, commissioners are turning to some independent organisations that can provide services such as IV antibiotics or an integrated approach encompassing care in a residential setting and care at home.

There are variations in the way that local areas are preparing for winter – some are better prepared than others, and the approach is far from systemic.

The challenge is not convincing people out of hospital care is necessary, but getting it to work within existing funding flows and overcoming artificial divides between health and care services. ●

A MISSION TO CUT ADMISSIONS

Since two thirds of emergency hospital admissions involve people with long term conditions, keeping this group as healthy as possible and helping them cope with any exacerbation of their illness is key to reducing the pressure on hospital A&E departments and beds.

In 2010 there were 15 million people in England with one or more long term conditions: that number is expected to grow to 18 million by 2025.

However, the number with three or more long term conditions is expected to grow from 1.9 million in 2008 to 2.9 million by 2018.

How can these people be kept as well as possible and preferably out of hospital? In the longer term, early intervention and health promotion could reduce the burden on ill health on both the individual and the healthcare system. Chief executive of the Association of Chief Executives of Voluntary Organisations Sir Stephen Bubb advocates addressing the underlying causes of poor health, and offering support to stay healthy.

In the shorter term, however, it is also important to think about practical ways health and social care services can adapt to avoid unnecessary admissions to hospital.

Many health economies are therefore looking at admission avoidance and supporting people at home or other appropriate care setting in the community.

NHS Confederation policy director Johnny Marshall says about 20 per cent of unplanned admissions to hospital should be treated in the community – although he adds that a short stay in hospital at the 'right' point in someone's illness is preferable to an unplanned admission.

"The aim must be to try to manage their independence. It is important to facilitate that outcome rather than trying to stop people being admitted to hospital."

Dr James Kingsland, president of the National Association of Primary Care, uses the example of a patient with diabetes who was admitted at the weekend and ended up staying in hospital for nine days,

CASE STUDY: COPD PATIENTS IN SOMERSET

David Miles likes to walk up Glastonbury Tor: it takes him quite a time and people sometimes look at him when he gets breathless but it shows him, he says, that his COPD does not stop him doing the things he enjoys.

Mr Miles, who has had COPD for five years, is supported by a Bupa Home Healthcare/ Avanaula service set up to provide additional specialist support for patients in Somerset. For Mr Miles, this service has included two courses focused on exercise and education, a three monthly review at a specialist clinic, a telephone helpline if he runs into problems, and advice on how to cope at home if his condition gets worse. He has an emergency supply of steroids and antibiotics, and also has access to a nebuliser if he needs one. But for him one of the key parts is the nurses.

"They give you the incentive to get up off your backside and get on with life," he says. "It is a state of mind as well as a state of physical health."

He also values the courses he has been on where he has met other people with same condition. He has been encouraged to take exercise and lose weight, and his condition has remained stable for much of this time.

A care plan has reduced variability of services for COPD patients

Mr Miles is one of 2,600 patients across Somerset on the scheme. Dr Richard More, who developed the programme with a colleague and now works alongside Bupa, says that proper treatment of COPD has the potential to reduce emergency admissions by 10 per cent.

The model involves highly specialist nurses seeing COPD patients from across many practices – something that was easier than training up 76 practice nurses, he says. COPD patients are diagnosed in general practice and will then see one of these nurses for an appointment lasting up to an hour which will look at how their condition is being managed and what can be done to improve it. Patients will leave with an individualised care plan.

Dr More says this has reduced variability of care – something which was known to be an issue in COPD care. Patient satisfaction with the service is also extremely high: 92 per cent said they were either entirely satisfied or satisfied, while 82 per cent attended their pulmonary rehabilitation classes – important in helping them manage their condition.

Julie Excell, Bupa Home Healthcare's regional clinical manager, says: "If we see patients early enough then we can educate them on their condition."

The service is evolving, and she wants to see increasing numbers of patients in their home as well as to respond quickly if they do have a hospital admission. This involves enhanced use of IT, so that patients at risk of deterioration can be spotted earlier and proactive interventions started to avoid hospital admissions.

It's a model which she believes could work for other chronic conditions, such as heart failure and diabetes, where patients also need education and ongoing support, as well as clinical interventions.

'The nurses give you the incentive to get on with life. It is a state of mind as well as a state of physical health'

FACTS ABOUT COPD

- COPD is the second most common cause of emergency hospital admissions and one of the most costly inpatient conditions to treat, costing the NHS over £800m annually
- Currently around 835,000 people in the UK are diagnosed with COPD, with an estimated 2.2 million undiagnosed
- Between January and December 2010, non-elective COPD admissions cost the NHS £287m. According to Dr Foster research, GP practices could save £40m by reducing these admissions to expected levels
- COPD costs employers and the economy £3.8bn annually in lost productivity. Some 25 per cent of people with COPD are prevented from working due to the disease
- A third of those admitted to hospital as a result of COPD are readmitted within a month
- Some 40 per cent of those with COPD also have heart disease

Early intervention and health promotion are two ways that the burden on the health system could be lessened

‘A patient with diabetes was admitted at the weekend and ended up staying nine days, at a cost of £5,000’

at a cost of £5,000 to the NHS. It’s not an uncommon occurrence but if each GP practice could avoid one admission like that a week the NHS could save £2bn a year. He suggests the answer is better integrated care, based around a practice population, and pulling in the services needed to support people closer to home.

As a first step it is vital to identify risk and target such services to the patients who are most at risk of an emergency admission. Data analysis is becoming increasingly important in understanding the likely shape of demand on services.

Risk stratification, both at a population level and within smaller groups such as those with particular conditions, can predict which patients are most at risk of admission to hospital and allow early intervention to prevent this.

Bupa has developed a risk stratification tool which brings together NHS data, demographics, and census data to pinpoint which patients are most at risk of admission. It uses GP and secondary care datasets to help the NHS plan service redesigns.

The tool is already in use in Worcestershire, where clinical judgment within GPs’ surgeries is then used to decide if they are appropriate for a virtual community ward approach.

The tool is a building block in a system which is designed to ensure people receive the right care in the right setting. Janet Austin, clinical services locality manager at Worcestershire Health and Care Trust, says: “Community matrons have a meeting with the practices to discuss the patients who have a high risk score. The matrons will then visit appropriate patients at home and discuss their needs. When we implemented the system two years ago we saw a dramatic fall in unplanned admissions.”

Once appropriate patients are identified, schemes – which can encompass nursing care, telephonic coaching, nutrition advice, and fitness monitoring – can be put in place to ensure they stay as healthy as possible. Integration is key to delivering this, as often patients will require a mix of health and social care services, and ones which are immediately responsive if a patient’s condition deteriorates.

Tiffany Hall, managing director of Bupa Home Healthcare, says the last 18 months have seen an upturn in interest in commissioning services which are intended to avoid unnecessary admissions for a range of long term conditions. With risk stratification expertise, and capability in both health and social care provision, Bupa is well placed to provide such services, often working closely with local NHS organisations.

In Somerset, Bupa is working with COPD patients to keep conditions stable in a groundbreaking scheme which could be applied to other long term conditions (see box). Patients get regular appointments, courses to educate them on self management and then a plan on how to cope if their condition unexpectedly deteriorates – such as emergency supplies of medicine.

But for some patients, home care may not be enough. They may require more intensive support for a short time, with the aim of ultimately returning home. Step-up care can help when they need, for example, more concentrated physiotherapist input but do not need to be in an acute hospital.

Inevitably some people will need the sort of care which can only be delivered in a hospital bed: but by making use of the community-based alternatives, NHS commissioners and providers can ensure the beds are there for those who really need them. ●

TECHNOLOGY: UNDERPINNING NEW MODELS OF CARE

It is critical that the health service works with new technologies to drive forward models of care such as virtual wards and specific admissions avoidance schemes.

This can improve co-ordination between those caring for patients, information sharing and also outcomes reporting. Alan Payne, Bupa’s head of healthcare IT, says previously healthcare technologies could be very expensive because they were proprietary. Now there are opportunities to make new uses of existing and cost-effective technology which is also likely to be familiar to patients, carers and healthcare staff.

By e-enabling healthcare services, more efficient care can be delivered. Increased technology does not need to be faceless and can provide greater interaction with even the remotest of patients.

ALAMY

EARLY DISCHARGE

FACING UP TO HOME TRUTHS

Virtual community wards can help patients reap the benefits of discharge from hospital – and offer potentially big savings to the NHS

Reducing the time patients spend in a hospital bed they don't need is crucial as the NHS tries to meet savings targets and improve care.

An extra night in hospital is likely to cost the NHS at least £250. In 2011, the benefits of early discharge to home were calculated at £1.3bn and 14,500 bed days, while other patients could be better cared for at lower cost in a supported environment such as a care home.

As well as the financial benefits of discharging patients from hospital earlier, there are benefits for the patient, too. Some patients may be particularly suitable for care at home – those who are in hospital primarily because they need intravenous antibiotics, for example, are often well enough to go home. Administering antibiotics at home can save bed days and get the patient back to their normal life more quickly.

Dr Paula Franklin, Bupa's medical director, says patients benefit from being in a home environment: "It can make a huge difference to their quality of life," she argues. "I was recently out with one of our nurses who was supporting an elderly gentlemen with a chronic condition. We are supporting him in managing his IV line and various other elements of care. If he did not have this done at home he would be in hospital for a long time."

Being in their home environment often enhances patients' quality of life and supports them towards regaining independence. "We have to see it as an ongoing continuum and come back to what the goal is – restoring maximum independence," says Johnny Marshall, policy director at the NHS Confederation.

But not all patients who could currently benefit from early discharge either straight to home or to a step-down environment have such an option. In some cases this will be because there is not enough capacity in the local NHS – be that in the form of beds in a residential setting or staff with the required specialist skills to support patients at home. It is not surprising, then, that many NHS organisations are now looking at independent providers to support them in this regard, whether on a short term or longer term basis.

One approach that could support earlier discharge from hospital is the virtual community ward. This brings together staff with different skillsets to support patients in the setting that's right for them. For some patients this will be discharge straight to their home, but with a package of support which could include nursing and therapy services. For others, a care home environment is appropriate. Whatever the setting, the idea is that healthcare professionals deliver closely coordinated care. This can include multidisciplinary meetings to discuss the progress of patients and to adjust care accordingly.

'Jacqui Lyttle says virtual community wards "take the professional to the patient rather than forcing the patient into hospital"'

Jacqui Lyttle, who advises a number of CCGs on commissioning, says virtual community wards "take the professional to the patient rather than forcing the patient into hospital".

They need to be backed up with teams of professionals who can provide access to good domiciliary care. Some patients with specialist needs may require care from specialist nurses, which can often be delivered in the home.

She says patients in need of IV antibiotics are one group who could be cared for at home relatively easily. Despite the benefits of such an approach, take-up has been sporadic. This can be down to a lack of resources to support such a shift in approach, as well as the lack of a model to shift the culture and operation of the local NHS towards a new approach. Although

CASE STUDY: LIVERPOOL

Rowan Garth nursing home in Liverpool is an example of how residential care can help reduce pressure on the acute sector and ensure that patients are helped to regain independence, whenever possible.

The Bupa care home has 30 beds commissioned by Liverpool CCG to provide care and support to carefully selected patients who are medically fit to be discharged from hospital but can't go straight home. Patients can be admitted to the care home within two hours of the decision to discharge and the aim is that the average stay is under 30 days.

The most recent statistics show that 70 per cent of patients were able to return straight home after their stay in the care home, something which is made possible through working closely with local health services.

Five per cent moved into a residential setting, and 25 per cent were readmitted to hospital – which the team at Rowan Garth is striving to reduce.

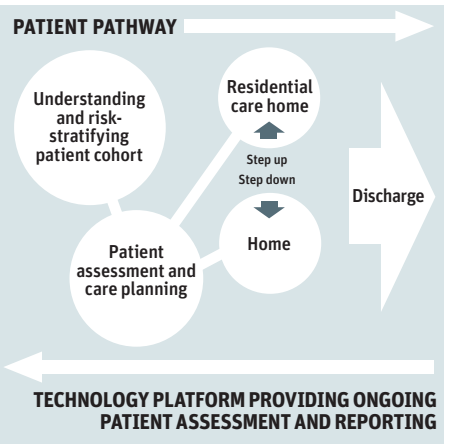
Vivienne Birch, director of partnerships at Bupa Care Services UK, says the self-contained unit within the home has an ethos of encouraging independence and supporting people return to their own homes; a very different ethos from that traditionally found in care homes. This mindset shift is being enhanced through training, but staff already find it tremendously satisfying to see patients recover confidence and the ability to live independently.

'We coach people through dressing rather than do it for them'

"It's important to do things with patients rather than for patients," explains Ms Birch. "For example, we coach people through dressing rather than do it for them."

Close coordination between local health and care services is vital to the success of the scheme – it is crucial to carefully select the patients who are able to benefit from early discharge from hospital into the reablement unit. Liverpool CCG is now commissioning other beds in Bupa care homes in the city for patients who need rehabilitation rather than nursing care.

One additional benefit to come from the scheme is that a Bupa nurse has been seconded to the CCG where she attends multidisciplinary meetings to discuss patients and helps co-ordinate care. This has aided understanding of problems and strengthened working relationships. ●



TREATABLE IN A VIRTUAL WARD

Range of care activities

- Monitoring eg bloods, weight, fluid retention, oxygen saturation
- Administration of medicines
- Management of wounds, catheters, port
- Physiotherapy for mobility, breathlessness
- Domiciliary care support
- Reporting on patient progress and underlying conditions
- Self-management coaching and care plans for chronic conditions with frequent exacerbations

Range of patient conditions

- Chronic heart disease
- Stroke
- Chronic obstructive pulmonary
- Osteoporosis
- Diabetes
- General frailty

barriers exist, there is clear opportunity to develop such models more widely. Bupa has been working with the NHS in a large number of health economies to support this shift towards care outside hospital. According to Tiffany Hall, managing director of Bupa Home Healthcare, this virtual ward approach is already helping patients on IV antibiotics, parenteral nutrition, or chemotherapy to leave hospital and have their care delivered at home.

The emphasis has to be on what is clinically appropriate for the individual patient – and can complement what is already available in the local community. Bupa Home Healthcare sometimes provides services for patients who are some distance from a hospital, while the hospital's own outreach team deals with those who live closer, for example.

It may be that some patients will need additional support after they leave hospital, and so are best cared for in a residential setting before going home. Transferring patients to this setting, with an emphasis on reablement, frees up NHS capacity but it requires a joined up approach between commissioners and providers across both health and social care. Coordination is also needed between staff in the care home and those in the hospital.

Andrew Cannon, managing director of Bupa Care Services UK, says that, as average lengths of stay have come down, patients being discharged have higher levels of dependence.

"We have seen a very dramatic acceleration of that over the last 18 months. The whole mix of what we are doing has changed."

This can often involve working alongside NHS organisations which may provide dedicated occupational and physiotherapy staff to support patients in a care home setting.

However, the reablement approach goes deeper than that and involves all the staff in encouraging patients to regain mobility, functional skills and confidence.

When patients are ready to leave the residential setting, they can return home but with support that helps them gradually maximise their independence and that may reduce costly readmissions. Tiffany Hall, managing director of Bupa Home Healthcare explains: "We have the capability to deliver healthcare across a number of settings. If we add that all together we can help many more patients."

A good out of hospital service needs planning, communication between partners, and a focus on identifying patients who will benefit from different settings – all of which can be hard to do.

But carefully designed and delivered schemes offer the chance to improve patient experience and quality of care, while also meeting the NHS's need for savings. And they could offer a way for early discharge to become the norm and average length of stay to reduce. ●

Find out more

Turning Vision Into a Reality: a practical guide to moving care out of hospital. Bupa Home Healthcare.
➔**http://tinyurl.com/c59sf8m**
Taking the Pressure Off: the opportunity for home healthcare in today's NHS. Bupa Home Healthcare.
➔**http://tinyurl.com/p5epena**

ALAMY