Monitor

Making the health sector work for patients

Moving healthcare closer to home: Summary

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About Monitor

As the sector regulator for health services in England, our job is to make the health sector work better for patients. As well as making sure that independent NHS foundation trusts are well led so that they can deliver quality care on a sustainable basis, we make sure: essential services are maintained if a provider gets into serious difficulties; the NHS payment system promotes quality and efficiency; and patients do not lose out through restrictions on their rights to make choices, through poor purchasing on their behalf, or through inappropriate anti-competitive behaviour by providers or commissioners.

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Foreword

The health and social care system in England is under huge pressure to deliver better outcomes for patients in the face of increasing demand, limited resources and tightening budgets. These pressures came to a head last winter with most hospitals performing poorly against A&E standards.

The NHS faces the twin challenges of developing solutions to address these operational and financial challenges now and of building a more sustainable and resilient health and care system in the future. A number of approaches are being looked at. These range from developing new care models nationally, to local health economy reconfigurations and schemes that would radically improve provider productivity. Many of these solutions have a common feature: they involve ambitious strategies to move healthcare closer to home.

The Moving Healthcare Closer to Home project emerged from conversations between Monitor, the Nuffield Trust and the sector. These revealed questions about the extent to which shifting healthcare closer to home and away from hospital settings would deliver significant cost savings for local health economies. We were keen to understand the reasons for these assumptions to help support better decision-making.

Evaluating the financial impacts of schemes to shift healthcare closer to home is difficult because understanding what schemes cost and their broader effects is complex. Fluctuations in admissions and length of stay, and the stepped nature of overheads and staff costs in hospitals all mean that the relationship between volumes and cost is far from linear. Monitor has used a simulation modelling approach in this research to better understand these complex effects.

Our research finds that moving healthcare closer to home will indeed be important in addressing the pressures of future demand and that this **may** avoid further costs in the longer run. In this set of reports, Monitor highlights some of the potential challenges of developing effective schemes that run efficiently, at scale and address the specific circumstances and needs of the local health economy, and shares learning on some solutions.

That said, our findings caution against expecting too much from a shift away from hospital settings: this is no panacea. Developing schemes to move healthcare closer to home should sit alongside work on other solutions, such as improving internal processes and decision systems within acute hospitals. For example, further work on efficiency opportunities (of the sort set out by Lord Carter in his review of operational productivity) and improving patient flow (the subject of current Nuffield Trust research) could provide support to deliver the short-term improvements needed.

When they develop strategic plans, providers and commissioners will benefit from making pragmatic, evidence-based appraisals of how the benefits (both for patients and for organisations' own finances) compare with the costs of the various approaches. Our ambition is for this set of reports to help the sector to do that.

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1. Introduction

Demand for acute hospital care is increasing in England. Demographic change alone is estimated to lead to 1.7% annual growth in demand for acute hospital services and this is expected to be compounded by changes in disease prevalence. The Nuffield Trust estimates that without changes in the way in which care is provided, 17,000 new hospital beds will be needed in England by 2021/22.

To meet this challenge, recent national policy such as the Five Year Forward View[1] and the New Care Models Programme[2] has encouraged efforts to deliver more healthcare out of acute hospitals and closer to home, with the aim of providing better healthcare for patients, cutting the number of unplanned bed days in hospitals and reducing net costs.

Providers and commissioners considering strategic changes to the way in which services are delivered need to agree what they wish to achieve, understand the range of options and be able to assess the overall clinical quality and financial impact of each scheme.

To support this decision-making, we ran a project to examine cases where provision of non-elective care moved from an acute hospital to the community, meaning community hospitals or the patient's own home or usual place of residence.

We asked:

- What are the options for moving healthcare to community-based settings (including the clinical rationale and impact, and some of the business models)?
- What is the best way to assess the schemes' financial impact? What would it take for a scheme to make cost savings?
- What are the main implementation challenges? How have other providers and commissioners overcome them?

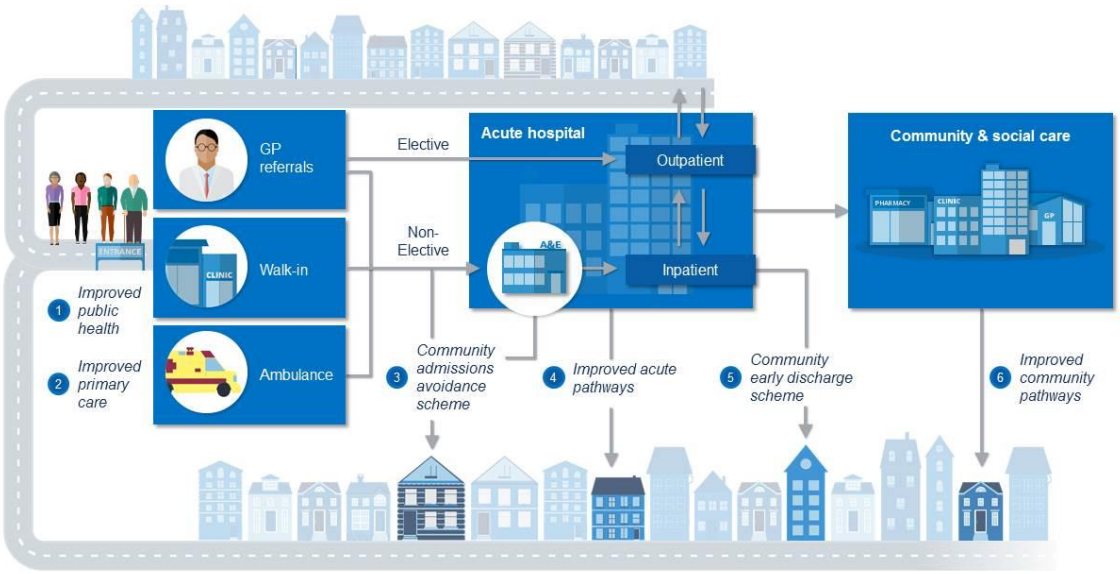
We then developed a range of resources to support the sector in strategic planning, particularly planning new care models. See Section 5 for more details.

[1] The Five Year Forward View (www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf) outlines how the NHS in England needs to change to provide high quality, financially sustainable care in the future. Increasing out-of-hospital care is a key component of this approach and the NHS is committed to support new care models which deliver viable local health and social care services.
[2] The New Models of Care Programme was established to support 'vanguard' areas to rapidly develop and implement the new care models outlined in the Forward View. Models such as the Primary and Acute Care Systems (PACS) will integrate primary, community and acute services to reinforce out-of-hospital care.

2. What we looked at

Changing patient flows and pathways could deliver clinical, financial and operational improvements in a local health economy. Options range from improving public health to reduce flows into primary care and hospital, to improving flows within acute and community settings to deliver care to patients more efficiently. See Figure 1 below.

Figure 1: Six methods of delivering cost savings in health and social care by changing patient flows



For this project, we focused on schemes to provide care closer to home that aim to avoid emergency admissions to acute hospital (flow 3) and/or discharge patients more quickly from acute hospitals (flow 5). In addition, we worked with the Nuffield Trust to consider methods of reducing length of stay in acute hospitals by improving internal efficiency (flow 4).

Moving healthcare to closer to home is not a new topic. Existing analysis ranges from evaluations of specific schemes to wider reviews of sets of schemes combined with cost modelling.[3] We built on this work by developing a new approach to modelling schemes to gain a robust and realistic view of their financial impact across a local health economy. This included:

- calculating the impact on underlying costs over a five-year period rather than on provider revenues or commissioner spending

[3] See, for example, NHS England's *Any town* reports (www.england.nhs.uk/2014/01/24/any-town/).

- taking into account the stepped nature of cost reduction in acute settings, where bed bays and wards need to be freed up to be able to take out any costs

- using a scenario simulation tool to take into account the variability and subsequent impact of schemes that move healthcare to community-based settings (Annex 2 of the financial impacts paper provides more detail on this technique).

We applied this approach to modelling the cost effects of four types of scheme:

- **Telehealth**, which prevents acute hospital attendances and admissions by providing 24-hour remote support and triaging through a video link.
- **Enhanced step-up**, which prevents acute hospital attendances and admissions by treating all adults in crisis not suffering hyper-acute episodes in a community hospital day-case setting.
- **Rapid response and early supported discharge**, which provides treatment in patient homes to patients entering crisis or recovering from inpatient stays to reduce attendances and admissions and length of stay for patients.
- **Reablement,** which helps patients with complex needs to recover at home and live as independently as possible again after an illness or hospital admission, as well as reducing ongoing social care costs, through regular visits for up to six weeks.

More information on these schemes, including the types of patients they target, the costs they can avoid and how much they cost to run, is provided in Annex 1 to the financial impacts paper.

We put together a wider set of case studies for lessons on implementing schemes. We focused on moving patients needing non-elective physical healthcare out of acute hospitals rather than on patients with mental health needs.[4]

3. Key findings

3.1. Well-designed schemes to move healthcare closer to home can deliver benefits in the long term

Treating more patients out of acute hospitals is one way to meet growth in demand for acute care. The schemes reviewed show it is possible to treat patients with quite severe clinical needs in community-based settings. Our literature review of the clinical impacts indicates that although there are risks, well-designed schemes are

[4] There has already been a substantial shift of mental health services to community-based settings. For example, the King's Fund's 2014 report, *Service transformation: lessons from mental health,* provides an overview of changes in the provision of mental health services, drawing lessons that apply to moving more acute provision to community-based settings.

likely to have clinical outcomes that are equal to hospital care and sometimes better. Patient access may also be increased as schemes to avoid admissions may provide healthcare to patients who otherwise wouldn't have accessed acute hospital services and provide them with the care they need (although this may increase total costs of the scheme).

However, caring for patients with some severe needs out of hospital can be challenging. The implementation considerations paper discusses these challenges and possible solutions.

Our financial analysis shows that, when implemented well, these schemes could deliver care at lower cost than comparable care in an acute setting in the longer run. We found that:

- Some schemes incur lower costs of care per day, for example, through using technology. These schemes also tend to operate with lower fixed costs than care in acute hospitals, so savings can be greater in local health economies where estates costs are very high. In addition, lower proportions of fixed costs allow schemes to run more flexibly, helping local health economies to manage fluctuations in demand.
- Some schemes provide more intensive care for patients but take fewer bed days to treat them. Although higher intensity staffing means that the per bed day costs of these schemes are higher, overall costs for the patient spell can be lower.

3.2. It is difficult to cut costs across a local health economy in the short run

Although schemes can help hospitals avoid future capital spending, it is difficult for local health economies to save costs in the short run through community-based schemes. Three of the four schemes we modelled did not break even within five years. This is because:

- Schemes can take up to three years to set up, recruit and become sufficiently credible to attract referrals. So providers and commissioners should not expect immediate impacts.
- Even when schemes are cheaper per patient, it may be difficult for the local health economy to realise any savings. A local scheme (or schemes) will only lead to health economy-wide savings if it consistently diverts enough patients from local acute hospitals to allow them to close bed bays or wards. The cost saving is then only realised if providers and commissioners have the will to close down capacity that is freed up. In the context of rising demand for acute care, commissioners and providers will need to be entirely confident that community-based schemes can safely absorb expected extra demand before they will feel justified in closing acute capacity. However, community-based

schemes will help commissioners and providers to avoid or delay future capital spending whether acute capacity is closed or not.

3.3. Better data and improved pricing would help

Our findings above only apply to schemes that are well designed and well suited to individual local health economy circumstances. Good quality data and well-thought-out pricing incentives are important in ensuring that schemes suit local health economy circumstances and have the incentives to operate effectively and efficiently.

Good quality data is required to enable proper evaluation of the impacts of schemes that will support planning and implementation decisions for providers and commissioners. This includes data on the characteristics of patients that will be affected by schemes, the ongoing care needs of these patients and the resources and costs required to run schemes. For example, providers say admission avoidance schemes may reduce readmissions in the long term, but lack of robust data prevents them – and us – from modelling these effects for planning purposes. Annex 1 to the financial impacts paper provides more detail on the data required to conduct full evaluations of the types of schemes we have reviewed.

Better data would also enable providers and commissioners to set payment incentives that ensure:

- The costs, benefits and risks of schemes can be shared across local health economies. For example, reablement schemes can deliver significant savings for the local health economy in the short and long run, but benefits accrue to social care (including self-funded social care) whereas costs may be incurred in health. This shouldn't be a barrier to effective schemes being developed, but in practice it can be.
- Schemes run effectively and deliver value to patients. Payment incentives can help ensure schemes are well designed in the patient cohorts they target, the quality of care they offer to patients and the resources they take to run.

4. Conclusions

Developing ways to deliver quality care for patients closer to home, whether that is through providing treatment and rehabilitation at home or in the local community, is an important part of the new care models currently being developed. Our analysis shows that well-designed schemes can bring about patient benefits and may be able to deliver care at lower cost over time, although providers and commissioners should be mindful of the time and investment taken to deliver these changes.

It is very important that schemes are well designed; clinical models need to be robust to treat severely ill patients and schemes need to run efficiently and effectively to be able to deliver any cost savings. Providers and commissioners need to ensure they

understand the challenges and the aims of change before developing options and schemes need to be tailored to individual circumstances. Often these schemes will be part of wider strategic changes to deliver care differently across a local health economy; they will have more impact if they are linked up and seamless from the perspective of the patient. Good data and aligned incentives to share losses and gains across different organisations and health and social care will support the design of such schemes.

Developing schemes to move healthcare closer to home is just one option available to providers and commissioners dealing with capacity-constrained acute hospitals and tight finances. Although these schemes will be important in addressing longer term needs, they may not be able to address more immediate operational challenges. This suite of papers does not review other methods of addressing these challenges but examples of other options are outlined in brief below.

- Addressing flow challenges in acute hospitals through better triage and discharge processes to ensure that patients with less severe needs who are safe to return home without extra support can do so as quickly as possible. Utilisation reviews conducted across England suggest that significant bed days can be reduced by ensuring that patients who are safe to return home do so more promptly. We have worked with the Nuffield Trust on these flow challenges and they will shortly publish recommendations on addressing these challenges and further case studies.

- Optimising elective care pathways so that elective care patients stay in acute hospitals only when they need to, releasing capacity in acute hospitals. Monitor has conducted a review of productivity opportunities in elective care and this will be published shortly.

- Providing more proactive care to prevent patients from entering crisis and reduce attendances and admissions. This is the aim of many of the new care models vanguard sites and further guidance is provided here.

5. Using our resources

This project is part of Monitor's ongoing programme to support the sector in strategic planning, particularly when it comes to planning new care models. In this set of resources we provide further analysis to support the conclusions described above, as well as practical tools to support providers and commissioners in developing options, producing business cases and delivering schemes. The resources are:

- a literature review of the clinical impact[5] of schemes that provide care in community-based settings that is equivalent to care in an acute setting
- a financial impacts paper[6] setting out insights from our financial modelling, based on the cost collection and simulation modelling of four established types of schemes that offer at least clinically equivalent patient outcomes; this includes an annex to help providers and commissioners develop business cases for these types of schemes, and an annex on simulation modelling, the technique we used in developing this analysis
- an investigation of implementation challenges and solutions[7] from 30 providers who took part in this work
- 15 case studies[8] developed from interviews with providers on moving healthcare to community-based settings.

These resources are a part of Monitor's ongoing work to support sector strategy development, and in particular to support the sector in delivering operational and financial improvements through changing and improving patient pathways. We aim to support providers in their strategy development through framing and diagnosing the challenge, developing options, prioritising changes and delivering change. This diagram sets out how these and other resources fit into the structure.

[5] www.gov.uk/guidance/moving-healthcare-closer-to-home#literature-review-of-clinical-impacts
[6] www.gov.uk/guidance/moving-healthcare-closer-to-home#financial-impacts
[7] www.gov.uk/guidance/moving-healthcare-closer-to-home#implementation-considerations
[8] www.gov.uk/guidance/moving-healthcare-closer-to-home#case-studies

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