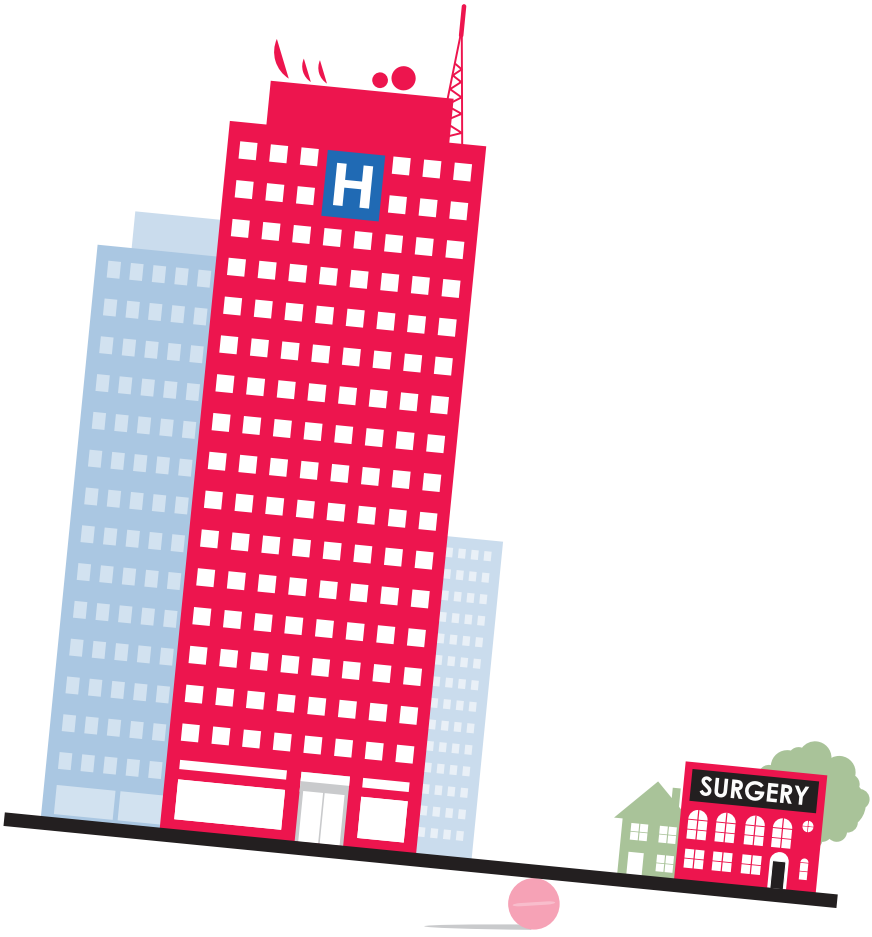
Evidence in brief:

Getting out of hospital?

The Health Foundation
Inspiring Improvement

The evidence for shifting acute inpatient and day case services from hospitals into the community

June 2011



Identify Innovate Demonstrate Encourage

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Evidence: Getting out of hospital?

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Commentary from the Health Foundation

The need to increase value for money in the delivery of healthcare services without compromising quality is a critical challenge that many current policies and initiatives are designed to address. One longstanding response to this challenge is the drive to move care out of hospital settings and into primary and community care.

The Health Foundation therefore commissioned a review of the evidence to explore the extent to which it is known whether this is an effective policy to achieve improved patient care with reduced costs of provision. We wanted to make the knowledge base more accessible to decision-makers who are seeking to explore the opportunities and risks of shifting care into other settings.

Our conclusions are appropriately cautious but we hope they are useful nevertheless. We found that for some conditions, and under the right circumstances, there is an alternative to hospital-based treatment, and patients often prefer these alternatives. Unsurprisingly, the quality of the care that is provided is the major determinant of success, not the place of delivery.

We also found that costs are only reduced if the shifts are associated with active disinvestment in hospital-based services. The evidence base is to a large extent provided by pilot studies, operating at a small scale, with highly selective inclusion of patients. Any large-scale or sustained shift in the location of services is therefore not reported in these cases.

The majority of the published evidence fails to contain robust cost information on infrastructure, planning and start-up costs. However, our review did find that successfully implemented projects tended to be a part of a wider strategic plan to deliver service improvements.

Despite the relative lack of progress in the last decade that has been made in actually shifting care from acute hospitals at an appreciable scale, it is more appealing than ever in the current period of financial constraints and heightened awareness of patient safety and the need to engage with patient preferences. Hospitals are expensive, impersonal and risky places in which to deliver care that does not require a high tech and specialised environment.

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The challenges for healthcare commissioners are significant: How to identify which approach to pursue, for which group of patients, at which stages in the care pathway? Whether to invest in community support for people with chronic conditions to prevent hospital admissions? Whether to develop intermediate care services in the community to support early discharge from hospital?

The impetus for the shift will come from those responsible for improving quality and driving down costs by rethinking how services are designed and delivered. In pole position must be the new commissioning groups that are currently being established. The onus is on these groups to demonstrate that a strong and informed clinical voice can deliver the changes that previous incarnations of commissioning have found so difficult.

This report, therefore, speaks to commissioners and other decision-makers in a way that is relevant to the enormous challenge of delivering better care while controlling costs in the health service. Rethinking traditional patterns of where and how care is delivered and decommissioning services is fundamental to addressing this challenge. We hope that this report will make a useful contribution by encouraging commissioners to carefully consider how the report's findings can be applied to their local setting. They can also use it alongside the other information they hold on the opportunities and risks of shifting care.

Introduction

In recent years, health policy in both England and abroad has very clearly aimed to shift the provision of at least some elements of care out of hospitals and into community settings. While specific drivers for this change vary from country to country, the policy is generally associated with three common goals:

— improved health and wellbeing for patients

— more cost-effective provision of healthcare

— greater patient satisfaction.

Proposed changes also need to be located in the context of what NHS Chief Executive David Nicholson has warned may include, 'the possibility that investment will be frozen for a time'. His 2009/10 annual report went on to say that productivity gains would be achieved through quality improvements and innovation. This was reaffirmed in the pre-budget report and the *NHS Operating Framework for England for 2010/11* and has been termed both the quality and productivity challenge and the QIPP (Quality, Innovation, Productivity and Prevention) initiative.

The Health Foundation evidence report, *Getting out of hospital?*, reviews evidence concerning the relative efficacy and cost-effectiveness of community-based treatment regimes. In particular, it focuses on the evidence for shifting acute inpatient and day case services from hospital into the community. It is a rapid evidence assessment (REA) which updates earlier systematic reviews in the light of more recent research.

In keeping with the Health Foundation's aim to inspire improvement, the review focuses on the implications the evidence has for GP commissioners and policy makers when making decisions concerning health provision.

Approach

The review team from Matrix Evidence carried out an REA to explore international evidence on the benefits and potential harms of shifting acute inpatient and day case services from hospitals into the community. Supported by the Information Retrieval Unit at King's College London, the review team searched the following sources:

— Medline
— Embase
— HMIC (a recognised source of 'grey' literature)
— SPP
— ASSIA
— Web of Knowledge.

The search revealed 26 studies reporting primary research or systematic reviews of primary research that compared the effects of community-based services with equivalent services for hospital inpatients. See References on pages 13 and 14 for details of the studies included.

The review team assessed each study for methodological quality using a standardised evaluation tool. The overall quality of the studies was high, with only two studies failing to reach at least the mid-level quality rating . The team also conducted supplementary searches for additional reports and opinion pieces on the topic.

Results

The available evidence shows that, under the right circumstances and for some conditions, community-based services can be an effective alternative to hospital treatment. However, the effectiveness, cost-effectiveness and safety of admission avoidance associated with community-based services varies according to the characteristics of the patients being offered treatment and the quality of the community services on offer. This section summarises the main review findings under three headings:

— What was done?

— Was it successful?

— What did it cost?

What was done?

Under the terms of the review, the research literature we identified was primarily aimed at comparing the effectiveness of hospital-based care with community equivalents. It did not typically include details of how local community-based services have been established. Information that service commissioners might need, such as the level of infrastructure, planning and start-up costs needed to shift services into the community, is not usually reported in studies that evaluate the effectiveness or cost-effectiveness of these services compared with inpatient care.

The research review found some interesting examples of community-based services using multidisciplinary teams with a nurse and specialist practitioner or GP providing care, either at home or within community hospitals or rest homes. Services involving multidisciplinary teams often include nurses visiting at least daily and physicians every one to three days. Other examples from outside the UK provide a more resource-intensive model. For example, one study described a service in Italy involving a 14-person team that was able to care for 25 patients a day, or a total of 450 patients a year.

When asked, patients expressed greater satisfaction with treatment-at-home regimes than hospital inpatient care. Similarly, patients were generally more satisfied with community-based minor surgery compared with hospital treatment, typically citing ease of access, travel and shorter waiting times.

Was it successful?

In terms of health outcomes, most studies reported broadly similar findings for community-based services and inpatient care. The findings for length of treatment varied: some studies reported longer and some shorter durations than inpatient care.

The new studies we found suggested that there is particular potential for community-based services to help reduce NHS costs by promoting early discharge from hospital for patients who no longer need intensive acute care, but are not yet ready to fend for themselves at home. However, as with previous systematic reviews, the evidence is still not sufficient for us to be certain that shifting care into the community will always reduce costs.

The findings for patient satisfaction are less equivocal. When asked, patients expressed greater satisfaction with treatment-at-home regimes than hospital inpatient care. Similarly, patients were generally more satisfied with community-based minor surgery compared with hospital treatment, typically citing ease of access, travel and shorter waiting times.

As with many evidence reviews, care must be taken when attempting to base decisions about treatments for local patient groups on the findings from research studies, even when they are robust. We found that many of the studies that evaluate community-based interventions were highly selective in terms of who was offered the service. Based on the evidence review alone, it would be unwise to assume that community-based services would be as effective across a wider range of patients.

The research literature did not reveal any examples where establishing community-based services had led to a reduction in, or decommissioning of, the corresponding acute inpatient service.

What did it cost?

The provision of detailed cost data was inconsistent in the studies we reviewed. We found no comparative studies that calculated the staff–patient ratios or the total number of staff needed to provide equivalent care to all relevant patients who are currently treated in hospital. We also did not find any calculations showing how the total cost of an entirely community-based service with a supportive infrastructure would compare to hospital-based care. Such evidence that does exist suggests that community-based services may be more cost-effective than inpatient services.

Any conclusions concerning relative cost-effectiveness should be considered with caution, as community-based services typically treat less severe and less complex cases, and may only be offered to patients who already have carer support at home.

Most of the costs of community-based services are staff costs. Daily costs tend to be lower, although some studies have found that after taking into account the longer durations of community-based care, the total costs are either lower than or no different to inpatient costs.

We need more evidence on the resources needed to deliver the kind of community-based services that are likely to prevent admission to hospital or facilitate early discharge from hospital. Evidence from practice examples would be particularly helpful in supplementing the sparse details reported in the existing literature.

On the other side of the cost-effectiveness equation, commissioners would no doubt benefit from more robust financial data on the savings that could be achieved by shifting services from hospital into community settings. The research literature did not reveal any examples where establishing community-based services had led to a reduction in, or decommissioning of, the corresponding acute inpatient service.

Key messages

— Primary care can be an effective alternative to hospital treatment for some patient groups, in particular the elderly and those with complications arising from long-term conditions such as heart failure and chronic obstructive pulmonary disease (COPD).

— Intermediate care from community hospitals may reduce mortality and lead to similar quality of life compared with inpatient care in elderly people with acute illness.

— The effectiveness of primary care solutions is very much influenced by the quality of those services rather than simply the setting (primary or secondary) in which they are provided.

— Patients seem more satisfied with treatment at home compared to hospital inpatient care.

— Early discharge from hospital into community-based care settings is associated with better patient satisfaction scores and equivalent quality of life scores.

— Patients report high satisfaction with community-based minor surgery due to ease of access, shorter travelling times and reduced waiting times. However, in some cases, minor surgery delivered by GPs may be of lower quality than that done by surgeons in hospitals.

— Because existing research has not consistently focused on collecting robust financial data, there is little evidence that discharging patients early to hospital-at-home care delivers cost savings to the healthcare system. The delivery of significant cost savings is likely to depend on inpatient services being decommissioned, yet there is little evidence that commissioners do this once a new service has been set up.

— Studies evaluating community-based care are often highly selective in terms of who is offered the service. Consequently, it is difficult to generalise from the available evidence as to whether community-based care would be as effective when used across a broader range of patients.

— Developing a consistent framework for research and analysis, identifying key factors that can be monitored and evaluated across interventions and settings, would help to inform commissioning decisions. A consistent analytical framework for summarising information would support the collection of comparable information that could show how to successfully implement systemic and strategic changes to service provision.

Where can I find out more?

The full report, *Evidence: Getting out of hospital?*, which this summary is derived from, is available to download free of charge from the Health Foundation website at:

www.health.org.uk/publications

The full report includes more details of the research methods used, together with in-depth information on all the findings and all references.

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The Health Foundation is an independent charity working to continuously improve the quality of healthcare in the UK.

We want the UK to have a healthcare system of the highest possible quality – safe, effective, person-centred, timely, efficient and equitable. We believe that in order to achieve this, health services need to continually improve the way they work.

We are here to inspire and create the space for people, teams, organisations and systems to make lasting improvements to health services.

Working at every level of the healthcare system, we aim to develop the technical skills, leadership, capacity, knowledge, and the will for change, that are essential for real and lasting improvement.

The Health Foundation
90 Long Acre
London WC2E 9RA
T 020 7257 8000
F 020 7257 8001
E info@health.org.uk

Registered charity number: 286967
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