Bringing care home

Candesic's **Dr Joe Taylor** and **Dr Leonid Shapiro** consider what opportunities 'medicalised' home care will bring to providers as the sector expands

Large scale 'out of hospital care' has been a goal of the NHS for many years and a topic of intense debate, but only now has it become both a reality and a necessity. 'Medicalised' home care involves clinical care and medication, normally requiring hospital administration, being provided in the patient's own home with nursing support. It is a major aspiration of the NHS. Candesic believe that previously, growth in this market has been historically restricted by a lack of reliable home monitoring, acute hospital provider concern about a reduction in their market share, and the absence of integrated budgets. However, the confluence of three events has the potential to bring about a step change in this market:

1) Barriers being broken down between hospital inpatient and home care provision as care, budgets and oversight become integrated. An example of this step change is the Care Quality Commission (CQC) measuring quality across the entire care pathway as a KLOE (key line of enquiry)

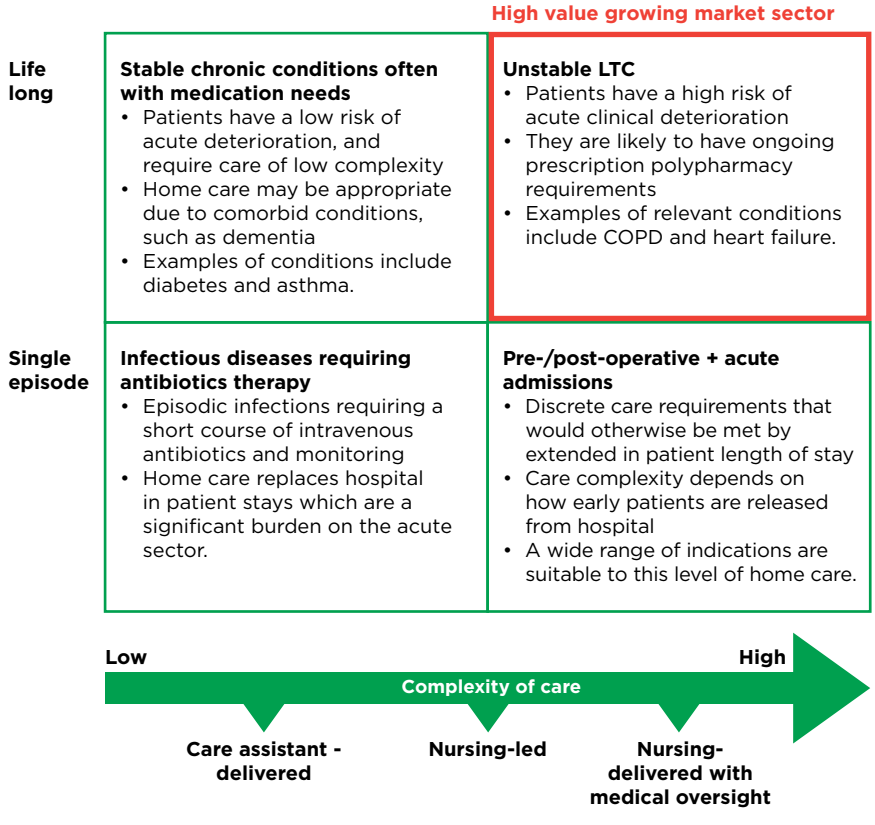
2) Vanguards sites are trailblazers of change and primed with support from NHS England to encourage adoption of new models of care which combine hospital and out of hospital care, incorporating a significant home care component

3) Technology that has become commonplace, although requiring some initial investment, is enabling home based tracking of live health and staff data, giving confidence to clinicians who ultimately sanction medicalised home based care.

As a result of these three factors, the market for delivery of clinical care and drugs into patients' own homes is set to expand significantly over coming years. Addressing this market will require providers who can both operate at scale (having a high local geographical density allows providers to deliver services cost-effectively) and create innovative value propositions that are attractive to commissioners.

FIGURE 1: DURATION-COMPLEXITY HOMECARE MATRIX

The high complexity, long duration home care required for patients with unstable LTCs is an attractive market segment and set to grow to support admission avoidance

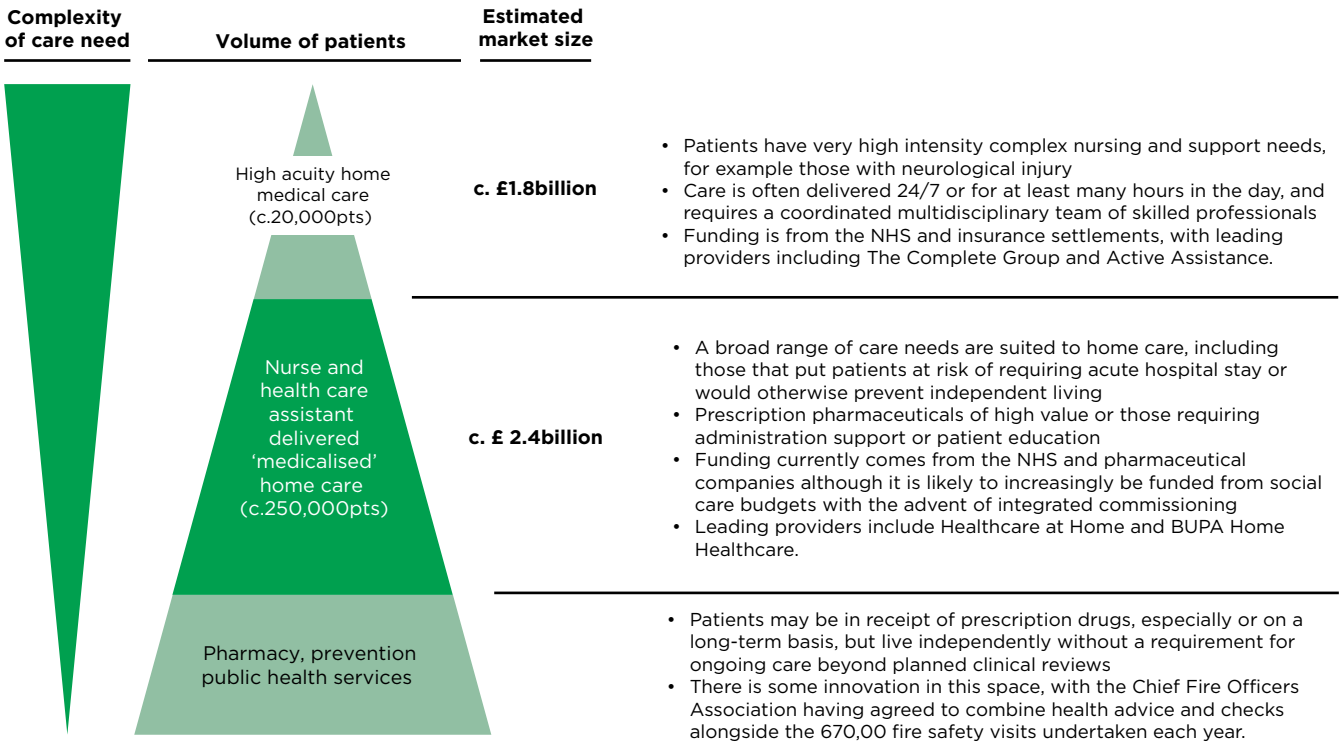


Sources: Candesic analysis

There currently exists a wide range of clinical services delivered into the home *(figure 1)* and their breadth will continue to expand with technological and commissioning innovation. The pharmaceutical delivery opportunity will grow as more patients are in receipt of costly biologic agents. Clinical care in the

FIGURE 2: CARE ACUITY PYRAMID AND COMMUNITY PROVISION STRATIFICATION

The 'medicalised' home care market is stratified on the basis of the complexity of care need



Sources: Candesic analysis

home is also set to grow as facilities-based NHS providers come under increasing capacity pressure and commissioners seek to deliver more care in the community.

While a range of providers could potentially enter this growing 'medicalised' home care market, however existing 'pure players' remain very well positioned to capture the most valuable complex care and expensive drug delivery segments.

Medicalised home care has grown from a basis of drug delivery and administration into additional areas of clinical care

Current market leaders in 'medicalised' home care, including Healthcare at Home and Bupa Home Healthcare, base a significant portion of their activity around the delivery of pharmaceutical agents directly to patients, replacing outpatient clinics and pharmacies as distribution points. Home based delivery improves persistence, adherence and continuation of therapy; research has demonstrated that patients with home based delivery more reliably take their drugs. In chronic conditions, home drug delivery leads to improved clinical outcomes. This is of course a benefit to pharmaceutical companies, but it is also beneficial to commissioners who have to pick up the bill for wasted drug courses or the consequences of poor pharmacological management of disease.

Another area of 'medicalised home care', the delivery of clinical care by nurses and care assistants, is far more complex than delivering a drug and potentially helping administer it *(figure 2)*. Principally, this type of care supports patients with long-term conditions (LTCs) but also enables people to leave hospital earlier following an acute care episode, potentially avoid an admission into a hospital during a chronic disease 'flare up'. It also gives those with terminal illness the chance to die in their own home.

This second type of home care benefits overstretched facilities-based providers in two ways: by extending supply and by limiting demand. It reduces pressure on fixed capacity facilities such as hospitals and care homes whilst providing a flexible buffer for peaks and troughs in demand.

The Nuffield Trust has estimated that an additional 17,000 new hospital beds will be required in England by 2021-22 unless models of care change (figure 3). If the construction of some of these beds can be eliminated through 'medicalised' home care, it will save the NHS huge capital costs. In a recent report the health regulator Monitor suggested "instead of achieving cost savings for the local health economy, [community-based schemes] are more likely to reduce the rate of expenditure growth by substituting for, or at least delaying, the need for investment in new acute hospital facilities".

The second benefit comes through the adoption of more person-centred on-going care and monitoring, which can prevent acute admissions and support independent living, thereby truncating demand in other parts of the care system.

Current problem: The need for scale to enable cost-effective delivery of care

Anybody who has visited a GP, hospital outpatient clinic or A&E will know that there is some waiting involved. Most facility-based care is centred on clinical ▶

staff, not the patient. The very existence of expansive waiting rooms in the NHS estate is evidence of the effective utilisation of nurses and doctors. This same degree of staff utilisation efficiency cannot be replicated in home care; trained professionals will have to spend a significant portion of their working day travelling between locations.

In order to make medicalised home care attractive, providers must be able to operate at sufficient geographical density to minimise staff travelling time and provide rapid specialist cover should a problem arise. Drug delivery-based 'medicalised' home care has achieved this scale broadly through national contracts with pharma companies or with NHS England. However, the more clinically led 'medicalised' home care has been slower to reach scale and few providers are capable of delivering it efficiently. There exists significant geographical diversity in spending on 'medicalised' home care and providers will need to persuade some commissioners to sanction a step change in home care activity before services can become financially and clinically successful. Once we are over this 'hump', demand (and proof of cost-effectiveness for 'medicalised' home care will rise significantly.

Current problem: Lack of integrated budgets

One major obstacle to 'medicalised' home care has been the fact that investment from one budget leads to savings in another, creating a disincentive for individual commissioning organisations when there is clear benefit for the system as a whole. A study by the Nuffield Trust shows that 'medicalised' home care can bring about a 5% cost savings in patient care (figure 4), however, the spend profile/mix between hospital and home based care is dramatically different, with local authorities being responsible for a significantly larger proportion of costs in home based care. The self-centred thinking commissioners have about their own budgets has to change before 'medicalised' home care can become commonplace.

Future solutions: Integrating budgets and operations from NHS led innovative models of care will drive demand for 'medicalised' home care

Simon Stevens, NHS England's chief executive, has argued that "something is not working right about how we are providing community nursing and primary care for people at home.... The NHS of the future will be one where more support for frail older patients is provided locally".

Home care could become an integral element of new models of care, especially in the context of capitated reimbursement mechanisms. Two of the proposed new models are likely to require significant additional home care components:

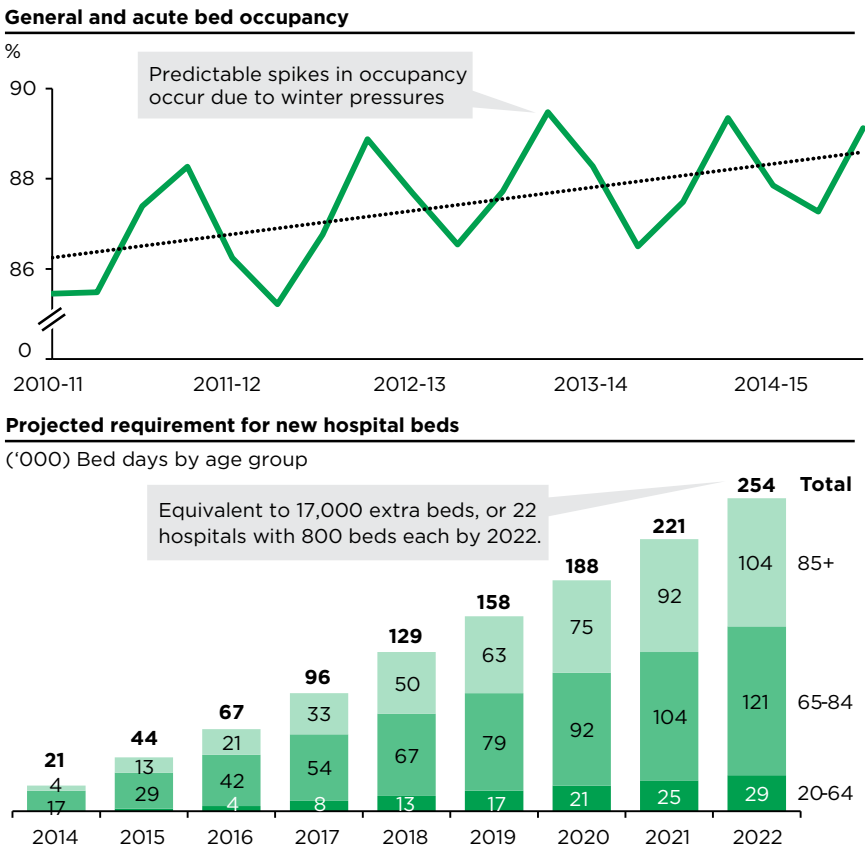
- **Primary and acute care systems (PACS)** are one of the new models of care outlined in the NHS 'Five year forward view'. PACS will provide GP and hospital services, together with mental health and community care, by single NHS organsations for the first time,

- **Multispecialty community providers (MCPs)** are similar, expanded GP practices, bringing in nurses and community health services, hospital specialists and others to deliver integrated out-of-hospital care. The objective of MCPs is to move outpatient consultations and ambulatory care out of hospitals.

Each of these models is based in the community, without the fixed-base infrastructure characterising existing NHS care delivery. They will need to integrate 'medicalised' home care in order to succeed. In order to achieve change at scale and pace, they will look to those with experience in the sector (including many private providers) to work in partnership with.

FIGURE 3: PROJECTED DEMAND FOR ADDITIONAL ACUTE HOSPITAL BEDS

Bed demand is set to grow significantly, whilst winter demand peaks are already outstripping hospital supply



Sources: NHS England; Nuffield Trust; Candesic analysis

Alongside new models of care, new ways of commissioning services will enable home care providers to take initiative in driving the market. Budget integration across health and social care, alongside capitated budgets, are all positive market drivers. Private providers can play a lead role in proposing new models of 'medicalised' home care to these new commissioning structures and will be pushing on an open door.

A range of existing providers are positioned to exploit the growing home care market

There are a number of care providers already operating with a geographical density such to enable them to rapidly develop home care services, however, existing pure players remain best positioned to exploit market growth:

- Some **acute NHS hospitals** have been able to provide home care and there is an increasing enthusiasm amongst some acute hospital providers to enter the market in competition against the independent sector, particularly in pharmaceuticaldelivery. Guy's and St Thomas' NHS Foundation Trust in collaboration with King's College Hospital have developed their '@home service' to both avoid admissions and support earlier discharge. However, many smaller trusts will be unable to deliver home care, as they possess neither the experience nor infrastructure required for the complex challenges it entails

- **Mental health trusts** have a long and successful history of establishing community teams that use hospitals as a base from which to deliver care, support and monitoring in people's homes, and demonstrate that the NHS hospital sector is capable of innovation in the home care space.

- **Primary care providers** have appropriate and significant medical and nursing expertise and are likely to have well-established clinical relationships with home care recipients. However, operating at scale will not be easy for primary care group practices, and delivering home care efficiently will not be possible outside of provider chains or within new models of care. General Practice is therefore an unlikely breeding ground for new home care provision without the partnership of larger experienced organizations

- **NHS community care trusts** should be the natural provider agents for the delivery of home care, but have become emaciated by a failure of funding to keep pace with increasing service demand. Their leadership is frequently weak and innovation rare; these trust types will be dependent upon leadership and capability from outside in order to become significant providers of home care. Furthermore, with the new models of care being pushed by NHS England, community trusts may all but disappear in the long term

- **Residential nursing homes** could evolve from isolated enclaves of clinical activity to community healthcare hubs. They have a number of features that make them suitable providers of care outside of their traditional roles:

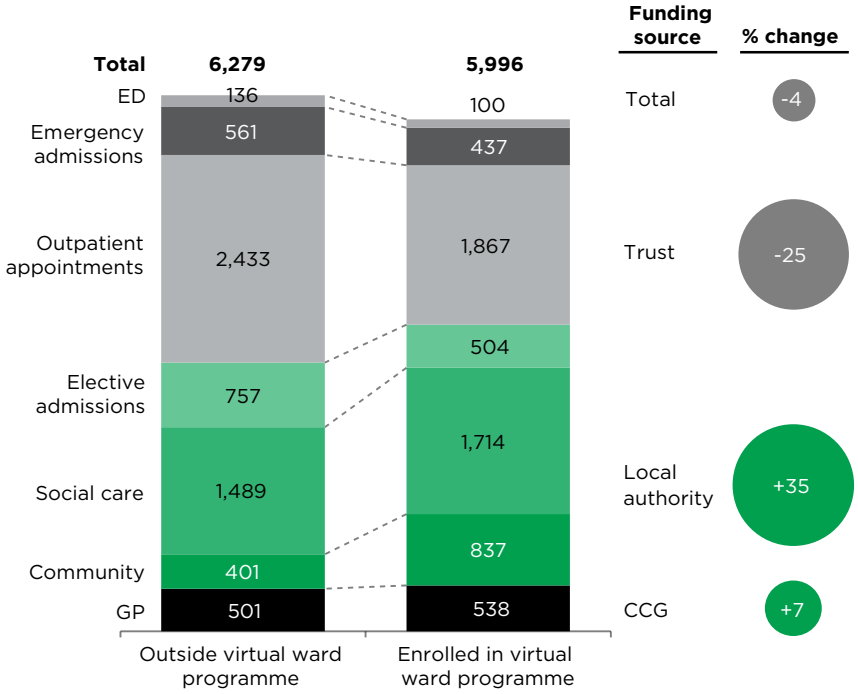
  - Many nursing home chains have a high geographical density, with a workforce already operating nearby patients in need of nursing care in their homes,

  - Home staff, both nurses and care assistance, are trained and experienced in dealing with the conditions home delivered care is most suited to,

  - The majority of recipients of long-term home care will transition into residential nursing home clients; establishing carer-patient relationships early will achieve care continuity and secure a customer pipeline for the homes

FIGURE 4: COST BEFORE AND AFTER INTRODUCTION OF A 'VIRTUAL WARD' PROGRAMME

Clinical care delivered in the home has the potential to shift the burden of care from more expensive hospital setting to the potentially less expensive community setting, in some instances reducing the total cost of patient care by c.5%



*The Nuffield Trust evaluated three separate virtual ward pilot programmes and examined the average per patient cost over the six months before and after trial enrolment

Sources: Nuffield Trust; Candesic analysis

- Some chains may move into the home care space, but it will require vision and significant investment

- **Pure players**, particularly Healthcare at Home and Bupa Home Healthcare, are the only ones with the existing scale and experience required to rapidly expand the home care sector. However, they should be the willing partners of other organisations and proactively seek opportunities to work with the range of NHS and independent providers with a stake in the community care market.

Home care providers can proactively drive market growth and achieve greater profitability

While there are a number of positive drivers for the sector, competition and cost-effectiveness will keep margins in check. There are strategies, however, that 'medicalised' home care providers can adopt to maximise the viability and profitability of the sector:

- **Additional revenue sources** are available to home care providers, principally in the form of the valuable data they collect regarding patients, – it's not a zero sum game. Home care operators need to be able to operate efficiently and find ways of adding additional value to their activity.

Home care providers have the ability to generate rich data about the needs of people who are likely to be heavy users of multiple health and social care services. The data can be used by the pharmaceutical industry to better understand responses to their agents, by commissioners to understand the needs of their populations, and by other providers to appreciate how they can best integrate into a complex web of care delivery. Not only could collection and analysis of this information differentiate home care providers, but it could be directly monetised

- **Operational efficiency** can be greatly improved by achieving high regional activity density, which will support margin growth by minimising the comparative inefficiencies inherent in home care delivery. However, this means diversifying activity and generalising the skill base of the nursing staff.

It would be a mistake to assume that because the requirement for capital investment in infrastructure is much lower for home care, ramp-up of activity can be slower. In reality, profitability can only be driven by strong staff productivity, which in turn requires high geographical patient density.

Covering the widest range of care requirements with the same nursing and care assistant team will reduce the time professionals spend on the road; broadening home care activity down the care complexity pyramid may reduce average per patient revenue, however, it will also enable scale required for efficient staff deployment

- Home care operators need to maximise **workforce leverage through technological innovation** – staff are the main cost for hospital providers, but an even greater chunk of operational cost for home care. Not only are skilled home care workers and nurses difficult to recruit, they're expensive per unit of care delivered. Our team has previously written about the potential of new technologies to support effective remote care delivery and workforce management. Software needs to do more than simply solve the travelling salesman problem. It must increase productivity of staff when they are in a patient's home and enable them to provide support from a central base.

Home care has huge potential to address the capacity constraints of NHS hospitals and improve the quality and convenience of clinical care for patients. ■

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