FUTURE HEALTH

Care closer to home

The role of clinical homecare in the revolution of patient care

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About Future Health

Future Health is a future focused Research Centre with a mission to advance public policy thinking that improves the health and wealth of people, communities and nations. Healthcare systems around the world are facing significant challenges of demographic, societal and technological change.

The importance of prevention and the development of new technologies have long been seen as ways to transform health systems to improve patient outcomes and performance, but progress has often been slow.

COVID-19 is an inflection point, demonstrating the need and opportunity of investing in and delivering more effective and efficient healthcare services in the future.

In undertaking cutting edge public policy research and generating new insights and solutions, Future Health seeks to shape the global healthcare policy debate and inform the decisions made by Governments and health systems to enable healthier, wealthier people, communities and nations.

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Executive Summary

The arrival of the coronavirus pandemic in early 2020 took lives, devastated communities and shook our health and care system. In the face of such a major challenge leaders, managers and staff across health and care worked to try and ensure that patients got the care they needed. A great deal of the way care was delivered changed. Care went online and it came into the home. New service models were procured and built in weeks instead of the usual months or years.

The pandemic has shown us that we need to change the way healthcare is delivered. Care needs to be more patient-centred, health inequalities tackled, digital solutions embraced, and more preventative care models used.

Before the pandemic steady, if unspectacular, progress had been made at moving care out of hospital and into the community. Over 350,000 people were receiving clinical homecare services before the arrival of COVID-19. In the immediate twelve weeks after the pandemic, an additional 765 services covering 20,000 patients were set up.[1] Across the next two waves of the pandemic 70,000 additional patients benefitted. Virtual wards were commissioned, new digital technology and monitoring services established, and home delivery services for medicines deployed.

This short paper from Future Health explores the benefits that delivering clinical care closer to home can bring for patients: reducing costs for travel, pressures on family members and carers, and ensuring greater continuity of care. It explores progress during the pandemic and the potential wider health system benefits of more systemic adoption.

It then looks at some of the traditional challenges to delivering more clinical care at home: IT and data systems that do not connect properly, inefficient and piecemeal contracting, a lack of leadership and clear direction setting, workforce planning, unclear regulation and fragmented delivery structures.

It explores the opportunities in the health policy environment to build on some of the progress seen during the pandemic. The chance, through structural changes and greater collaboration, to build more integrated services; to help join up health and care data; to engage patients more at home through digital tools and monitoring; to alleviate hospital pressures and increase capacity; and to align with the new regulatory structures and be a feature of future workforce planning.

The paper concludes by setting out the actions needed to realise the opportunities for greater care at home, particularly from the Government which should set a new ambition for doubling clinical homecare access over five years, and consider it as part of its efforts to tackle health disparities. In doing so, clinical homecare has the potential to play an important role in revolutionising the way patients access care.

CHAPTER 1 Overview of clinical homecare

Clinical homecare enables patients to be treated for a range of conditions in the comfort of their own home, at their place of work, or in the community. The treatments would otherwise be provided in secondary care settings such as a hospital, and clinical homecare services can range from straightforward delivery of often high-value medication, to specialist nursing and treatments for complex conditions.

Clinical homecare involves trained healthcare staff including pharmacists and nurses. These teams often work closely with hospital consultants and the wider NHS to co-ordinate care and provide a comprehensive service for each patient.

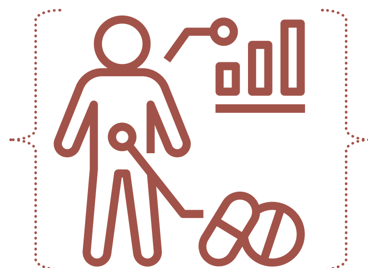
Clinical homecare can be at a patient's home, via a static or mobile treatment unit, or in a community pharmacy

Clinical homecare can deliver specific therapies such as:

- Cancer Therapies
- Enzyme Replacement Therapy
- Growth Hormone
- Home Parenteral Nutrition
- IV Antibiotics
- IVIG
- Oral Immunosuppressants

It can also support improved infection management. This service can help patients with a range of chronic conditions to better manage their treatments and symptoms. These include chronic conditions such as:

- Crohn's Disease
- Cystic Fibrosis
- Dermatological Conditions
- Haemophilia
- Hepatitis
- HIV
- Motor Neurone Disease



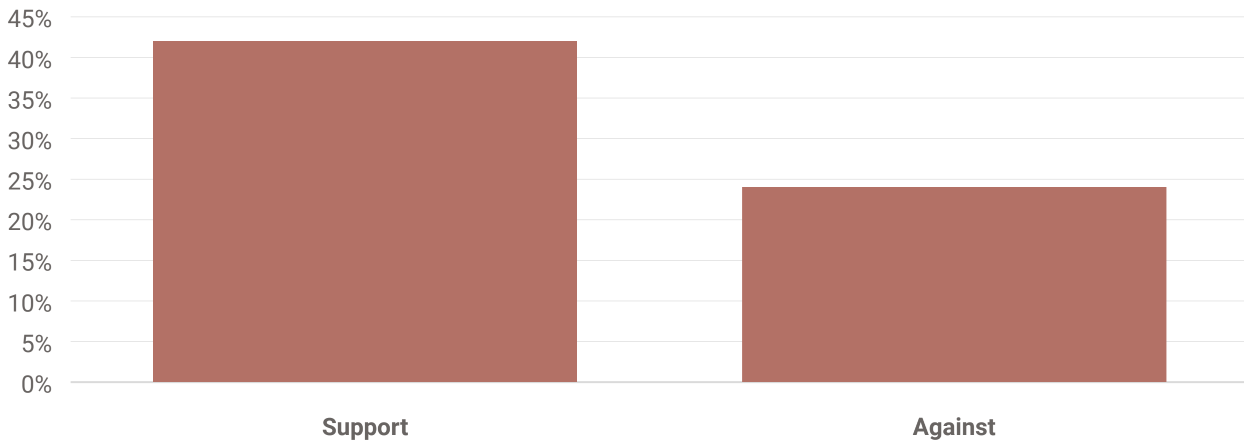
- Multiple Sclerosis
- Osteoporosis
- Parkinson's
- Pulmonary Arterial Hypertension
- Renal Anaemia
- Thalassemia

Within the NHS in England homecare medicine arrangements are typically those where the hospital contracts directly with a homecare provider or where a hospital purchases medicines that include the provision of homecare services, which are contracted by the manufacturer of the medicines. Around 372,000 patients were receiving homecare medicines services before COVID-19.[2]

CHAPTER 2 The patient and carer benefits

A survey conducted during the pandemic found strong public backing for clinical homecare. 42% agreed that the Government should do more to support care at home, and the same number said they would prefer treatment at home over hospitals. By contrast just 20% and 24% respectively were against such approaches.[3]

Chart 1: I would prefer treatment at home over hospitals



Provides continuity of care and improves patient quality of life

Clinical homecare enables patients to build a relationship with a particular nurse or pharmacist as part of a wider integrated team enabling continuity of care. This predictability and familiarity can provide a sense of safety and ease pressure on patients dealing with stressful conditions. It has also been shown to improve adherence to treatment thereby improving patient outcomes and reducing relapses or worsening the condition.[4]

Many patients feel they get more time with a healthcare professional in the community, than in hospital or with their GP, giving them more time to talk through issues, and to find better ways to manage their condition. Evidence shows that this approach can actually improve self-management and in turn, quality of life and outcomes for the patient.[5]

NHS England in turn notes that “prolonged stays in hospital are bad for patients, especially for those who are frail or elderly. Spending a long time in hospital can lead to an increased risk of falling, sleep deprivation, catching infections and sometimes mental and physical deconditioning.”[6]

A recent study, funded by the National Institute for Health Research (NIHR) and led by researchers from the Nuffield Department of Population Health at the University of Oxford, showed that caring for a select group of vulnerable, older people at home can improve patient outcomes, while reducing pressures on hospitals.

The same study also reported higher levels of patient satisfaction with Hospital at Home care. In particular, Hospital at Home scored highly regarding the length of time waiting for care to start, contacting staff, being involved in decisions and discussing further health or social care services.[7]

Minimises the impact on patient lives

Care at home, at work or in the local community, is more convenient and has a lower cost-impact for patients. For those juggling work, family responsibilities and their own health, it could be the difference between receiving support or not seeking it at all, leading to a deterioration of their condition.

Trips to hospital for an appointment take time – sometimes up to an entire day, unlike a home visit, or trip to the pharmacist. Such trips can also be stressful and cause anxiety for patients, carers and families. Clinical homecare could be particularly helpful to those living in rural communities who often have to travel long distances to their local hospital. Giving time back to patients helps improve their quality of life and limits disruption to employment.

Patient case study

Professor Aldwyn Cooper has Pompe's Disease – a rare genetic condition which requires fortnightly infusions which take four hours. As CEO and Vice Chancellor of Regent's University London, often working an 80 hour week, having to travel to hospital for this treatment would have had a detrimental impact on his career. He therefore opted for an available homecare service which enables a nurse to visit him at work to connect the infusion, enabling Aldwyn to continue working during treatment, and avoiding travel and waiting time in hospital.

"Without homecare I probably would have had to retire. I wouldn't have been able to lead the life I wanted to." Professor Aldwyn Cooper[8]

Travel to and from hospital can be expensive, particularly for those patients living on the poverty line, or for parents with work or childcare responsibilities.

Eases pressure on carers

Many patients with chronic and complex conditions will have reduced mobility or may not be able to access transport, making travel to hospital challenging. Those with particularly severe disability will be reliant on the availability of a carer, who is able to drive them to and from the hospital, and stay with them during their appointment. With a national carer shortage for basic support packages, patients often have to rely on family / friends to take them to and from hospital appointments. This burden can impact wider family members' lives and their ability to work. If there is no-one able to take a patient to their appointment they could miss critical health treatment and guidance on how to manage their condition, leading to worsening outcomes.

Patient case study

Gary needs 19 hour infusions on a daily basis to help manage his condition, jejunostomy, which has left him with very little function of his small intestine. This was initially delivered in hospital, severely impacting Gary's life and that of his family through time-consuming hospital visits.

Being freed up from the time and emotional burden of having to visit Gary on a regular basis in hospital has given them all the flexibility to lead normal lives as much as is possible with such a serious condition. Prior to homecare, Gary noticed the visible impact his condition was having on his mum and dad in particular, so he fully appreciates the benefits homecare has on those around him.

"It's important to remember that it's not just you, the patient that is affected by the condition, but your family too" said Gary.[9]

CHAPTER 3

The pandemic and health system transformation

COVID-19

The pandemic accelerated progress in delivering care closer to home. This was driven by a need to protect vulnerable patients from having to attend hospital and risk infection, as well as an urgent need to create capacity to cope with the rapidly rising numbers of COVID-19 patients. Across the NHS, services had to adapt and innovate, often through the use of new technologies and delivery partners including clinical homecare services.

This included adaptions to services like moving infusion clinics to 'COVID-free' sites and delivering hospital dispensed medicines directly to the patient's home. The first three months of the pandemic saw 20,000 new patients being referred for over 765 types of homecare services.[10] This was supported by the creation of standard template contracts being agreed to commission new homecare services to protect cancer patients and those with respiratory illness who were considered to be the most vulnerable.

Patient case study

Jessica was prescribed chemotherapy to treat her cancer in the first few months of the pandemic and referred to Lloyds Pharmacy Clinical Homecare. In summer 2021 she was visited at home by an Oncology Healthcare Assistant (HCA) for a pre-chemotherapy toxicity assessment and blood test. During this appointment the HCA identified a spinal cord compression. This can happen when cancer grows in the bones of the spine or in the tissues around the spinal cord and is considered an emergency in oncology. The HCA followed the escalation pathway appropriately and Jessica attended the hospital for clinician review where spinal cord compression was confirmed and then treated appropriately.

The use of technology was also rapidly rolled out to support remote consultations and monitoring of patients at home. A good example of this was the use of COVID-19 virtual wards such as at Pennine Lancashire NHS which supported over 2,000 patients. The service enabled support and monitoring to be provided on a daily basis over the phone, via video consultation or through a home visit if required, preventing the need for admission to hospital. The service secured national recognition and an award for its effectiveness.[11]

The NHSX Innovation Collaborative has also helped scale the use of digital tools during the pandemic to support over 78,000 patients with long term conditions across England.[12]

Helping to build NHS capacity and transform service delivery

The NHS in England could save a potential 500,000 bed days each year if every acute trust used virtual wards. It could also save £120 million by implementing clinical homecare across England.

There's no place like home (2016), Expert Clinical Homecare panel

Hospitals are battling long and growing waiting lists which had grown even before the arrival of the pandemic.

The Government's NHS Elective Recovery Plan sets out ambitious targets for the NHS to tackle these waiting times.[13] Clinical homecare can play a supportive role in delivering on this plan by providing care outside of the hospital setting, in turn freeing up clinical capacity and helping alleviate pressure on an already stretched service.

More effective care in the community can also prevent hospitalisation by helping patients manage their condition and prevent exacerbations. This in turn frees up hospital beds for the treatment of other patients on waiting lists.

This will remain important beyond the COVID-19 recovery to support the delivery of the growing number of new, innovative, complex treatments – some of which will require hospital care – displacing older treatments and care pathways, which will need to be provided in other settings.

Patient case study

Following a diagnosis of breast cancer, Linda opted to receive her ongoing chemotherapy treatment in a pharmacy, instead of in hospital. The flexibility of appointments has been one of the best parts of receiving treatment in a pharmacy – Linda can pick and choose her treatment times to fit around other responsibilities like work. She also found the continuity of care with the same healthcare professional really valuable giving her the confidence to discuss the wider management of her condition. Linda also noted the value of being able to park right outside the pharmacy and not having to queue for the hospital car park or in the hospital for her appointment.

CHAPTER 4 The policy challenges and opportunities for new action

Challenges

Despite the positive evidence which shows the value of care in the community to the NHS, patients and their carers, progress on expanding clinical homecare has been challenging due to structural, governance, cultural and societal processes and attitudes.

A review into homecare medicines and related services undertaken by Mark Hackett in 2011, identified several key areas where improvements were needed to both improve and scale up services. These included:[14]

- Variable and unclear procurement processes
- A lack of a coherent governance structure
- Difficulties with connecting and integrating IT systems
- Limited patient consultation and choice

As a result of the report, a series of workstreams produced new helpful standards, templates and frameworks including:[15]

- A Handbook on Homecare Services in England (produced by the Royal Pharmaceutical Society)
- A Governance guide
- An online tool for service level agreements
- Patient Charter
- Outputs based specification and technical specification
- Pharmacy Systems Homecare recommendations

These developments helped lay the foundations for an expansion of clinical homecare services. However, there remain some ongoing challenges for the NHS in implementing homecare services at scale.

Contracting and reimbursement

Contracting homecare services often falls to an individual hospital with each Trust operating a different model and approach. Contracting can be complex and involve significant resource, particularly legal and administrative time to set up and monitor agreements for each clinical condition which can be for relatively small groups of patients.

The cost of the out of hospital service is often contracted at the same cost as the traditional service, leaving little opportunity for savings or the exploration of gain-sharing benefits between commissioners and providers from the up-front investment in the new service model.

Poor IT and data systems interoperability

A lack of interoperable IT systems is a major barrier to implementing clinical homecare services. Systems between providers that are not able to connect effectively raise safety and service delivery concerns.[16] To run an efficient and effective homecare service there is a need for patient health records to be joined up - linking clinical (prescribing systems and clinical systems), pharmacy (ordering, invoicing, patient medication records, repeat prescription records), homecare provider systems, and financial systems. Despite some recent progress this is still not possible in many parts of the NHS.

Unclear service regulation

Clinical homecare services find themselves 'at the edge' of different traditional service models and regulatory pathways. Services are also covered by three different regulatory bodies, the MHRA, GPhC and the CQC.

This creates difficulties in how services can be regulated, monitored, inspected and assessed effectively. The need for example for each individual medicine manufacturer supplying a clinical homecare service to themselves ensure the service is MHRA compliant leads to multiple audits and interventions. Audits are an important part of safe care but duplication such as this can take-up large amounts of management time.

Such duplication and the lack of clarity of where services sit in the system feeds through into challenges set above regarding service contracting and commissioning.

Workforce pressures

Many homecare services are nurse-led so there would need to be an increase in the number of nurses recruited into this type of service delivery if this model of care is to be effectively scaled. Once recruited and in place, these nurses also need the right training, equipment and technology to carry out their duties effectively. As noted in the NHS Long Term Plan – community nurses face a myriad of challenges particularly in relation to the interoperability of technology.[17]

Table 1: Challenges to effective mobile working by community nurses in patient's homes.

Challenge	%
Poor connectivity when in patient's home	**85.1%**
Cannot access GP electronic record	**56.8%**
Limited or no training to use devices	**20.8%**
Mobile device not compatible with other software	**21.1%**
Uploading onto systems that do not talk to each other leading to multiple data entry	**32.7%**

Source: The Queen's Nursing Institute (QNI). Nursing in the digital age: Using technology to support patients in the home. 2018.

Prioritisation and patient voice

Care at home services have never been a strong political or system priority. The 2019 Conservative manifesto includes major commitments on new hospital plans but little on care in the community.[18]

There is often confusion about where responsibility and accountability for these services resides across health and social care. Politically care at home sits across a number of different priorities in Ministerial portfolios including social care, community health, integration and primary care. This lack of prioritisation translates into a lack of clear commitments on ambitions for delivering care at home and for a mature and scalable market to emerge.

Opportunities

As the health service starts to emerge from the pandemic a set of major reforms are underway to its operation including:

- Integrated care – The Health and Care Bill[19] currently going through Parliament sees the introduction of Integrated Care Systems aimed at better joining up NHS and social care at a regional level. The recent Integration White Paper takes this further with the creation of place based integration leaders to support local and community health and care integration[20]
- Health inequalities – There is a new focus on tackling health inequalities that have been highlighted through the pandemic, with the NHS rolling out CORE20PLUS5[21] focused on five major programmes of care and plans for a white paper on health disparities from the new Office for Health Improvement and Disparities

- Data – Significant progress has been made in connecting and improving the publication of healthcare data throughout the pandemic. The draft NHSX data strategy looks to take these learnings and build from them through the greater digitisation and interoperability of the healthcare system[22]
- Elective Recovery – The Plan to tackle the Elective Recovery includes not only measures to tackle the waiting list, but also provide greater support and public health information to those waiting for treatment[23]
- Workforce – Health Education England has been commissioned to develop a 15 year workforce plan[24]

Clinical homecare is well placed to support some of these agendas:

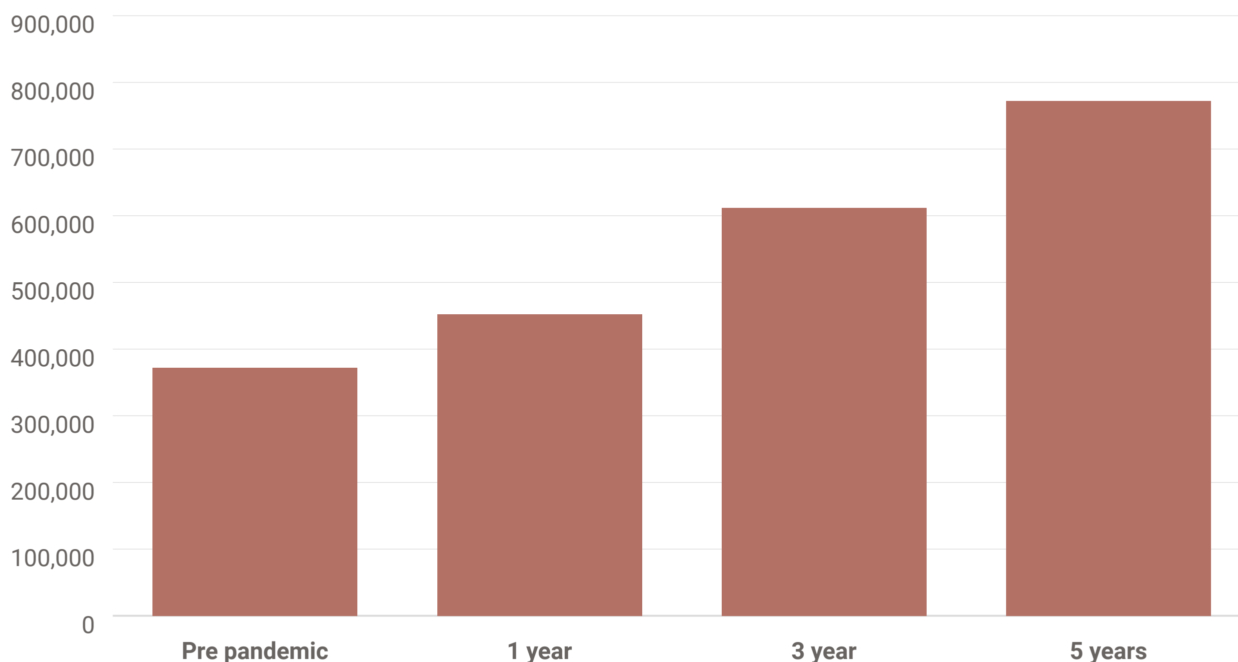
- In providing care closer to home, clinical homecare supports the delivery of care through a co-ordinated and multi-disciplinary team, supporting integrated and patient centred-care
- In delivering care closer to where patients live, inequalities in care access can be tackled
- In ensuring more care is delivered outside hospital, clinical homecare can help free-up capacity within hospital settings.

The following actions from the main actors across the health and care system will help expand services for patients.

Government – For Government there is a strong case to be made for setting a new level of ambition on care at home post pandemic. The change in where services are delivered seen during COVID-19 should be built from and progress maintained.

In doing so, the number of people receiving clinical homecare can be doubled over five years, see chart below:[25]

Chart 2: Projected expansion of clinical homecare services based on pandemic growth (patient numbers)



Ministers should include these commitments on expanding the provision of care at home, in the forthcoming health disparities white paper, helping carers and more vulnerable groups with accessing the care and support they need.

With this new ambition should come clearer Ministerial accountability for care at home policy.

NHS England – For NHS England, producing guidance and updated contracting support for ICSs in how they contract for clinical homecare services, could help reduce bureaucracy and administration, removing barriers to the adoption of care at home

NHS England/X/D (NHS Transformation Directorate) – As it finalises its data strategy, the NHS Transformation Directorate should report regularly (quarterly) against its ambition to "deliver comprehensive shared records in line with the commitments in the NHS Long Term Plan so that authorised staff for other care partners can easily and appropriately access data regardless of where care is delivered (by 2024)"[26]

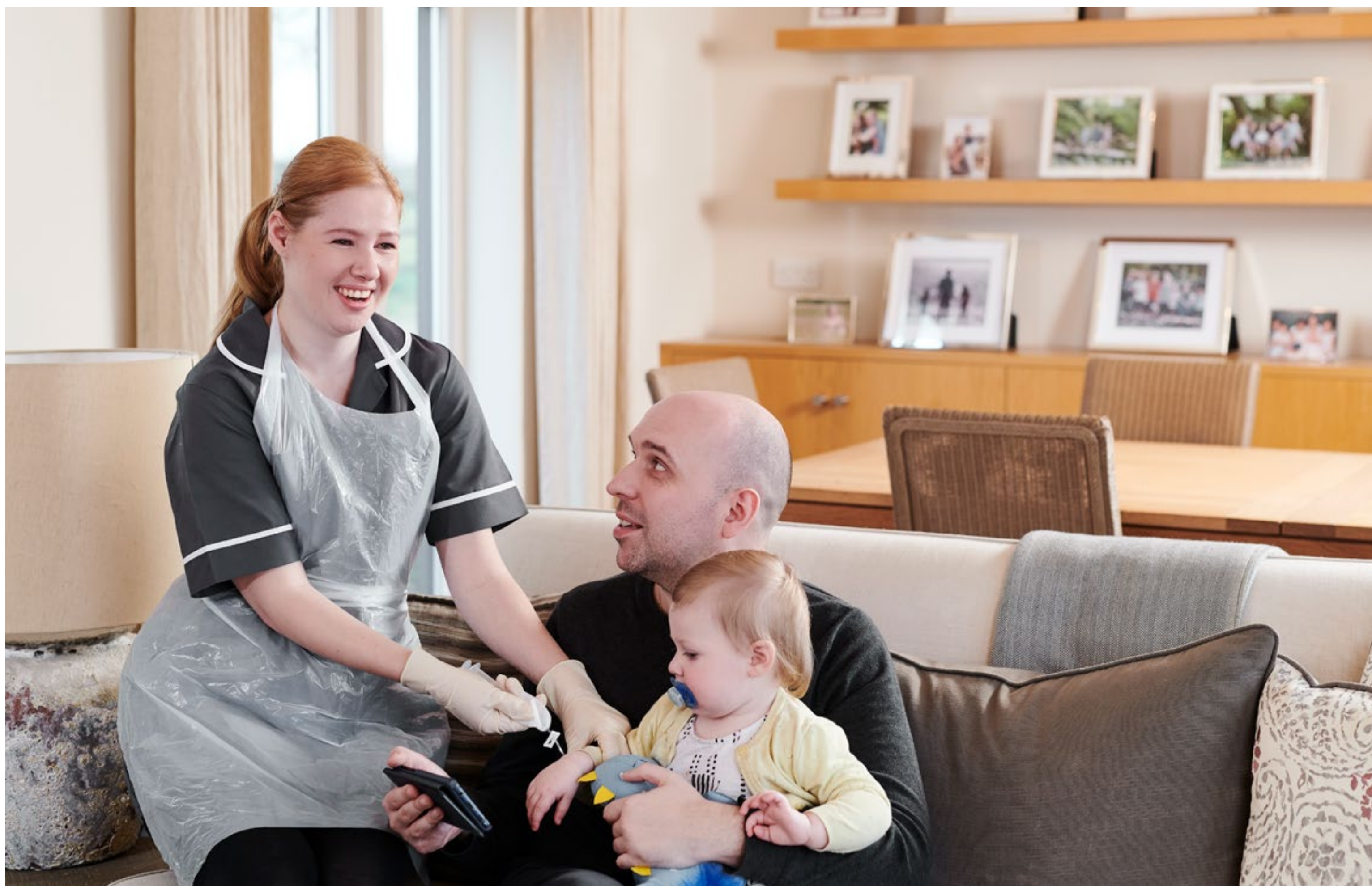
Health Education England (NHS England) – As part of long-term workforce planning HEE should ensure that the role-mix being developed is future-proofed for where care delivery will be needed in the future, and in particular a likely expansion of community and home-based care. HEE should also make sure that training packages for nursing staff working in the community are in line with the latest technologies and devices, particularly in light of the rapid innovation and adoption of new tools during COVID-19 and further expansions in the future

Integrated Care Systems – As ICSs develop their new plans for services it will be important that medicines and the delivery of medicines is part of strategic and board level discussions. The NHS Confederation recently set out how medicines optimisation can be prioritised and delivered at system level[27]

CQC – As part of their work in building a single assessment framework, the CQC should ensure that the new framework is applicable for clinical homecare services

MHRA – Should work with the pharmaceutical industry and clinical homecare providers to build a new framework for effectively auditing clinical homecare services aimed at reducing administrative burden

NHS Trusts – Trusts should ensure that patients accessing services beyond traditional healthcare settings are engaged effectively in their care and support and are provided with ways to provide feedback on their experience, particularly through the use of new digital tools and the NHS App



CHAPTER 5 Summary of recommendations

Leadership – Clearer Ministerial accountability for care at home and clinical homecare and a new ambition for doubling the number of patients using clinical homecare services over the next five years

Health inequalities – Embedding the new ambition for care at home within the health disparities white paper and using it to tackle health inequalities and improved carer support

Contracting – National level contracting frameworks to support improved system commissioning of clinical homecare

Prioritisation – New NHS models of integration at system, provider and place level to place a new emphasis on medicines and place of delivery, to help deliver service expansion

Regulation – Make sure the new single assessment framework for health and care being introduced is supportive of efforts to expand clinical homecare services and efforts are made to reduce un-necessary bureaucracy

Reporting – Regular reporting on the ambition for connecting health and social care data systems that can support more people to be cared for at home

Workforce – Ensure future workforce planning includes a requisite expansion of community and homecare based staff

Patient experience – Improve the capture of patient experience of care at home through new digital tools and devices

Endnotes

1 NHMC Covid 19 review

2 NHMC Covid 19 review

3 Representative public survey of 2000 people across England conducted in February 2021

4 https://www.zpb-associates.com/measuring-the-value-of-clinical-homecare/

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23 https://www.england.nhs.uk/coronavirus/publication/delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care/

24 https://www.hee.nhs.uk/news-blogs-events/news/hee-looking-future-health-social-care-workforce

25 Projections based on 20k growth in a quarter of a year at start of the pandemic; estimated 80k additional patients per year (across the three pandemic waves clinical homecare patient numbers increased by 90k)

26 https://www.gov.uk/government/publications/data-saves-lives-reshaping-health-and-social-care-with-data-draft/data-saves-lives-reshaping-health-and-social-care-with-data-draft

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