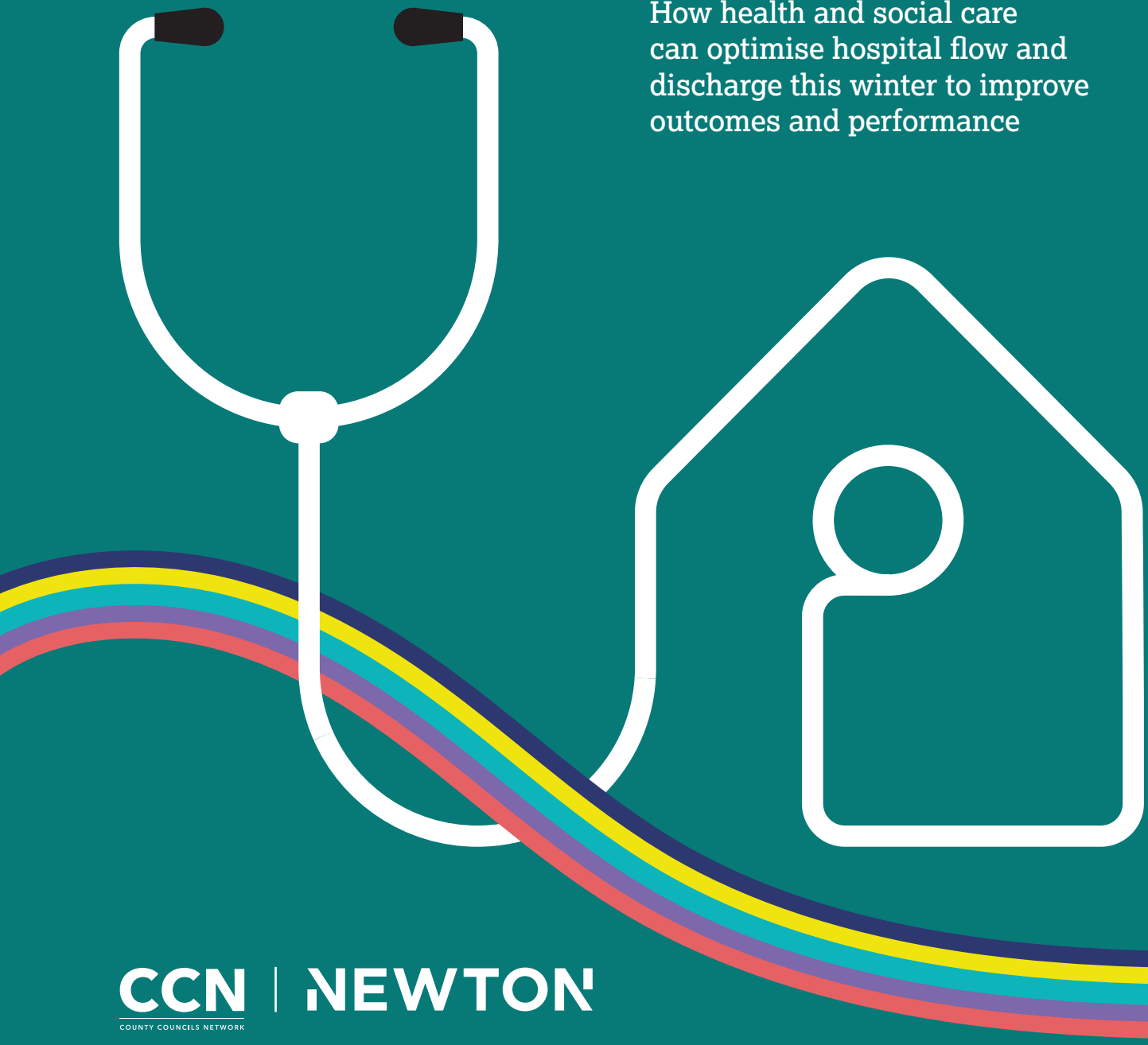
Finding a way home

How health and social care can optimise hospital flow and discharge this winter to improve outcomes and performance



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COUNTY COUNCILS NETWORK

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The County Councils Network

Founded in 1997, the County Councils Network (CCN) is the voice of England's counties. A cross-party organisation, CCN develops policy, commissions research, and presents evidence-based solutions nationally on behalf of the largest grouping of local authorities in England. In total, the 20 county councils and 17 unitary councils that make up the CCN represent 26 million residents, account for 39% of England's gross value added production, and deliver high quality services that matter the most to local communities.

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Coupling deep subject matter expertise with a bespoke and holistic approach to transformation – Newton blends digital and technology, operations, and behavioural insights to effect meaningful impact.

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CCN and Newton have a longstanding strategic partnership, developing a basis of good practice, policy, and advocacy for local government, with a strong focus on social care.

01

Executive summary

"As the Chief Operating Officer of this organisation, the number one thing that concerns me above all else is keeping our patients safe.

Ultimately, when flow stops, harm starts.

That is awful for our patients, isn't the standard of care that our staff want to provide, and hurts us all.

Making this system work for our residents, patients, and staff is what we're here to do – and that's what has to happen."

Chief Operating Officer – Teaching Hospital NHS Trust

Project overview

If you are an older person (aged 65 or over) in England who has need to use urgent or emergency healthcare provision, the reality is that your 'journey' through the health and care system is likely to vary significantly depending on where in the country you live and access health and care services.

Nationally, the evidence points to people being admitted to hospital unnecessarily and delays during hospital stays, which could mean people spend longer in hospital than they need to, and/or then experience further delays in being discharged. There is also clear evidence that people may not always achieve the level of long-term independence they may be capable of and may want for themselves.

Strategically, this recurring issue is often viewed simplistically, as a problem for the health service primarily driven by a lack of capacity in social care. As a result, policy solutions have tended towards the Government making short-term investments in care beds to ease demand during the winter period, even though – as last winter – the efficacy and value for money of such solutions is often later shown to be patchy.

The research in this paper shows that the underlying causes of winter pressures are, in reality, more complex and systemic. To achieve effective – and, importantly, cost effective – solutions that deliver the best long-term outcomes for people requires a more holistic approach, drawing together acute and community health services with public health and social care to facilitate better patient flow and discharge, and the prevention and mitigation of conditions that cause the pressures in the first place.

The objective of this programme of work, of which this report is the main output, is to help influence an evidence-based discussion on **how to improve the long-term outcomes of older people by optimising flow through the health and care system (including at the point of discharge), whilst reducing pressures on all organisations involved.**

Specifically, this programme of work has sought to:

- Better understand the operational challenges and pressures inherent across the system, particularly those that led to the 'winter crisis' last year, and the impact they may have on winter 2023/24.
- Explore the driving forces behind these challenges and assess the impact of existing interventions.
- Explore the role of local government and the NHS in easing these pressures (including opportunities for greater collaboration).
- Provide analysis and recommendations for local systems and central policy makers for the winter ahead, and years to come.

In doing so, it is the underpinning belief of this work programme that taking a person-centred approach is at the heart of optimising health and social care services to support older people to stay or get home, and avoid the risks associated with spending too long in an acute hospital.

The following report will start by introducing the work, describing the methodology taken, setting out the national challenges and context, and setting out the principle of a person-centred approach.

It is then segmented into three sections:

The current challenges – As health and care systems prepare for the winter ahead, this section of the report seeks to describe the situation today, with a specific focus on the flow into and out of acute hospitals.

The driving forces – This section of the report provides an analysis of the driving forces and root causes behind the pressures identified, and explores potential solutions to address these underlying challenges.

Conclusion and recommendations – This section explores the impact of optimising discharge and flow, before putting forward a set of recommendations for central policy makers and local systems.

The following Executive Summary naturally contains some duplication of the full report.

A note on the 'health and care system'

Whilst often and increasingly referred to as a 'health and social care system', which gives a sense of tightly linked, co-ordinated and integrated services, the reality is that this 'system' is in fact made up of several separate organisations, with markedly different statutory responsibilities, funding models, incentives, values, and cultures, each endeavouring to work together to plan and deliver care for the same individual.

A generic health and social care 'pathway' to demonstrate possible journeys through this system is pictured in Figure 1 – with the different colours denoting whether the service is typically run by acute or community health (the NHS) or care (the adult social care system, run by local authorities). Not shown on this diagram are the wider network of services and organisations involved in the 'system', including the voluntary and community sector, the private sector and the wider range of range of services run and coordinated by local authorities, such as housing and community development, which play a key role in the delivery of health and social care.

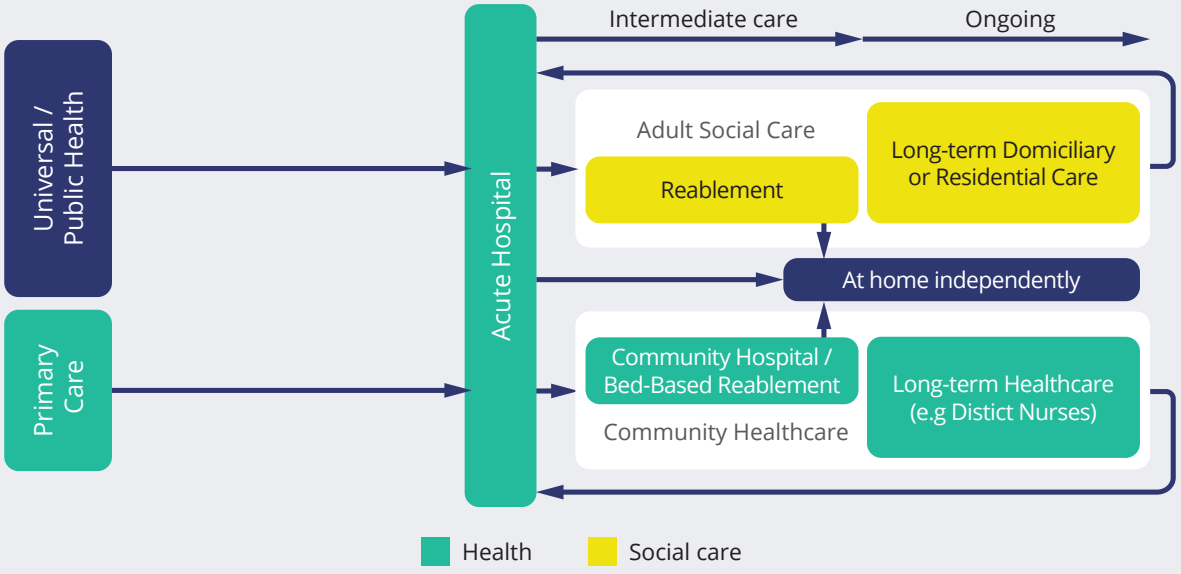


Figure 1. A generic and simplified health and social care 'pathway' to demonstrate possible journeys through the system.

Analysis of the current challenges

There are a number of macro, national challenges that are impacting most health and care organisations in England. These include – people living for longer and with multiple conditions; the impact of austerity; the cost of living crisis and continued legacy of the pandemic; workforce recruitment and retention; and the impact of short-term funding models (which particularly impacts local government).

In addition, health and care organisations are struggling with their own local challenges when it comes specifically to the flow of individuals with urgent and emergency healthcare needs through their system, particularly those aged 65 or above.

The findings of this research support the perception of a health and care system under strain:

- More people are calling for an ambulance with a 'Category one' urgent and emergency healthcare need (35% increase in 'Category 1' urgent and emergency calls to ambulances in the last four years).
- A&E departments are seeing more patients attend than before (6.2% increase in hospital attendance in the last year).
- Emergency hospital admissions have returned to pre-pandemic levels (albeit growth is more modest than A&E attendance), with those admitted being more ill than previously reported (3.8% increase in acute hospital emergency admissions in the last year and 16% increase in co-morbidities in the five years from 2018/19 to 2022/23).
- Individuals are staying longer in hospital (average length of stay is 34.8% longer in 2022/23 than it was in 2019/20). In part this is down to delays in either treatment or discharge (length of stay for people with criteria to reside in the hospital has grown by approximately 0.7 days and length of stay for people without criteria to reside has increased by approximately 0.5 days).
- Bed occupancy is increasing (6.75% increase in bed occupancy in general and acute, and critical care beds in the last year).
- There is an increase in short- and long-term care needs, putting greater strain on community healthcare and adult social care services (5.6% increase in the number of people receiving short-term care such as reablement and rehabilitation at home in the last year and 7.9% increase in individuals being discharged to long-term care).

The significance of this situation cannot be understated. As each individual component of the system grapples with mounting strain, the entire system has started to slow down. As a result, patient flow becomes more challenging, and staff are not able to support individuals to achieve the most ideal and personalised outcome.

The impact is therefore two-fold. Not only do acute hospitals have a higher proportion of beds being occupied, but the long-term outcomes for people are also worsening, with people becoming avoidably more dependent.

The driving forces behind the current challenges

This programme of work identified the following driving forces are behind these challenges.

Attending and being admitted to hospital:

Nearly a third (31%) of hospital attendances and 30% of admissions of older adults aged 65 or above were deemed to be inappropriate or avoidable. These people would have been better treated by alternative services in the community, such as primary care and community health.[1] The most common route for these inappropriate attendances was via ambulance conveyance and was most often down to a lack of knowledge of alternative services or risk averse decision-making.

Delays during someone's stay in hospital:

During an older person's stay in hospital, 35% of the total length of their stay (before they are deemed to be ready for discharge) is made up of avoidable delays.[2] This is mostly due to waiting for tests or decisions from medical staff.

Furthermore, at the point that they are deemed medically fit for discharge, further delays are experienced.

The most significant contribution to overall bed day delays is from people who are on 'Pathway 0' i.e., they are medically fit to go home immediately without further support (these delays range between one and three days). Because of the volume of this type of discharge, nationally this is contributing to one million delayed bed days every year.

Where people being discharged have an ongoing need for care and support in the community, delays range between 4.1 and 10.2 days, depending on the level and type of support required. The root causes of these delays are a combination of factors within the acute hospital (including decision-making) as well as delays in the availability of the right community resource and provision.

Summary of discharge to assess pathways

Pathway 0

- simple discharge home
- no new or additional support is required to get the person home or such support constitutes only:
  - informal input from support agencies
  - a continuation of an existing health or social care support package that remained active while the person was in hospital.

Pathway 1

Able to return home with new, additional or a restarted package of support from health and/or social care. This includes people requiring intensive support or 24-hour care at home. Every effort should be made to follow Home First principles, allowing people to recover, reable, rehabilitate or die in their own home.

Pathway 2

Recovery, rehabilitation, assessment, care planning or short-term intensive support in a 24-hour bed-based setting, before returning home.

Pathway 3

For people who require bed-based 24-hour care: includes people discharged to a care home for the first time plus existing care home residents returning to their care setting.

Those discharged to a care home for the first time will have such complex needs that they are likely to require 24-hour bedded care on an ongoing basis following an assessment of their long-term care needs.

Intermediate care:

40,000 additional older adults could benefit from greater capacity in reablement and rehabilitation services in the community. This makes reablement at home a clear candidate for additional funding to support flow and improved long-term outcomes.

Nationally, there is also a significant challenge in achieving effective onward flow for residents who are discharged into short-term beds. Only 11.6% of people, on average, are discharged on time once they are deemed fit (i.e., without criteria to reside in their bed), with the remaining 88.4% experiencing delays.[3] This data demonstrates that purely focussing on the acute hospital can often mask a problem whereby residents remain in beds in the community which risk becoming permanent placements. The availability of onward care is the most significant cause of delay, making up 65% of all delays.

Long-term outcomes:

Between 20% and 45% of people leaving hospital following a stay were not discharged on the ideal pathway for their needs and could experience both a better outcome in terms of long-term independence, and a significantly reduced delay. However, risk averse decision-making and service capacity is blocking this from happening.

The driving forces and national challenges identified above, combined with the views of system leaders engaged in this work, suggest that there are several local system challenges that also need to be overcome to facilitate the optimum flow and discharge of individuals through the health and social care system. These include:

- competing cultures and behaviours
- lack of trust in data
- unsustainable workforce pressures.

Recommendations

Despite the challenges outlined, there is clear cause for optimism; numerous examples of good practice have been observed (and included in this report). In some places system performance is improving; people are only admitted to hospital where necessary, delays are minimised, and long-term outcomes are optimised. This poses the question of how this practice can be consistently and sustainably adopted across the board.

Despite additional funding, progress in disseminating good practice is slow, and often observed in pockets in different parts of the country. As a result, this situation continues to have an impact on the extent to which long-term outcomes are being achieved for individuals. Along with impacting individual outcomes, pressure on hospital flow also continues to generate significant additional costs, felt by both the NHS and local authorities.

This programme has sought to provide a set of recommendations, both on the enablers to be developed centrally and specific practice to be adopted locally, to allow for consistent and sustainable adoption.

a. Recommendations for central policy makers

In order to enable and support local systems, there are a set of enablers which need to be put in place nationally. These enablers require alignment of policy and nationally funded and directed support programmes.

Recognising the immediate pressure faced by health and social care systems, there are three enablers which ought to be put in place as an immediate priority. The remainder are longer-term, enabling improvement over the medium to long-term.

Short-term recommendations

1. Focus any additional funding that is made available for community capacity on councils to expand home-based reablement and recovery and specifically the therapy workforce required to support this.
2. Bring national focus to attendance and admissions avoidance, alongside effective hospital discharge.
3. Make minimising simple discharge (Pathway 0) delays a national priority.

Long-term recommendations

1. End short-term funding; commit to multi-year arrangements.
2. Develop good practice and capability development for system strategic commissioning arrangements, in particular for the commissioning of intermediate care and demand and capacity planning.
3. Develop a transparent and extensive national data and performance framework, to more readily identify good practice and areas for improvement.
4. Reform information governance and data standards to enable effective and efficient data sharing across systems. Develop a comprehensive strategy for out of hospital dementia care.

b. Recommendations for local systems

This report provides a clear evidence base for optimised hospital flow and discharge. This leads to a set of actionable recommendations for local systems which if replicated across the country will help to achieve higher and more consistent performance.

Short-term recommendations

1. Ensure system-wide visibility of the community support offer, especially with paramedics.
2. Bring focus to tackling delays for simple discharges (Pathway 0) by smoothing discharges through the week.
3. Re-focus on the delays contributing to length of stay before patients are 'medically fit' for discharge.
4. Prioritise building the capacity of home-based intermediate care.
5. Unblock and optimise bed-based intermediate care.

Long-term recommendations

1. Ensure comprehensive data visibility across the system.
2. Optimise demand and capacity planning.
3. Support effective practice and decision-making through the discharge process.
4. Develop and deliver effective and targeted prevention.

Impact of optimised hospital flow and discharge

If the recommendations are fully embraced, and acted upon both nationally and locally, analysis from this work programme shows significant progress can be made towards optimising flow and discharge.

This will require the continued commitment of national policy makers, working together with local health and care system leaders to affect significant change. If this can be achieved, outcomes for people can be improved, operational pressure reduced, and financial sustainability enhanced.

The financial benefit of these improvements in each case is described (net of delivery costs) and therefore represents the realisable impact for the health and care system.

The potential benefits can be outlined in terms of:

1 **Avoiding people being admitted to hospital.**

2 **Reducing unnecessary delays when someone is in hospital.**

3 **Optimising long-term outcomes when someone is discharged from hospital.**

Avoiding people being admitted to hospital

175,000 fewer older adults (aged 65 or above) could be admitted to hospital, and instead supported in the community. This will save the NHS £0.6bn.

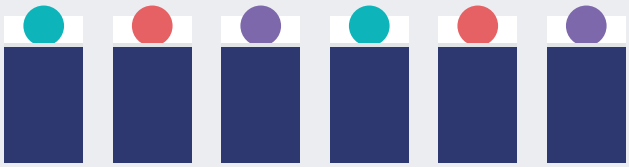
This is achieved primarily by building trust, confidence, and awareness of alternative community resources.

Reducing unnecessary delays when someone is in hospital

Over half a million

bed days are currently lost to delays during treatment that could be saved (before individuals are deemed to have no criteria to reside in the acute hospital). This will save the NHS £220m.

This requires increased diagnostic capacity and improvements to management processes.



500,000 bed days lost to delays with 'simple' discharges (Pathway 0) could be saved. This would save the NHS £200m.

The uneven discharge throughout the week is a major driver of these losses.

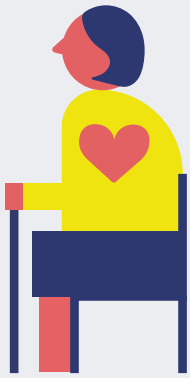
There could be 1.1m fewer bed days lost to delayed 'complex' discharges – primarily as a result of improving capacity in intermediate care and reducing delays in the discharge process.

There could be **440,000 bed days** saved by reducing discharge delays on Pathway 1 – a saving to the NHS of £176m.

There could be **300,000 bed days** saved by reducing discharges on Pathway 2 – a saving to the NHS of £120m.

There could be **400,000 bed days** saved by reducing discharges on Pathway 3 – saving the NHS £160m.

Optimising long-term outcomes when people are discharged from hospital



43,000 people could have a more independent long-term outcome, as a result of being discharged on to the right, more independent pathway – saving local government £575m.

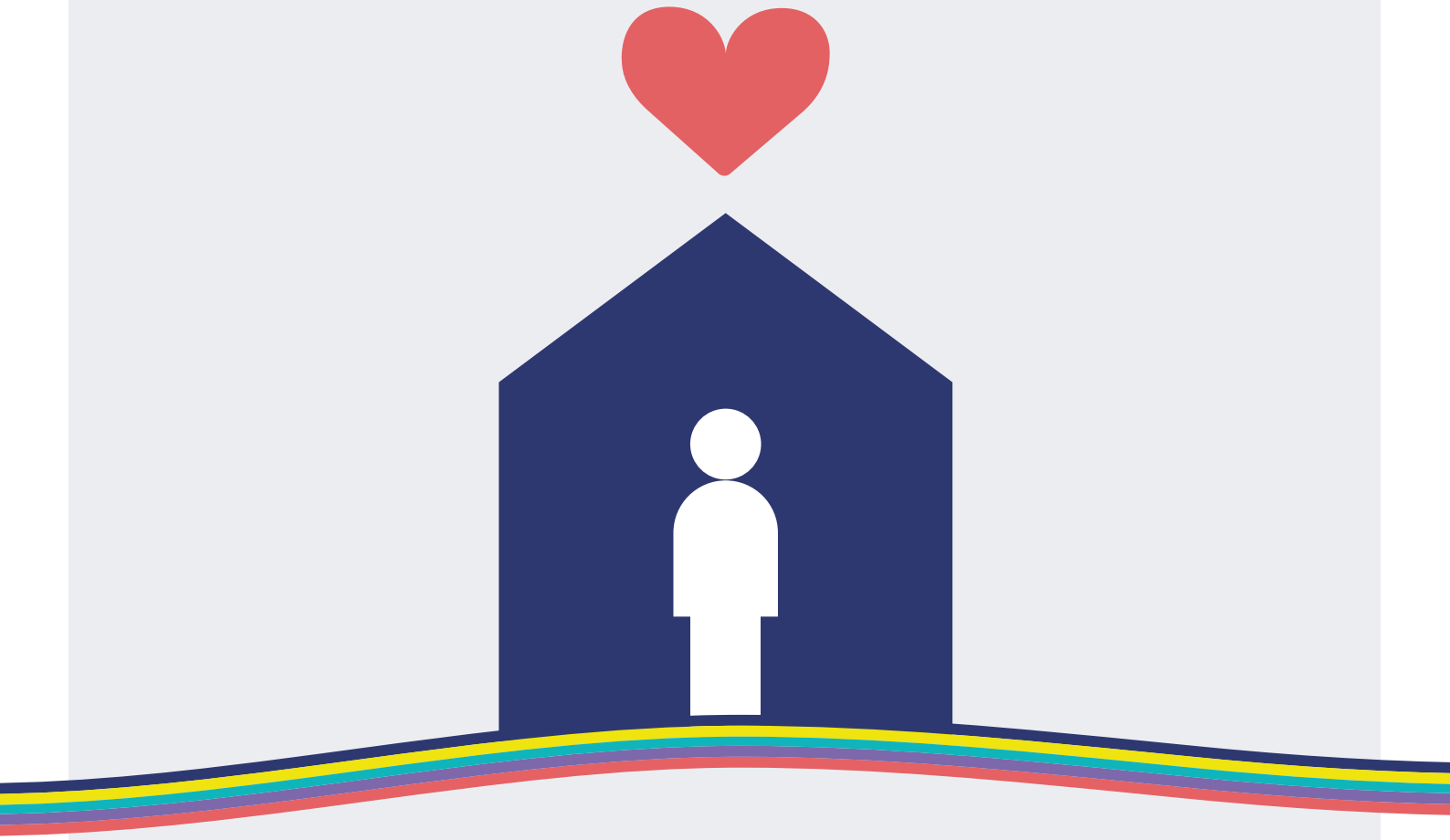
This is primarily as a result of lack of capacity of the right intermediate care, and risk averse decision-making.

40,000 people could have a more independent long-term outcome as a result of receiving effective home-based reablement and the effectiveness of this service could be improved for the 200,000 people already benefiting from it – saving local government £440m.

This is primarily as a result of increasing therapy input into home-based intermediate care.

In total this results in a potential financial benefit of £2.5bn to the health and social care system, of which £1.5bn is benefit to the NHS, and £1bn to local government.

Please see page 101 for more information on the workings behind these statistics.



02

Introduction

Background

If you are an older person (aged 65 or over) in England who has need to use urgent or emergency healthcare provision, the reality is that your 'journey' through the health and care system is likely to vary significantly depending on where in the country you live and access health and care services.

Nationally, the evidence points to people being admitted to hospital unnecessarily and delays during hospital stays, which could mean people spend longer in hospital than they need to, and/or then experience further delays in being discharged. There is also clear evidence that people may not always achieve the level of long-term independence they may be capable of and may want for themselves.

Despite this, there is cause for optimism; numerous examples of good practice have been observed (and included in this report). More than half of integrated care systems (ICSs) have managed to reduce their rates of delayed discharges this year[4]; and there are high performing places where people are only admitted to hospital where necessary, delays are minimised, and long-term outcomes are optimised. On the other hand, in 16 integrated care systems, the rates of delay have worsened in the same time period. This poses the question of how good practice can be consistently and sustainably adopted across the board.

It is also important to recognise the many hundreds of thousands of staff working in health and care who are passionate about, and dedicated to, providing the best possible care and achieving the best possible outcomes for people. However, these individuals often feel constrained by the complexity and pressures within the system, which inevitably get in the way of their ability to consistently achieve the best outcome for the individuals in their care.

Whilst often and increasingly referred to as a 'health and social care system', which gives a sense of tightly linked, co-ordinated, and integrated services, the reality is that this 'system' is in fact made up of several separate organisations, with markedly different funding models, incentives, values, and cultures, each endeavouring to work together to plan and deliver care for the same individual. A generic health and social care 'pathway' to demonstrate possible journeys through this system is pictured in Figure 2 – with the different colours denoting whether the service is typically run by acute or community health (the NHS) or care (the adult social care system, run by local authorities).

This report will often refer to the 'system' as a shorthand. However, it will, where possible, define and draw out the specific roles of the different organisations involved.

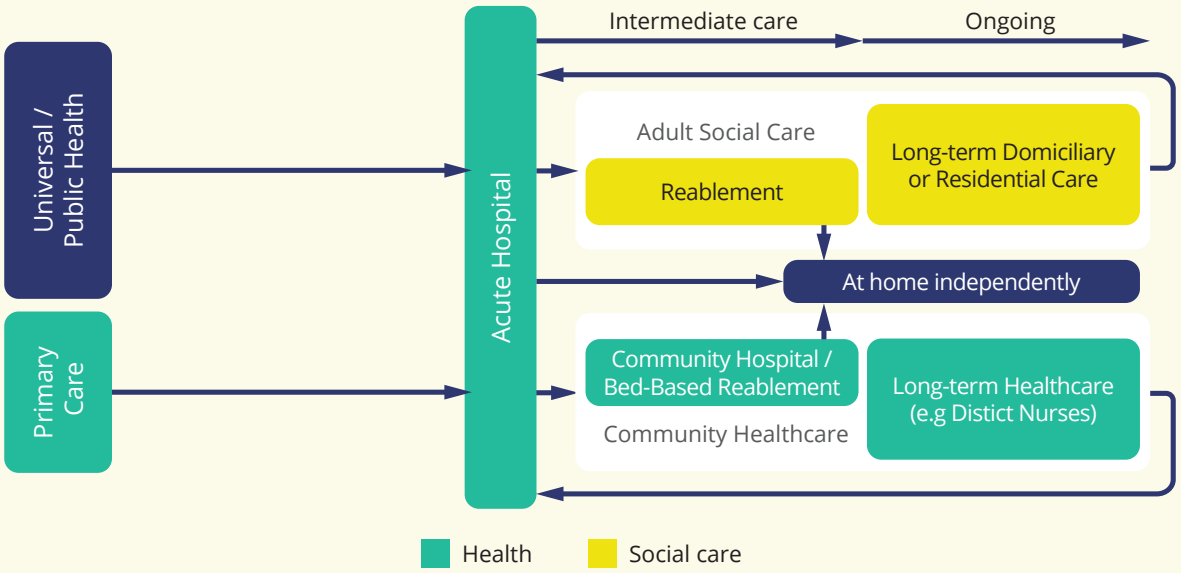


Figure 2. A generic health and social care 'pathway' to demonstrate possible journeys through the system.

Attempts to alleviate the pressure

During the pandemic, access to hospitals was limited. This report was commissioned after this point, when England was coming out of the extremely challenging 2022/23 winter period, where the legacy of Covid-19, shortages of staff, and general seasonal pressures (including flu season) were all evident.

While councils with statutory responsibilities for social care played a role in the policy interventions that were put in place last winter, local government leaders engaged in this work programme felt that their critical role was marginalised in the development of policy proposals. They felt that this contributed to a perception – often held by the public, media, and most importantly, Ministers – that capacity in the community and the delivery of social care was the root cause of the challenge of winter pressures, rather than part of the solution.

As a result of this increasing pressure, in November 2022 the Government announced £500m of additional funding for health and social care systems – £300m for Integrated Care Boards (ICBs) and £200m for social care, intended to:

- provide improved access to urgent and emergency services
- speed up patient discharge
- free up hospital beds
- reduce ambulance handover times
- improve capacity in social care.

In January 2023, an additional £200m was made available to ICBs, to specifically reduce the number of patients who did not meet the criteria to reside in acute hospitals but continued to do so. The primary focus of this funding was for local NHS bodies, not councils, to directly purchase residential care beds to increase capacity in post-discharge care and support. Health and care leaders engaged in this work programme noted that in this case, funds were released late in winter with a number of conditions attached, and it was difficult to mobilise two schemes in two months. As such, they reported that the funding was treated with some scepticism.

Despite this injection of funding, it does not appear that significant operational pressures (including delayed discharges) are easing, and this situation continues to have an impact on long-term outcomes being achieved for individuals. Along with impacting individual outcomes, this pressure also continues to generate significant additional costs, felt by both the NHS and local authorities.

Purpose of this report

The objective of this programme of work, of which this report is the main output, is to help influence an evidence-based discussion on how to improve the long-term outcomes of older people by optimising flow through the health and care system (including at the point of discharge), whilst also reducing pressures on all organisations involved.

The programme of work was commissioned by the County Councils Network (CCN) and delivered in partnership with representative groups from across the health and social care sector. It has been supported by Newton, who has gathered the evidence and insight presented.

It follows a significant piece of research conducted in 2021, by CCN and Newton, entitled 'The Future of Adult Social Care'.[5] This described how the delivery of adult social care could be optimised, and the role of local authorities in this. The core belief underpinning this research was that the best outcome that can be achieved for an individual is one which enables them to live as independently as possible – ideally at home.

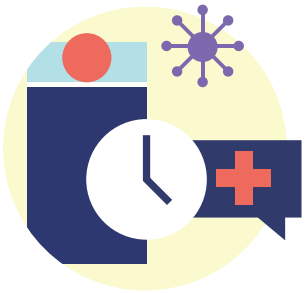
A stay in an acute hospital often results in increased dependency; whilst this can be entirely appropriate, it can also be an unintended consequence, leaving someone more dependent than they ought to be. Building on the experience of last winter and the policy interventions introduced, this programme is therefore interested in exploring the opportunities to better leverage initiatives to prevent, reduce, or delay the need for support in the first place, while also increasing the use of community services as an alternative to acute care settings (such as virtual wards).

It has also focussed on the point at which an individual is discharged from hospital – how the support provided might maximise their independence, minimise delays, and reduce pressure on the NHS and social care.

Many of the community services referenced in this report are run by local government, however, the nature and style of collaboration across the system is key. There is a level of co-dependency that needs to exist between the organisations, alongside a recognition that no single part of the system can solve the challenges in isolation. As such, the report also highlights where greater collaboration is required.

Specifically, this programme of work has sought to:

Better understand the operational challenges and pressures inherent across the system, particularly those that led to the 'winter crisis' last year, and the impact they may have on winter 2023/24.

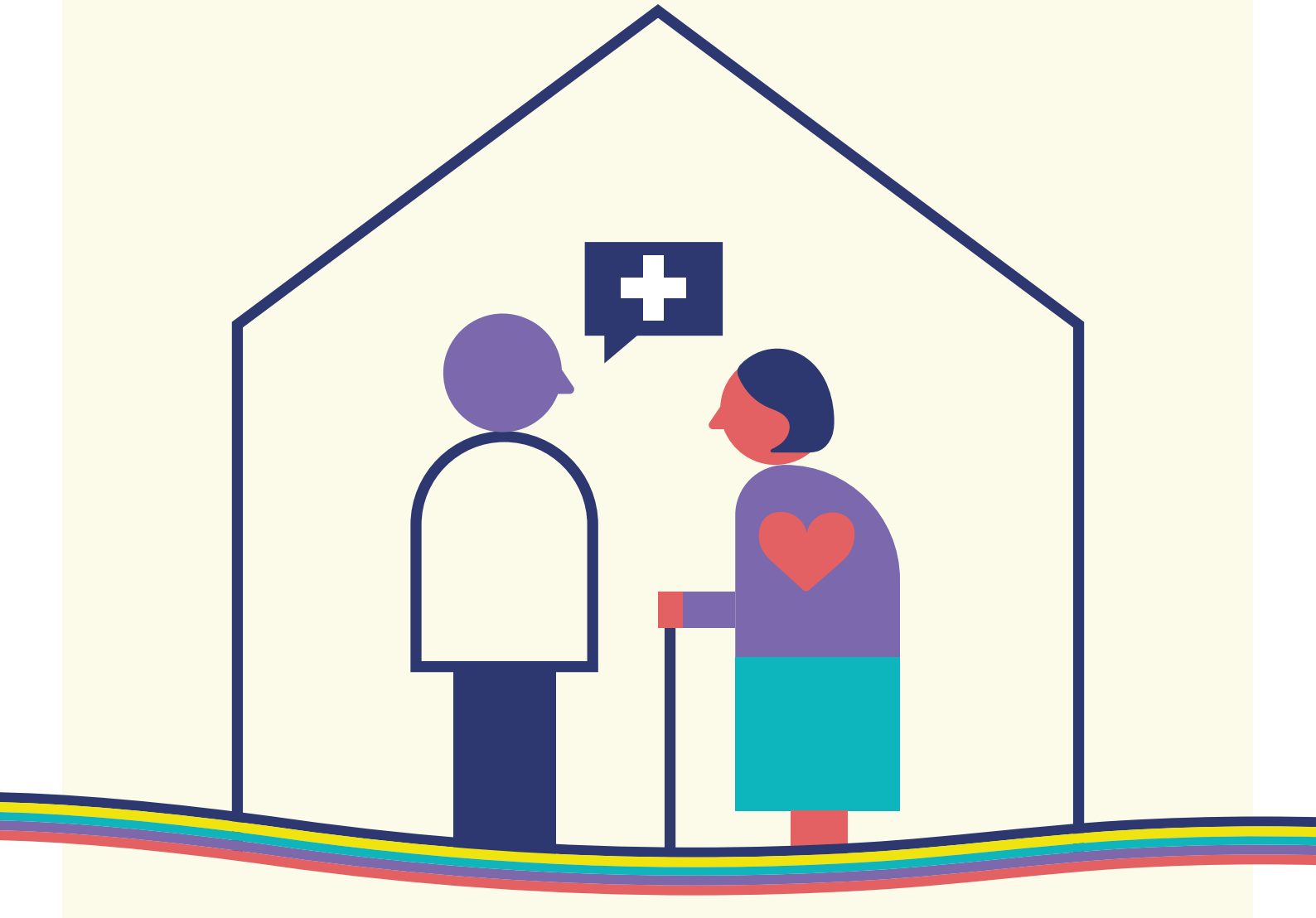


Explore the driving forces behind these challenges and assess the impact of existing interventions.

Explore the role of local government and the NHS in easing these pressures (including opportunities for greater collaboration).

Provide analysis and recommendations for local systems and central policy makers for the winter ahead, and years to come.

In short, this report seeks to explore how discharge and flow can be optimised to support older people to get home, before they come to harm by spending too long in an acute hospital.



03

Methodology

Introduction

This report is the result of a programme of work which involved bringing together analysis from several sources, including national data sets, bespoke data requests provided by samples of health and care systems, the Better Care Fund (BCF) plans of CCN member authorities; and change programmes undertaken by Newton.

This is overlaid with the rich insight from many conversations; the report is designed to reflect the breadth and depth of the views, opinions, and examples of good practice that have been shared.

Colleagues from across CCN's network of 20 county councils and 17 unitary authorities were invited to contribute.

To provide a balance of perspectives, national representatives and colleagues from non-county unitary, metropolitan, and London boroughs also engaged with the research, with a view to develop conclusions that should be relevant to the whole sector.

Engagement

In the summer of 2023, seven roundtables and numerous one-to-one conversations were undertaken with leaders from the NHS (including acute and community provider trusts) and local government.

Directors of finance, operations, adult social care, and public health contributed to the discussions, as well as representatives from the Local Government Association (LGA) and frontline staff. In total, over 80 individuals contributed.

Data analysis

This report primarily focuses on the provision of non-elective treatment and care for older adults, defined as those aged 65 and over. As much as possible, statistically reliable data sources have been used. However, in some cases, where data is difficult to obtain, small samples have been gathered manually and analysed, and as such should be treated with appropriate caution.

In the analysis of national datasets, the data does not always allow for a perfect comparison (for example between trusts of certain types or being able to isolate patients aged 65+); while best efforts have been made to navigate this, it inevitably leads to some degree of assumption and approximation. Where this is the case, the data is clearly highlighted.

Undoubtedly, there would be value in reviewing the impact and outcomes for different age groups of individuals, for example those aged 75+ or 85+, but the current lack of in-depth, consistent data countrywide means that it has not been possible to review the situation at a more granular level.

Advisory group

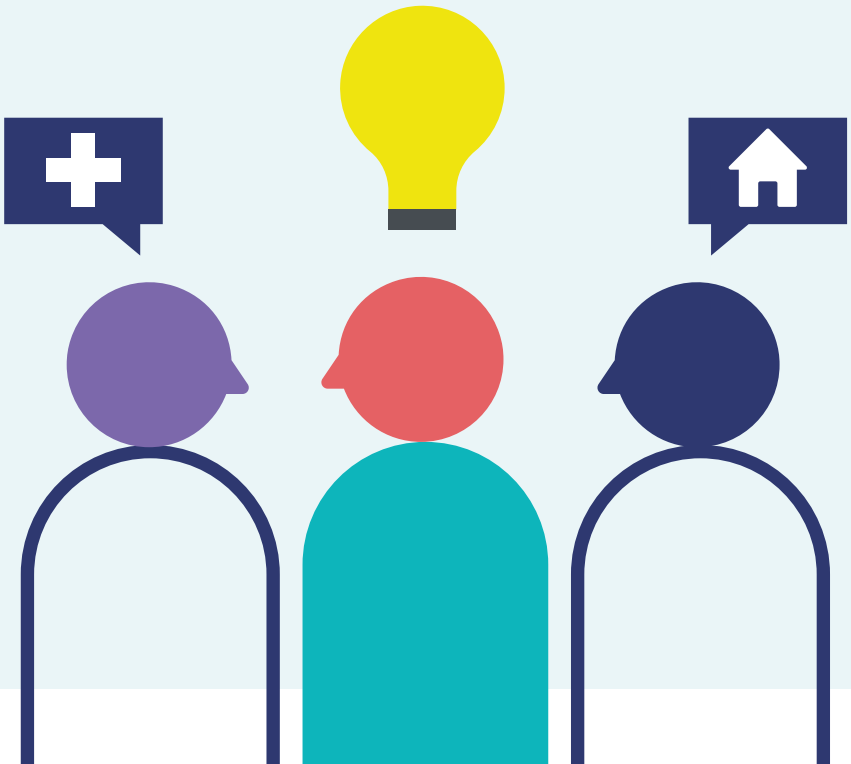
This work programme was overseen by a cross-sector advisory group.

The advisory group's objectives were to:

- set the direction for the work, and ensure a high-quality output
- build cross-sector alignment and broad agreement of the high-level recommendations
- facilitate engagement with wider groups of individuals to input into the research, for example by chairing roundtable discussions
- identify good practice to be included in the analysis and this report.

The following organisations were represented:

- Association of Directors of Adult Social Services (ADASS)
- Association of County Chief Executives (ACCE)
- Local Government Association (LGA)
- NHS Confederation
- NHS Providers
- Reform
- The Society of County Treasurers (SCT)



The advisory group members were:

Councillor Martin Tett, Leader of Buckinghamshire Council (chair)

Ian Gutsell, Chief Finance Officer at East Sussex Council, and Co-lead for Health and Adult Social Care at SCT

Melanie Lock, Director of Adult Services at Somerset Council and ADASS Regional Chair – South West

Melanie Williams, Corporate Director for Adult Social Care and Public Health at Nottinghamshire County Council and Vice President of ADASS

Miriam Deakin, Director of Policy and Strategy at NHS Providers

Rachael Shimmin, Chief Executive at Buckinghamshire Council and Adult Social Care and Health Lead for ACCE

Richard Webb, Corporate Director Health and Adult Services at North Yorkshire Council and Co-chair of the CCN Directors of Adult Social Services and Directors of Public Health network

Sarah Walter, Director – Integrated Care Systems Network at NHS Confederation

Sebastian Rees, Senior Researcher at Reform

Simon Williams, Director of Adult Social Care Improvement Partners in Care and Health at the LGA.

CCN and Newton would like to extend their thanks to all those involved in this programme of work for being so generous with their time, expertise, and support. It is hoped that this report will form a framework and starting point for proactive conversations and transformative action, improving outcomes for all.

04

National challenges and context

National challenges and context

Internationally recognised and often the blueprint for universal healthcare systems around the globe, the English health and care system has been a source of pride since its inception. The powerful contract established with the population, that wraps around the resident from 'the cradle to the grave', means that every citizen (or a family member, friend, or colleague) will have been supported and cared for by one, or many, of the thousands of people who make our unique system tick.

A 'health and care system' is a phrase that gives the impression of a unified, seamless, single, well-oiled machine that functions reliably and predictably. In reality, those working within the system know that it is rather negotiated collaboration between the NHS, local government, the voluntary sector, and private providers, with significant variability across the country, and even within the way individual organisations operate.

The dynamic between a universal, free at the point of use NHS, and a social care system that is delivered by local authorities that is largely means-tested, creates additional complexity.

There are several national challenges impacting most health and care organisations in England that are important to consider before looking at local challenges with flow and discharge. These are highlighted below, in addition to the policy context which frames the issue.

25%

of the adult population lives with two or more conditions

Demography

Over time, the population of England is becoming proportionately older. By 2030, more than one in five people will be over 65 years old (21.8%), 7% over 75 years old, and 3.2% over 85 years old.[6]

It is in this eldest category that the greatest shifts will happen, with the number of people over 85 almost doubling to 3.1m people by 2045.[7] The impact of this on demand for services is likely to be marked, with individuals living through a greater number of years of ill-health and therefore requiring more health and social care support.

Changing health of the population

Alongside an ageing population, the number of people in England living with multiple health and/or social care conditions is rising. More than 25% of the adult population lives with two or more conditions.[8] In comparison to those in the general population with a good quality of health and well-being, people with multiple conditions (multi-morbidity) are more likely to have poorer health, a poorer quality of life, and be at a higher risk of dying.

Furthermore, the prevalence of multi-morbidity is strongly associated with socio-economic factors that means the poorest in society are often at the greatest risk when it comes to their health and well-being. Supporting people with multiple conditions to remain well at home and recover after escalations in care is incredibly complex, and so often results in poorer outcomes and a greater dependence on services.

Cost of living crisis

In addition to the issues of age and ill-health, the macro-economic picture in England (characterised by relatively stagnant growth over the last decade and more recently higher levels of inflation) has impacted the ability of people to support their own health. For frail elderly people this picture is particularly distressing, resulting in rapidly escalating care and health needs.

Over time, the compounding factors of poorer nutritional choices and less well-maintained housing are likely to create additional pressures on health and care. Furthermore, the staff on whom health and social care services rely are ultimately facing the same challenges as the people they serve.

Impact of the Covid-19 pandemic

The Covid-19 pandemic had a long-lasting effect not only on the UK population but also on the health and care system on which it relies. To create capacity in the system to manage the additional demand stemming from the pandemic, elective care was inevitably deprioritised during the initial period of the pandemic.

Since then, a complex interplay of factors including revised and augmented control of infection protocols, lack of access to elective beds due to non-elective occupancy, and more recently the impact of industrial action, have all contributed to lower levels of elective activity than pre-pandemic levels. As a result, between February 2020 and August 2023 the NHS's elective waiting list grew by 61% (from 4.57 million to 7.47 million) prolonging ill health for many and creating a sustained pressure on the health and care system.[9]

The impact has also been felt on social care, with waiting lists for social care assessments or reviews peaking at 542,000 in April 2022, though reducing to 430,000 in March 2023.[10]

Workforce

Alongside the increases in demand being driven by the factors described above, the health and care system in England is facing a workforce crisis. It is currently unable to train, recruit, and retain enough staff to keep pace with the growth in demand, and this has been exacerbated by Brexit which caused an initial reduction in workers from overseas.

Although there have been recent increases in the overall number of doctors and nurses working in the NHS, the number of vacancies has also increased. While in recent years the number of vacancies in the adult social care sector has been increasing, a recent Skills for Care report shows a decrease to 9.9% in 2022/23 from 10.7% in 2021/22.[11] However, this vacancy rate is still significant, suggesting that while recent recruitment efforts are beginning to bear some fruit, this is still a challenge.

Beyond this, the workforce is drawn from the populations that they serve. As a consequence, sickness and absence, alongside the risk of lower than inflation pay, is likely to increase these gaps over time. This topic is explored further later in this report.

Impact of austerity

Following the financial crisis of 2008 and the associated decade of constrained public expenditure conceived to reduce the government deficit (often described as 'austerity'), the spending power of local authorities has been significantly reduced. Local authority spending power fell by 17.5% between 2009/10 and 2019/20, before partially recovering. However, in 2021/22 it was still 10.2% below 2009/10 levels.[12]

Despite some of the impact of this on services being mitigated through innovation and prioritisation by service leaders, by 2020 the care market was fragile and, in some areas, close to failure. This is particularly evident where the wages available to be paid to care givers cannot compete with those available in other roles (in both the public and private sector), further driving the levels of vacancies highlighted above.

Short-term funding

There is evidence of a short-term funding view of both health and social care, such as the pushing back to October 2025 of some of the commitments made as part of the Health and Social Care levy (included within the Build Back Better Strategy) and the social care funding reforms ('cap on care'). These delays have resulted in an ongoing uncertain financial environment for citizens and providers alike.

Health and care leaders engaged through this programme of work agreed that the funding view makes it much more difficult to plan effectively and inevitably leads to sub-optimal short-term solutions. For example, local government leaders engaged described a situation where additional bedded capacity has been commissioned as opposed to more desirable, long-term solutions i.e., the investment in, and training of, recovery and reablement teams.

Local government finances

Through a combination of the challenges outlined above, local government finances are under significant pressure. Recent research by the CCN and SCT has shown that the 41 councils they jointly represent face overspending their budgets in-year by over £600m during 2023/24.

The analysis shows that these overspends are worsening an already challenging financial outlook – with these councils having a combined funding gap of £4bn by 2025/26. As a result, some 1 in 10 of these councils are not confident or unsure they can balance their budget this year – a legal requirement – with this growing to 4 in 10 next year and 6 in 10 by 2025/26.[13]

This leaves local government leaders with limited options for further investment, and in many cases prioritising cutting services back, and retaining only what is statutory.

Discharge to assess

The implementation and widespread adoption of the discharge to assess (D2A) model has also driven a change in behaviour within health and care services. There is now an increasing expectation of people being assessed for their long-term care needs in the community, whether that be at home or within a short-term care bed.

Although the effectiveness of this model is undoubtedly impacted by some of the wider contextual challenges factors described above, as well as significant variation in terms of how successfully this model has been implemented, some systems have seen significant reductions in length of stay of over four days, with no associated increase in re-admissions.[14]

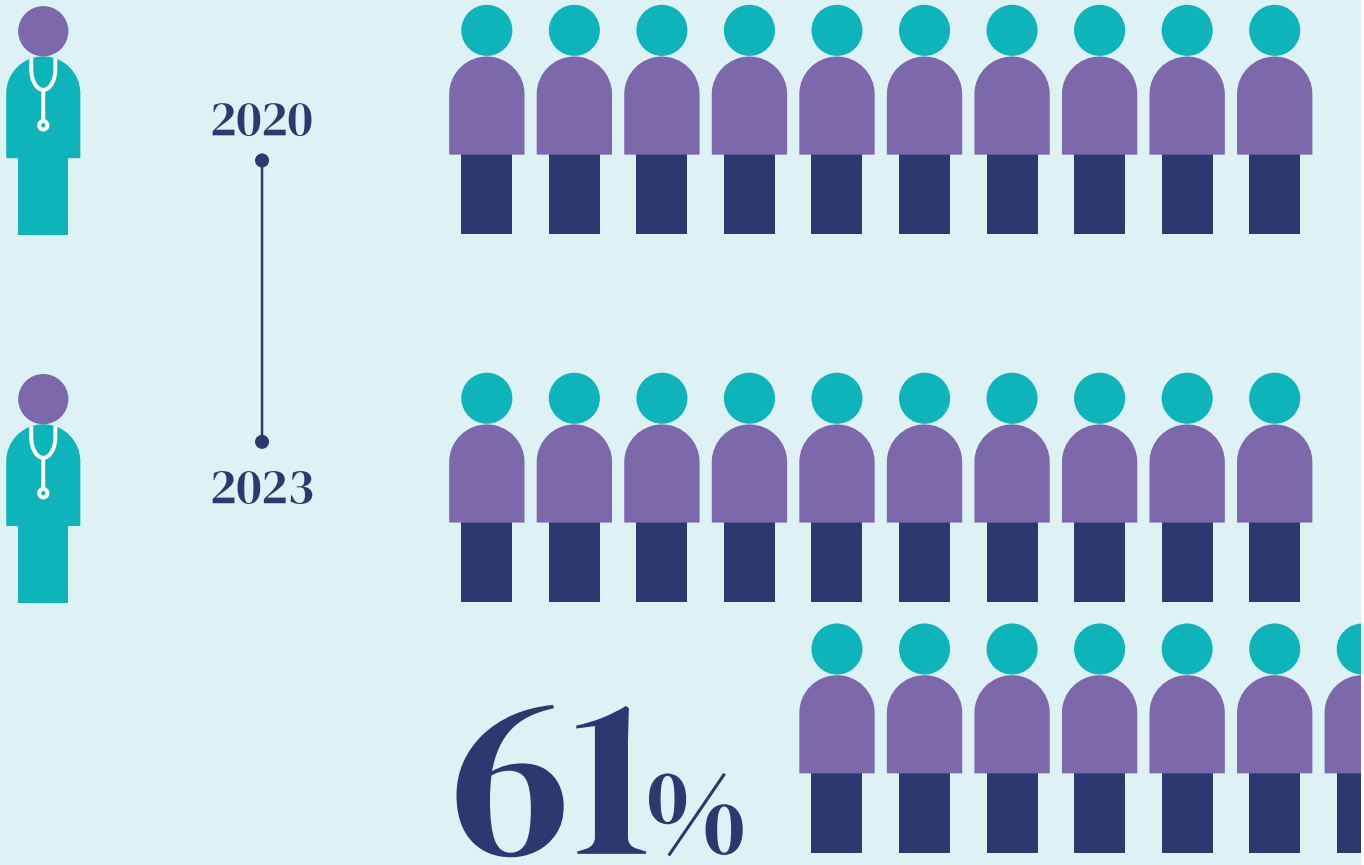
Integrated care systems

While there have undoubtedly been several headwinds facing the health and care system in recent years, policy developments in this space have sought to build a platform upon which more integrated thinking could happen.

Last year, the Health and Care Act (2022) established 42 integrated care systems (ICSs) as legal entities. Though there are significant variations in the ways in which ICSs and their constituent organisations are working, they have helped partners to think about provision on three different levels:

1. **Neighbourhood** – services that need to be delivered to residents at a very local level, often at a scale of 30,000 to 50,000 people.
2. **Place** – a broader population often co-terminus with city level scale of 250,000 to 500,000 people.
3. **System** – where health and care providers come together to deliver services at scale, serving a population of 500,000 to 3m people.

This is intended to provide a framework for systems to plan and deliver health and care, as well as a means through which consistency can be achieved.



61%

The percentage that the NHS's elective waiting list grew between February 2020 and August 2023.

Funding and policy changes (2020 to date)

The following describes some of the key policy and funding changes since 2020, but is not designed to be an exhaustive list.

March 2020

- NHS Funding Act 2020 becomes law, setting out NHS funding from 2021 to 2024.
- Covid-19 hospital discharge service requirements published by DHSC, outlining actions that must be taken immediately to enhance discharge arrangements.

July 2020

- HM Treasury's 'Plan for Jobs' outlines £31.9bn of support for health services, primarily to support the response to the Covid-19 pandemic.

August 2020

- Discharge to assess approach included in planning guidance for 2021/22.

October 2020

- Health and Social Care Select Committee, in its 'Social Care: Funding and Workforce' report, calls for extra £7bn per year to avoid the risk of market collapse.
- CQC 'State of Care' annual report reiterated their earlier statement that 'failure to find a consensus for a future funding model continues to drive instability' in social care.

February 2021

- The 'Integration and innovation: working together to improve health and social care for all' white paper announced by DHSC.

September 2021

- Health and Social Care Levy announced as part of the 'Build Back Better: Our Plan for Health and Social Care' strategy.

October 2021

- 40 new community diagnostic hubs announced to help tackle backlogs of care and reduce waits for diagnostic tests.

December 2021

- 'People at the Heart of Care: adult social care reform' white paper published by DHSC.

July 2022

- Health and Care Act comes into force, laying the foundations to improve health outcomes by joining up NHS, social care, and public health services at a local level.
- Hospital discharge and community support guidance released.

September 2022

- Government announces that the Health and Social Care Levy will be cancelled, although a planned £5.4bn of revenue explicitly assigned to support adult social care reform would 'still be maintained at the same level'.

November 2022

- £500m of additional funding allocated for health and social care systems – £300m for integrated care systems and £200m for social care.
- Cap on care costs and the reforms to how people in England pay for social care delayed for two years.

January 2023

- £200m made available to ICSs to build additional capacity in care homes.

July 2023

- Remaining £600m from delayed social care reforms distributed to councils through the Market Sustainability and Improvement Fund, with a focus on building social care capacity and improving market sustainability.

September 2023

- £200m of funding announced to boost NHS resilience during its most challenging period and £40m to bolster social care capacity.
- Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge released.

05

Taking a person-centred approach

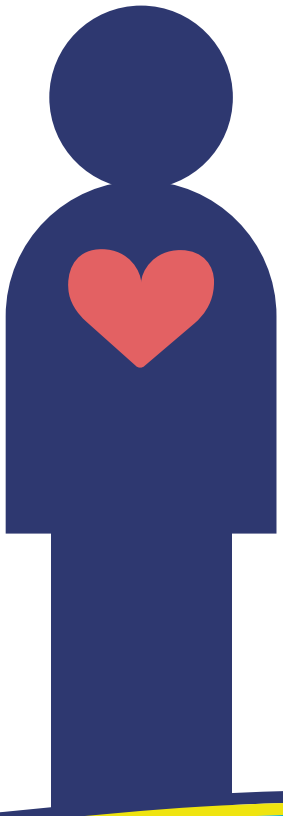
What is a person-centred approach?

This report seeks to explore how discharge and flow can be optimised for people with urgent and emergency health and care needs. It is the underpinning belief of this work programme that taking a person-centred approach is at the heart of this.

In 2018, Think Local Act Personal and the Coalition for Collaborative Care produced a framework for personalised care and support entitled "Making it Real".[15] This included several clear statements that should be used to underpin basic care and support. They start with the following basic value statements:

- I am treated with respect and dignity.
- I feel safe and I am supported to understand and manage any risks.
- I am supported to manage my health in a way that makes sense to me.
- I have people in my life who care about me – family, friends, and people in my community.
- I am valued for the contribution that I make to my community.
- I have a place I can call home, not just a 'bed' or somewhere that provides me with care.
- I live in a home which is accessible and designed so that I can be as independent as possible.

These values hold immense significance for individuals and simultaneously influence the operational and financial outcomes of health and social care systems. Often however, this is not the experience that is expressed by people who are being discharged from hospital as demonstrated in the following study.



An individual's most preferred outcome is often the most independent

In a study of acute and community hospital discharges in one county authority, 72 individuals were asked *"when you get discharged from this hospital stay, where would you like to be discharged to?".*

For the same individuals, expectations were collected from their families and several practitioners from across the different health and social care teams who were involved in the individual's discharge planning.

As demonstrated in Figure 3, the majority of individuals wanted to return to their own home. However, not all families and health and social care practitioners involved in their discharge agreed with their wishes.

This exemplifies the opportunity for more creative, risk-aware approaches to support planning, drawing on all possible community assets to help an individual achieve their wishes and maximise their independence.

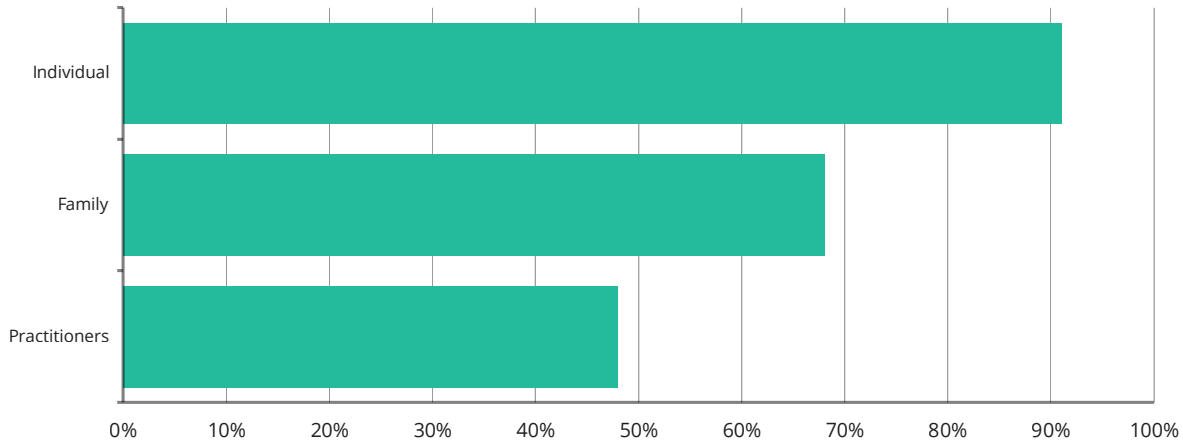


Figure 3. Proportion of individuals who wanted to go home after a hospital stay in comparison to their family and practitioners.

Promoting independence on hospital discharge

In 2017, a report published by the Better Care Fund Support Programme and Newton titled 'Why not home, why not today?' highlighted that 40% of older people were discharged from hospital on a higher care pathway than their needs demonstrated.[16]

Significant pressure on acute hospitals has led to staff focussing on 'getting patients out of the hospital bed by any means'. An example of this is when acute hospitals buy beds in residential care homes into which they place older people, without the necessary therapy input and without planning for their short- or longer-term needs.

A common consequence of this strategy is that these people then remain in that care home for the rest of their lives, without ever having the choice (or sometimes the ability) to return home.

People leaving hospital need time to recover from the trauma of an admission. Time to rebuild emotional strength and confidence, and lost muscle tissue that may have deteriorated when they have been immobile.

The development of the discharge to assess policy was originally formed from the belief that it is impossible to gain an accurate assessment of most people's long-term care needs prior to a period of recovery and recuperation taking place. Pressure to discharge patients can result in insufficient attention being paid to this recovery journey.

Intermediate care services are integral in practically embedding these values, and the skills of therapists, care workers, and nurses cannot be underestimated in helping individuals to recover, while maximising chances linked to their ongoing independence. As such, their role is consistently emphasised throughout this report.

Minimising hospital stays

Academic research has also shone a light on 'post hospital syndrome' whereby older adults are prone to experience a period of increased risk for a wide range of adverse health events, not directly connected to their original reason for admission.[17] Krunholz's 2013 study identified that nearly a fifth of patients discharged from hospital developed an acute medical problem within 30 days, subsequently requiring another hospital admission. Concerningly, in the majority of cases, the reason for readmission was different to the original ailment for which they sought help.

There is therefore significant justification and rationale to avoid (where medically possible) an admission in the first place; and where it is not possible to treat an individual at home, safely minimise their length of stay in hospital as much as possible. Not only is this in the best interests of the person, but it also reduces the operational and financial pressures linked to a hospital stay.

The following stories give representative examples of peoples' journey through the health and care system:

Rashmi's story

An 89-year-old woman, Rashmi had been living at home receiving three care visits per day. Rashmi suffered from a suspected stroke and was admitted onto a ward.

Two days later, Rashmi was medically fit. Unfortunately, by the time the nursing staff spoke to her previous care provider on 9 January, her previous care package had been cancelled. Rashmi's transfer of care form did not start until 11 January, as the note about her condition had been missed. Therapists then completed the form on 13 January – seven days after she had no criteria to reside. In the meantime, Rashmi's health had deteriorated, and she was deemed no longer medically fit to be discharged.

Eventually, Rashmi's condition improved, and she was once again ready to be discharged. Due to process delays, ward transfers, and the loss of the package of care, Rashmi was no longer able to go directly home, and required a period of rehabilitation. Rashmi was assessed within 24 hours and 21 days later she was discharged to a rehabilitation and recovery bed. One month later, Rashmi went into a long-term residential home, where she remains today.

Stan's story

Stan had recently become a widower and had been living at home prior to admission.

At the age of 92 Stan was admitted to hospital with pneumonia, severe malnutrition, and dehydration.
After becoming medically fit for discharge to a community hospital, he developed pneumonia while waiting for a reablement bed and became unwell again.

This additional illness delayed his discharge for 23 days.

Jean's story

Jean was a 90-year-old woman with a history of falls who was admitted to hospital. During her early stay, she used a commode, was able to wash herself, clean her teeth, brush her own hair, and move around regularly through the day. Jean expressed a wish to return home.

A point of care (POC) medical test to determine what support she might need at home could not be initially sourced, so she was moved into an intermediate care setting in the interim.

Despite being previously active, she spent the following two days in bed. After a further two days, she required full support to wash herself.

It took two weeks for the POC to be sourced at which point the physiotherapist determined that Jean's current level of need could not have been met with the package, and her needs package was declined. Four days later, a continuing healthcare checklist was completed, during which she repeats her desire to return home.

Three months after her admission, Jean was moved into a temporary bed within a care home. Three months later, in the same care home, Jean sadly passed away.

Reginald's story

Prior to being admitted into hospital following a fall, Reginald was living at home with support from his family and a one call per day domiciliary care package.

Despite being declared medically fit for discharge, he remained in hospital because his family requested an additional care package. 30 days after being declared medically fit, his condition had deteriorated to such an extent that it was decided that he was no longer able to go home. Instead, it was recommended that he needed to go to a discharge to assess Pathway 2 bed.

Another 30 days later, Reginald was finally transferred to a discharge to assess bed, where he waited another seven weeks before a long-term residential bed was secured for him.

06

Analysis of the current challenges

A system under pressure

A summary in numbers of the situation in health and care systems today, with a specific focus on the flow into and out of acute hospitals. This is explored further through this section of the report.

6.7%

increase in bed occupancy in general and acute, and critical care beds in the last year

Operational challenges at different stages

Hospital conveyance and attendance

6.2% increase in hospital attendance in the last year.

35% increase in 'Category 1' urgent and emergency calls to ambulances in the last four years.

However, **6% fewer people** are being conveyed to hospital by ambulance.

Hospital admissions

Acute hospital older adult emergency admissions have grown modestly when compared to attendances with a **3.8% increase** (2021/22 – 2022/23).

Individuals being admitted in an emergency are more unwell than before, with a **16% increase** in co-morbidities in the five years from 2018/19 to 2022/23.

While total admissions in the winter of 2022/23 were **up 6.3%** compared to 2021/22, on average, acute hospitals are admitting fewer patients than they were before the pandemic.

As health and care systems prepare for the winter ahead, this section of the report seeks to describe the situation today, with a specific focus on the flow into and out of acute hospitals.

The analysis above seeks to mainly examine the operational challenges, and the impact on long-term outcomes for people. The financial impact is explored in section eight.

Ultimately, the findings of this work programme support the perception of a health and care system under strain.

Length of stay (during treatment and waiting for discharge)

Average length of stay is **34.8% longer** (2019/20 – 2022/23).

16% increase in the volume of people medically fit for discharge remaining in hospital in the last year.

Length of stay for people with criteria to reside in the hospital has **grown by approx. 0.7 days** (from 6.8 days to 7.5 days) and **by 0.5** days for those with no criteria to reside (from 0.7 days to 1.2 days).

Intermediate care

5.6% increase in the number of people receiving short-term care such as reablement and rehabilitation at home since 2021/22.

A reduction in the requirement for long-term care is not being observed in the way that might be expected were short-term care services more effective.

Long term outcomes

7.9% increase in individuals being discharged to long-term care between 2021/22 and 2022/23.

In 2022/23, **15.6% more people** went into a long-term residential or nursing home following a stay in hospital than they did in 2021/22.

The significance of this situation cannot be understated. As each individual component of the system grapples with mounting strain, the entire system has started to slow down.

As a result, patient flow becomes more challenging, and staff are not able to support individuals to achieve the most ideal and personalised outcome.

The impact is therefore two-fold. Not only do acute hospitals have a higher proportion of beds being occupied, but the long-term outcomes for people are also worsening, with people becoming less independent.

Analysis of the current challenges

The operational pressures on health and social care systems are steadily growing.

There are two clear indicators of the pressure under which the system is operating:

- 6.7% increase in general and acute (G&A) and critical care (CC) hospital bed occupancy between 2021/22 and 2022/23.
- 7.9% increase in individuals being discharged to long-term care and a 5.6% increase in use of short-term care (2021/22 to 2022/23).

Bed occupancy is increasing

On average, 92,000 G&A and CC hospital beds were occupied at any one time during the winter of 2022/23 compared to 86,300 the previous winter.[18] This represents a 6.7% increase which shows the deterioration of out of hospital flow. Despite one-off injections of central funding to increase capacity (through buying more beds), the average occupancy of available G&A and CC beds rose from 92.6% (in the winter of 2021/22) to 94.8% (in the winter of 2022/23), as illustrated in Figure 4.

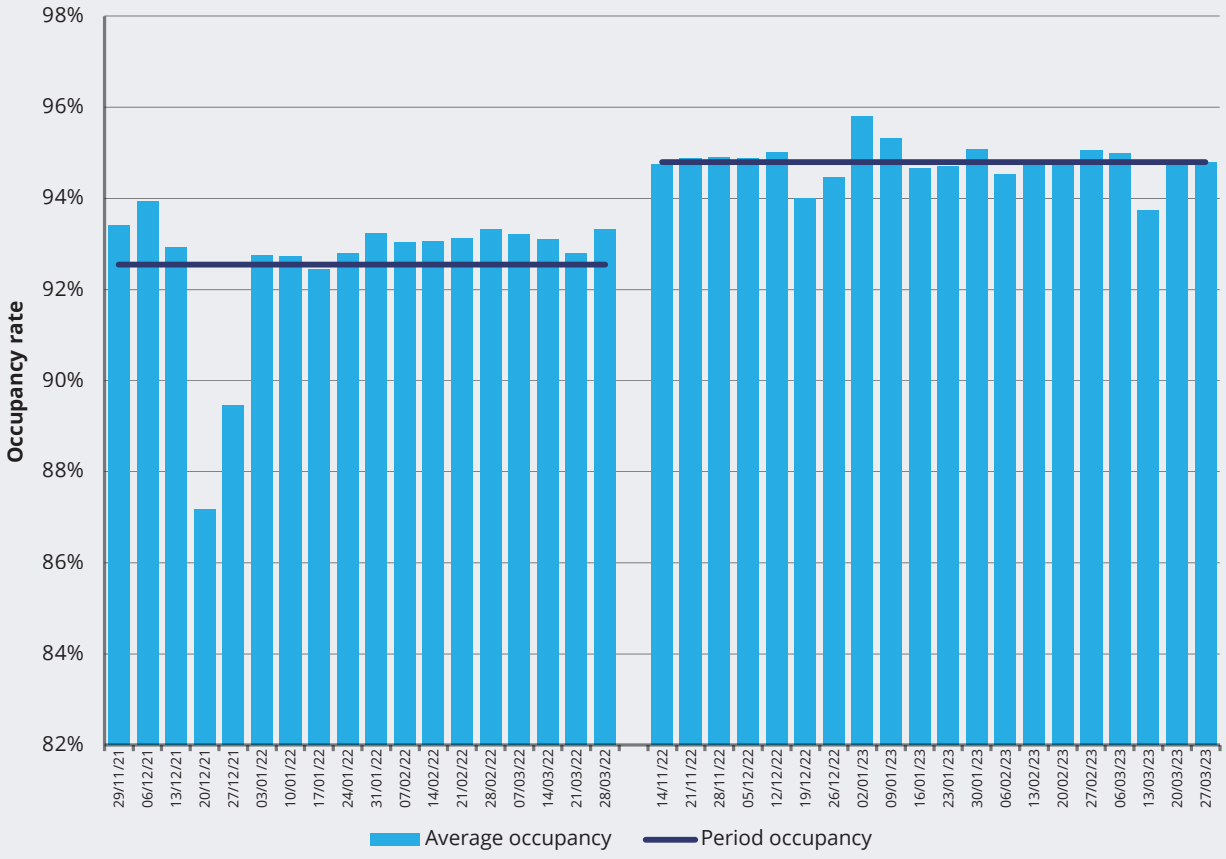


Figure 4. Weekly occupancy rate for general and acute, and adult critical care beds.

The number of individuals being discharged with ongoing care needs is increasing.

In addition, an increasing number of individuals are being discharged from hospital to long-term care, reversing a year-on-year decline seen since 2017/18. It is important to caveat here that the data in 2021/22 was impacted by a continued shortage of community services, and therefore use of beds was artificially inflated during that period.

As illustrated in Figure 5, in 2022/23 42,975 people were discharged from hospital to long-term care, compared to 39,380 the year before. This is an increase of 7.9%.[19]

In part, this reflects the growth and ageing of the population, as well as the increasing acuity of patients when they're admitted to hospital (as evidenced later in this report by the increase in average number of co-morbidities).

However, this reversing trend could also be a negative consequence of people spending longer than necessary in hospital, and a consequence of not consistently being able to access the appropriate intermediate care services on discharge.

Collectively, this data describes a system under significant pressure. Acute hospitals are experiencing high occupancy rates, limiting effective flow and stretching resources, and there is an increased reliance on long-term care for people following a stay in hospital, implying increasing long-term dependence on services for individuals.

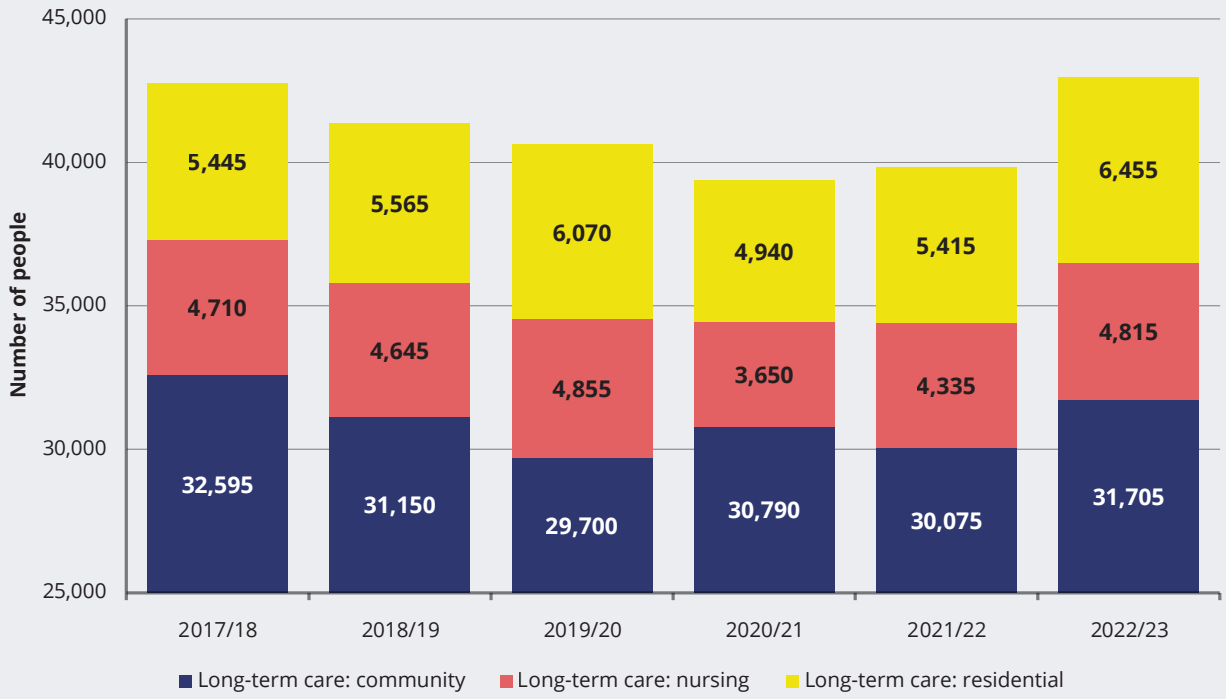


Figure 5. Number of 'new' people being discharged from acute hospitals to long-term care.

Operational challenges throughout the health and social care system

To understand the underlying factors impacting the flow of individuals through the health and care system, the operational challenges experienced across each of the following five areas were considered:

a. hospital conveyance and attendance
b. hospital admission
c. length of stay (both during hospital treatment and waiting for discharge)
d. intermediate care
e. long-term outcomes

a. Hospital conveyance and attendance

Headline findings

- Overall hospital attendance has increased by 6.2% in the last year.
- In the last four years, 'Category 1' urgent and emergency calls to ambulances have increased by 35%.
- However, 6% fewer people are being conveyed to hospital by ambulance.

There has been a substantial increase in the number of individuals attending hospital.

With the exception of the year 2020, there has been a steady, year-on-year increase in hospital attendance that is outpacing demographic growth. As shown in Figure 6, in winter 2022/23 an average of 1,873,146 people attended trusts with a type 1 accident and emergency (A&E) department each month.

This represents a 6.2% increase compared to the previous year, and a 14.8% increase in comparison to 2019/20 (the year before this data was impacted by the pandemic).[20]

This increase in attendances is adversely affecting A&E performance, with current waiting times the worst on record; four-hour targets were breached 38% of the time in the year 2022/23[21] and over 1,000 people were waiting for more than 12 hours.

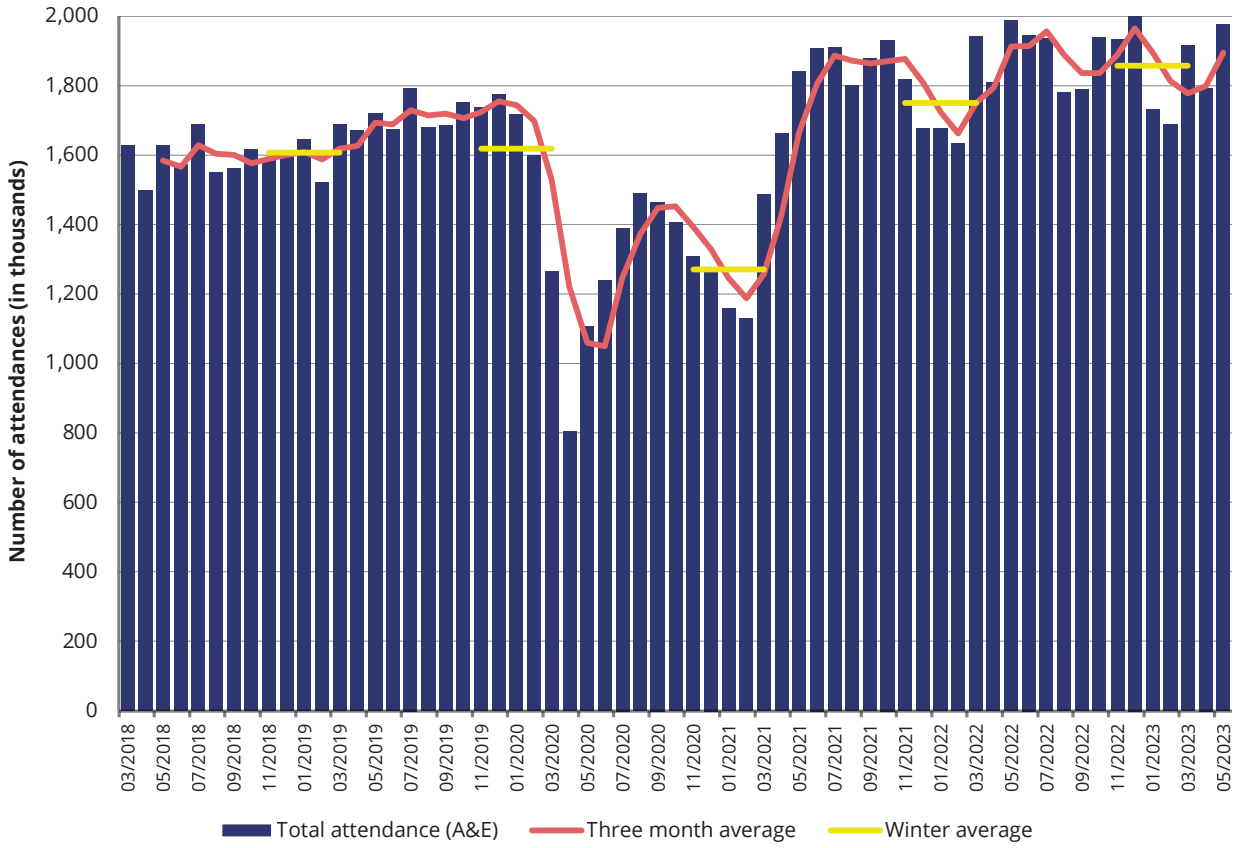


Figure 6. Attendance rates at all English trusts with a type 1 A&E department (between March 2018 and May 2023).

Despite the overall increasing number of attendances, ambulance conveyances account for 19% of A&E attendances, down from 25% in 2019.

The pressures on ambulance services and their crews have been well publicised, with significant delays being reported at the point of patient handover. In May 2023, there were 369,919 ambulance conveyances, out of a total of 1,977,105 attendances.[22] In the last four years, 'Category 1' urgent and emergency calls are also up 35%, with individuals seven times more likely to wait over an hour for a handover to A&E today than they were in 2019.

That said, individuals are now less likely to be conveyed to A&E following an ambulance callout. For example, in 2019, approximately 59% of calls resulted in a conveyance. Since then, this figure has dropped to 51%.

This means that the volume of people entering hospital through this part of the system has reduced (19% today, in comparison to approximately 25% in 2019).

Ambulance trusts are busier and they are responding to a greater volume of calls, however, they are triaging individuals more effectively and conveying fewer to the acute hospital than in previous years. Leaders engaged in this work programme hypothesised that this is in part due to efforts to deliver more care in the community, for example through urgent community response teams and virtual wards.

This means that the growth in attendances at emergency departments is via other routes, for example through self- or GP-referrals, or via the NHS 111 service.

b. Hospital admissions

Headline findings

- Acute hospital older adult emergency admissions have grown modestly when compared to attendances with a 3.8% increase (2021/22 – 2022/23).
- The admissions rate, in terms of conversion from type 1 A&E attendance to emergency admission, fell to 20% in 2022/23, compared to 20.9% in 2021/22, and 22.5% in 2019/20.
- Emergency admissions from other sources grew by 11% in the winter of 2022/23 (when compared to winter 2021/22) and 10.5% when compared to 2019/20.
- Individuals being admitted in an emergency are more unwell than before, with a 16% increase in co-morbidities in the five years from 2018/19 to 2022/23.
- In 2022/23, the average monthly elective admissions were 5.8% higher than 2021/22, but 3.3% lower than in 2020/21.[23] This means that, while total admissions in the winter of 2022/23 were up 6.3% compared to 2021/22, on average, acute hospitals are admitting fewer patients than they were before the pandemic.

Acute hospital emergency admissions are up by 3.8% compared with 2021/22.

Despite the significant growth in attendances at A&E, acute hospital emergency admissions have grown more modestly.

As shown in Figure 7, in winter 2022/23 an average of 504,447 people were admitted to hospital each month, an increase of 3.8% in comparison to 2021/22, and 4.0% from 2019/20.[24]

The admissions rate, in terms of conversion from type 1 A&E attendance to emergency admission, fell to 20% in 2022/23, compared to 20.9% in 2021/22, and 22.5% in 2019/20. This means that 2022/23 admissions via type 1 A&E were up by just 1.4% when compared to 2021/22 levels, and 1.8% against 2019/20 rates.

In comparison to the number of hospital admissions generated via A&E departments, more significant growth has been seen in emergency admissions from other sources. These include booked appointments (e.g., via NHS 111), urgent treatment centres, minor injury units, and type 2 single specialty A&E departments. Collectively, admissions via these sources grew by 11% in the winter of 2022/23 (when compared to winter 2021/22) and 10.5% when compared to 2019/20.

This demonstrates that despite efforts from A&E departments to reduce their rates of admission in the face of increasing attendances, the number of emergency admissions into acute hospitals is rising via other routes.

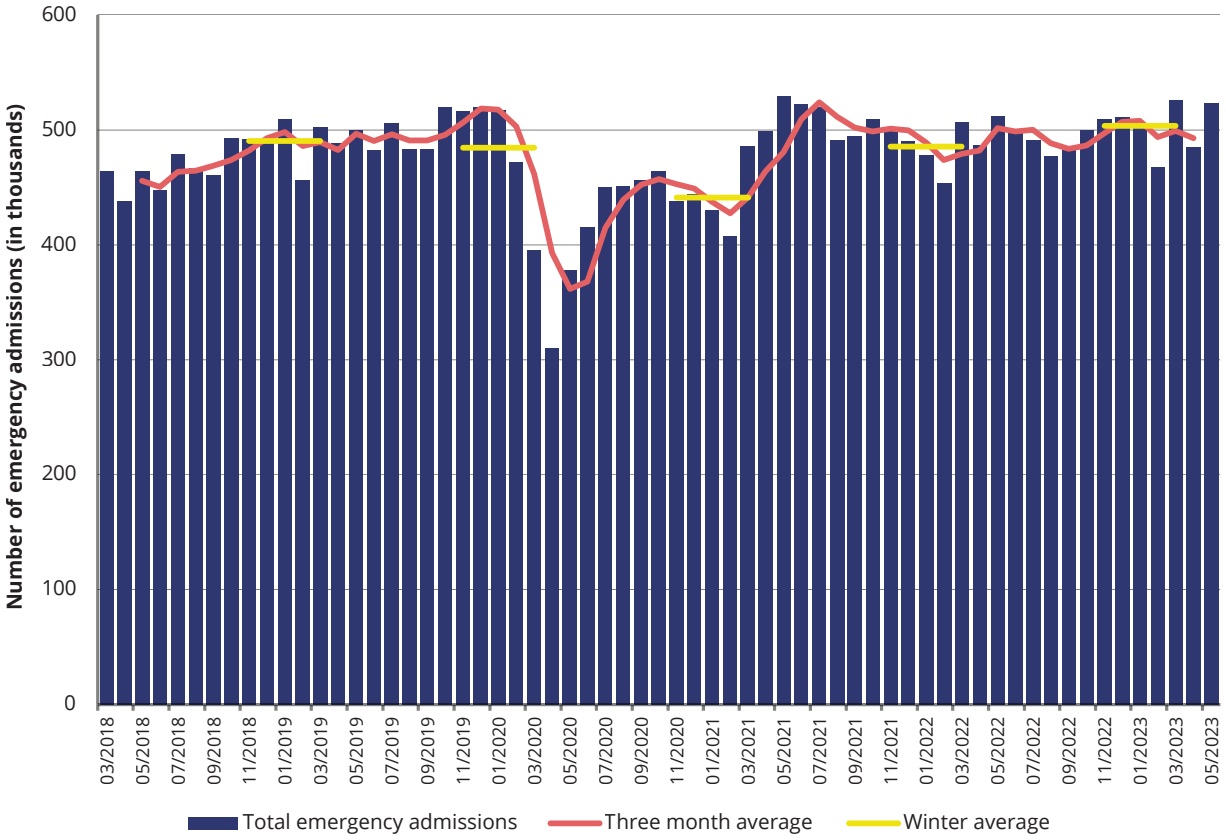


Figure 7. Acute emergency admissions to hospital trusts with type 1 A&E departments (March 2018 to May 2023).

Elective (non-emergency) admissions are still below pre-covid levels, meaning total admissions are also below historic baselines.

As the NHS seeks to manage the backlog of elective treatments (which significantly worsened during the pandemic), the data implies that elective admissions continue to lag pre-pandemic levels.

As shown in Figure 8, in 2022/23, the average monthly elective admissions was 861,785.

This was an increase of 5.8% from 2021/22 but a reduction of 3.3% in comparison to rates seen in 2020/21.[25] This means that, while total admissions in the winter of 2022/23 were up 6.3% compared to 2021/22, on average, acute hospitals are admitting fewer patients than they were before the pandemic. This implies that it is the fact that people are staying in hospital for longer which is the key driver of increased operational pressure in the hospital.

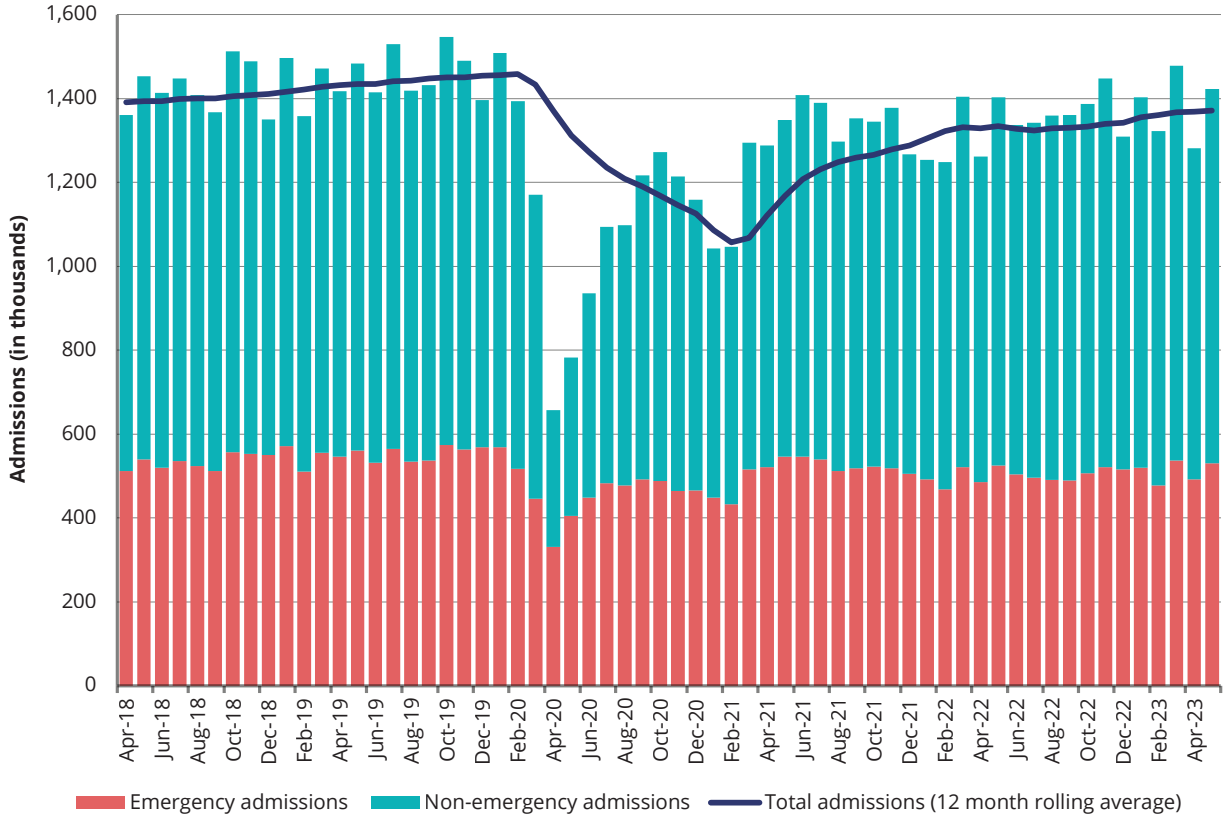


Figure 8. Total admissions from April 2018 to May 2023 across all English trusts.

People are more unwell when admitted to hospital.

Anecdotally, staff working in local health and care systems report that the individuals they are seeing and supporting are more unwell than those cared for in previous years.

This is an important discussion, as the underlying health of the population and those admitted to acute hospitals will have a bearing on the demand on, and performance of, health and care systems.

Statistical data to evidence this anecdotal feedback can be challenging to obtain and interpret.

Understanding the number of co-morbidities recorded for individuals admitted in an emergency can offer a useful proxy. The data shown in Figure 9 indicates a rising level of acuity in those individuals admitted to an acute hospital, with 16% more co-morbidities recorded in non-elective admissions in 2022/23 compared to 2018/19.[26]

While this does not lessen the imperative to improve overall performance, it does at least offer some explanation for the greater challenges observed, and the rising numbers of people going on to receive long-term care following an acute hospital admission.

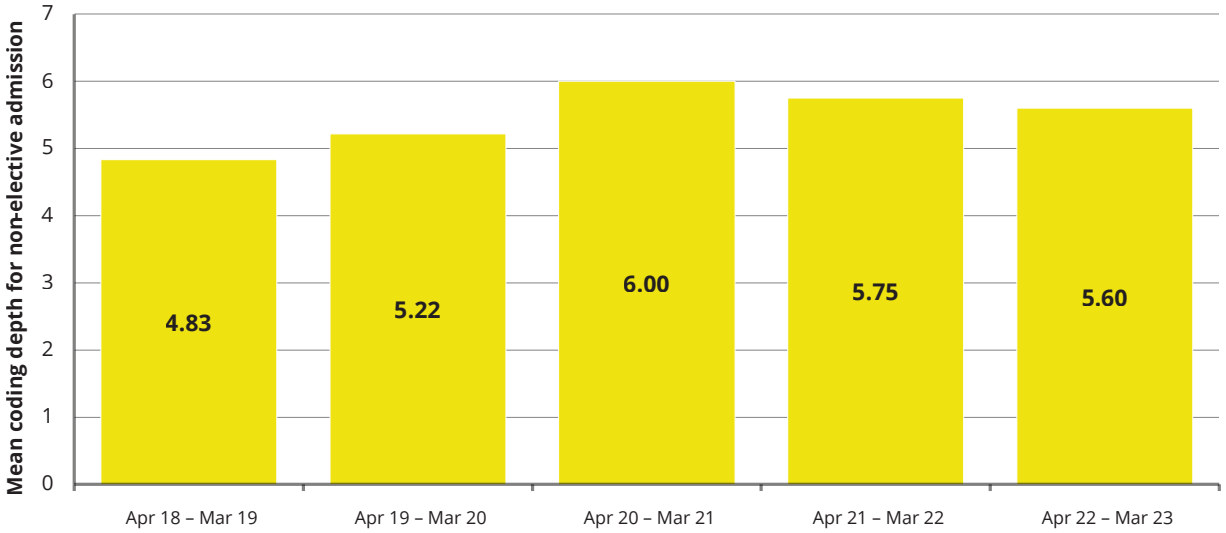


Figure 9. Average number of co-morbidities for non-elective admissions for all trusts with type 1 A&E departments.

c. Length of stay (during treatment and waiting for discharge)

Headline findings

- Average length of stay is 34.8% longer (2019/20 – 2022/23).
- The volume of people remaining in hospital without criteria to reside has increased by 16% (2021/22 – 2022/23).
- Length of stay with criteria to reside in the hospital has grown by approximately 0.7 days (2021/22 – 2022/23).
- Length of stay without criteria to reside in the hospital has also increased by approximately 0.5 days (2021/22 – 2022/23).

Older adults spent longer in hospital overall this year compared to previous years.

When compared to a relatively stable baseline before the pandemic, data supplied by nine trusts for this work demonstrates a stark increase in length of hospital stay for adults aged 65 or above in 2022/23. As shown in Figure 10, in 2022/23 the average length of stay in hospital was 8.7 days – 34.8% longer than the 6.4 days observed in 2019/20.

This corresponds with other data presented above that demonstrates a comparable level of non-elective admissions before the pandemic, but a lower level of overall occupancy when compared with 2022/23, suggesting that length of stay has grown.

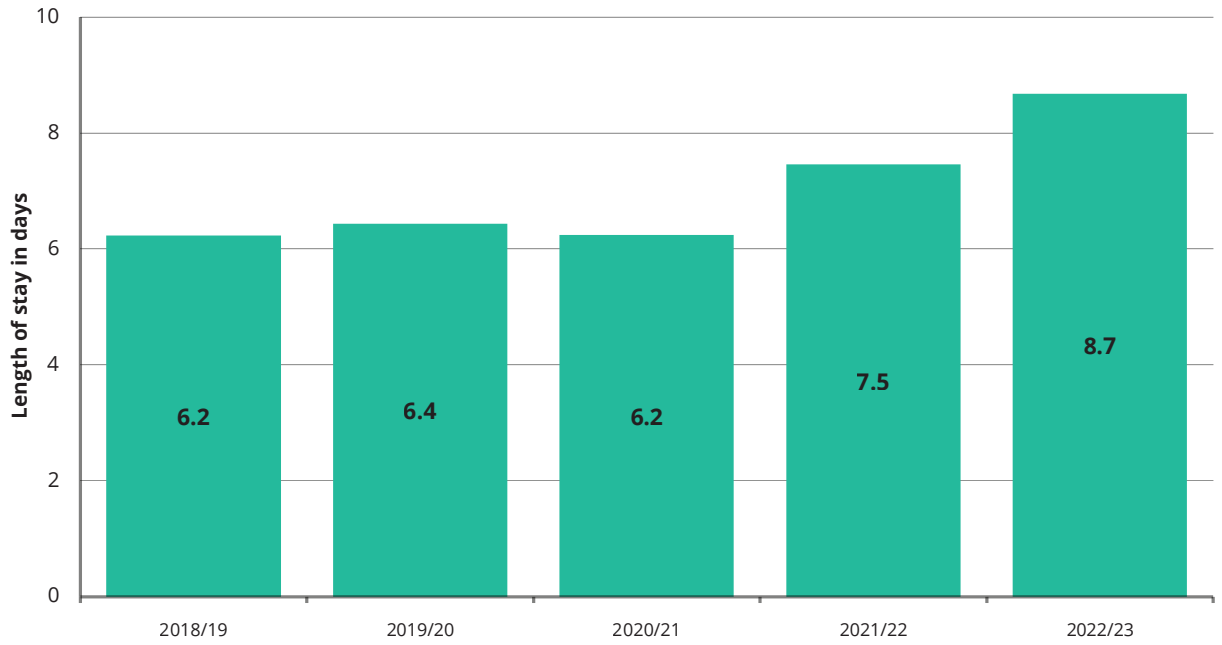


Figure 10. Average length of stay in hospital across nine trusts for individuals aged 65 or above, following a non-elective admission.

The number of people remaining in hospital who are medically fit (otherwise known as those having 'no criteria to reside' or 'NCTR') is a nationally reported statistic and one which is often used to describe system performance.

As shown in Figure 11, in the winter of 2022/23 the volume of people remaining in hospital who were medically fit had increased by 20% when compared to winter 2021/22 (the first year this data was recorded).

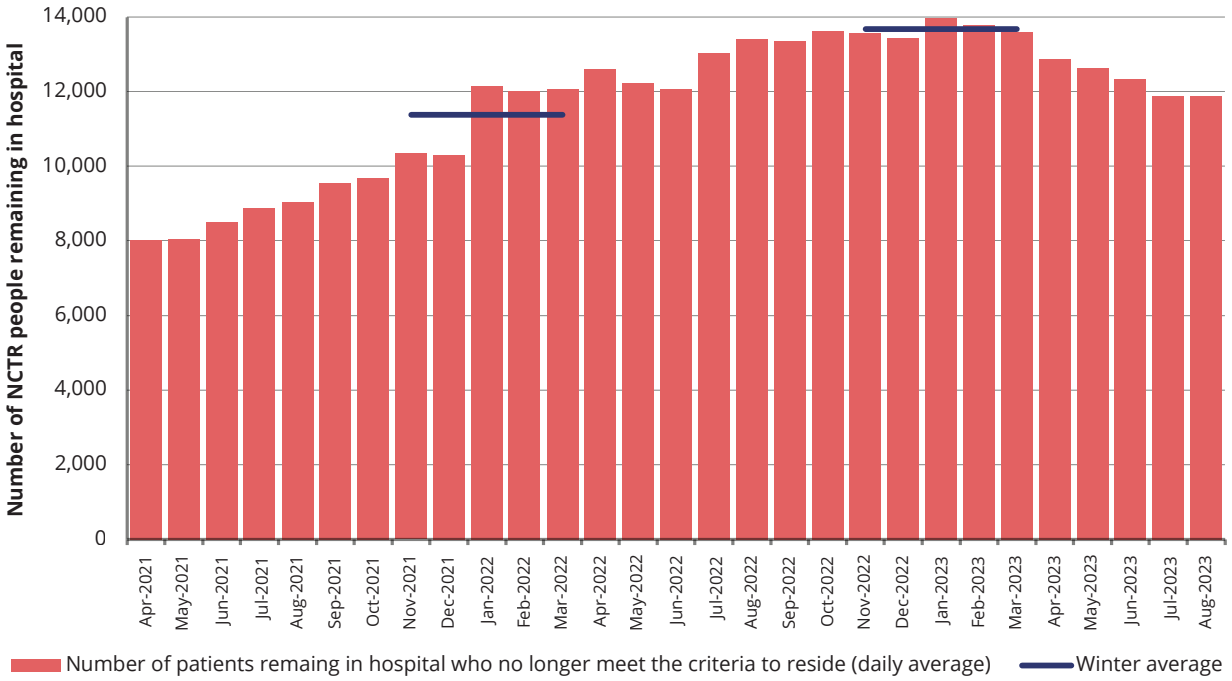


Figure 11. Number of people medically fit remaining in hospital (i.e., with no criteria to reside) for all trusts with type 1 A&E departments. April 2021 to August 2023.

However, this analysis also suggests that recent efforts to reduce the numbers of people delayed leaving hospital may be starting to pay dividends. The average daily number of people with no criteria to reside who remain in the hospital was 12,321 for the first five months of 2022/23, down by 3% from 12,677 in the same period of last year.

Length of stay has increased both during treatment and whilst waiting for discharge.

It should be noted that the increasing length of stay is evident both before someone is deemed to not have criteria to reside (during their treatment) and after (while waiting for discharge).

Data is not universally available from before 2021/22, and where it is, it is not always reliably reported. However, by overlaying additional data supplied for this programme by four trusts, and splitting the length of stay by when the person does and does not have criteria to reside in the hospital, a clearer picture has formed.

It can be approximated that the length of stay for people with criteria to reside in the hospital has grown by approximately 0.7 days (from 6.8 days in 2021/22 to 7.5 days in 2022/23). The length of stay for someone without criteria to reside in the hospital has also increased by approximately 0.5 days (from 0.7 days to 1.2 days), as shown in Figure 12.[27]

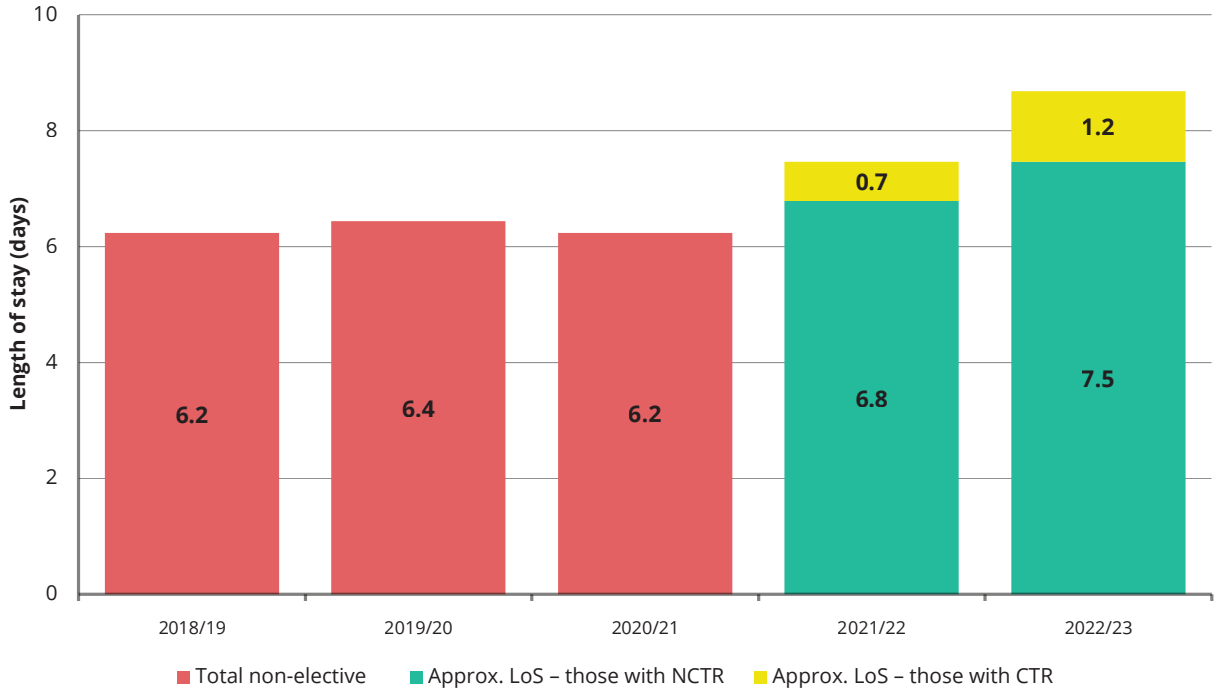


Figure 12. Average length of stay (LoS) across eight trusts for individuals aged 65 or above following a non-elective admission, for those with both criteria to reside (i.e., not medically fit to be discharged) and no criteria to reside (i.e., medically fit).

d. Intermediate care

What is intermediate care?

Intermediate care services are a type of short-term service provided to individuals, particularly older people, to help them rehabilitate and recuperate. These services may be implemented when an individual is starting to find things more difficult (but remains at home) or when they are recovering after a fall, an acute illness, or an operation.

Intermediate care can also help avoid an individual going into hospital unnecessarily. Regardless of whether the individual's condition was scheduled (an elected procedure) or not, for many (particularly those who have been in an acute hospital for some time) these services provide the time and space to recover and achieve what they want to do.

Intermediate care can be provided in different places (e.g., a community hospital, residential home, or in an individual's own home).

According to the NHS Data Model and Dictionary there are four types of intermediate care:

1. Reablement intermediate care.
2. Crisis response intermediate care.
3. Home-based intermediate care.
4. Community bed-based intermediate care.

Headline findings

- The use of short-term care (as a proxy for intermediate care) has increased by 5.6% (2021/22 – 2022/23).
- A reduction in the requirement for long-term care is not being observed in the way that might be expected were short-term care services more effective.

Whilst the use of short-term care for people being discharged from hospital has increased, the use of long-term care has also increased.

The use of short-term care, which would generally include intermediate care such as reablement and rehabilitation at home, has continued to rise year-on-year. As shown in Figure 13, in 2022/23 184,555 people received a short-term service, an increase of 5.6% from 2021/22.

Despite a continued increase in the use of short-term services, including intermediate care, which are designed to reduce the need for ongoing care and support, the use of long-term care has increased. This implies that the short-term services being commissioned and utilised are not as effective as they could be in terms of reducing the need for long-term care.

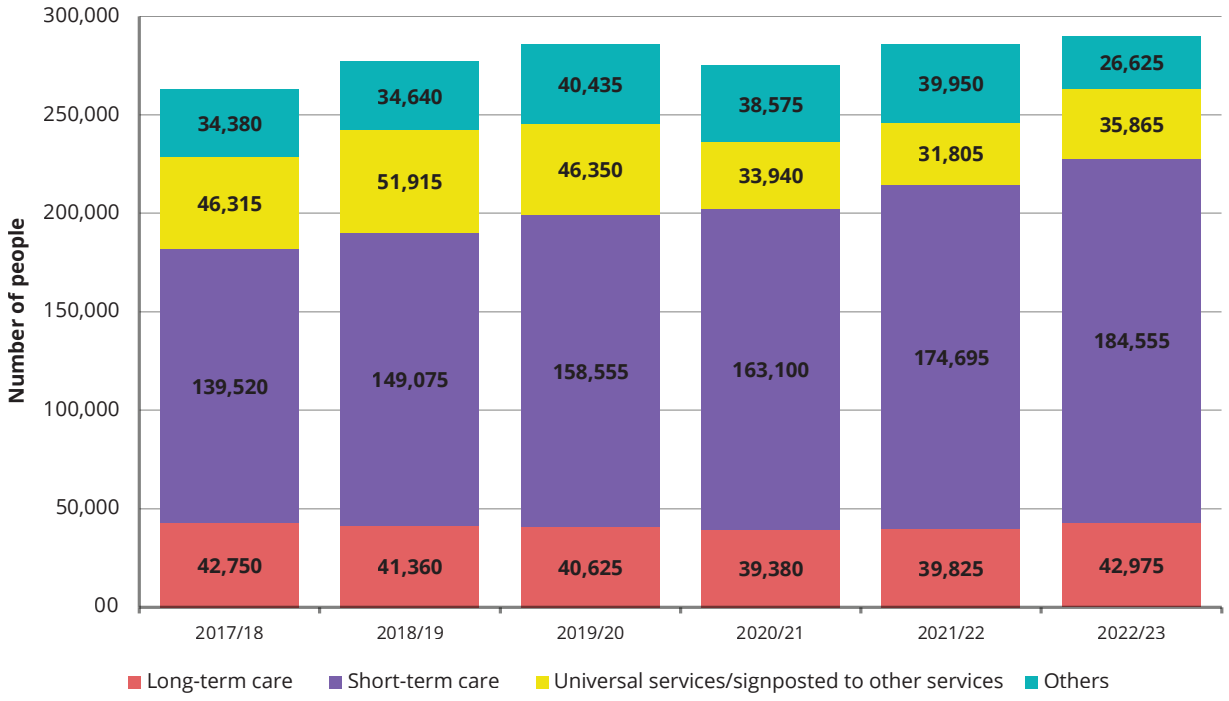


Figure 13. Type of care provided to older people from the point of hospital discharge.

e. Long-term outcomes

Headline findings

- There was a 7.9% increase in individuals being discharged to long-term care between 2021/22 and 2022/23.
- In 2022/23 15.6% more people went into a long-term residential or nursing home following a stay in hospital than they did in 2021/22.

More individuals are being discharged to long-term care following a stay in hospital.

As previously explored, the data (shown in Figure 13) confirms that more individuals were discharged into long-term care following a stay in hospital in 2022/23 than in 2021/22. This reverses a decline in numbers seen between 2017/18 and 2019/20. In 2022/23, 42,975 people were discharged into long-term care, compared to 39,825 in 2021/22 – an increase of 7.9%.[28]

It is important to caveat here that in 2021/22 the proportion of people going into the different settings was likely impacted by a continued shortage of long-term community services, and therefore use of beds may have been inflated.

A more significant increase is being seen in the cohort of individuals entering long-term residential or nursing care, rather than requiring care in their own home. Following their discharge from an acute hospital, in 2022/23, 11,270 people went into a long-term bed, an increase of 15.6% from the 9,750 the year before (Figure 14). Again, it may be the case that this is, at least in part, impacted by a lack of homecare supply which has been a feature of the last year.

The data implies an increased pressure on community services and adult social care from those individuals who have had a stay in an acute hospital.

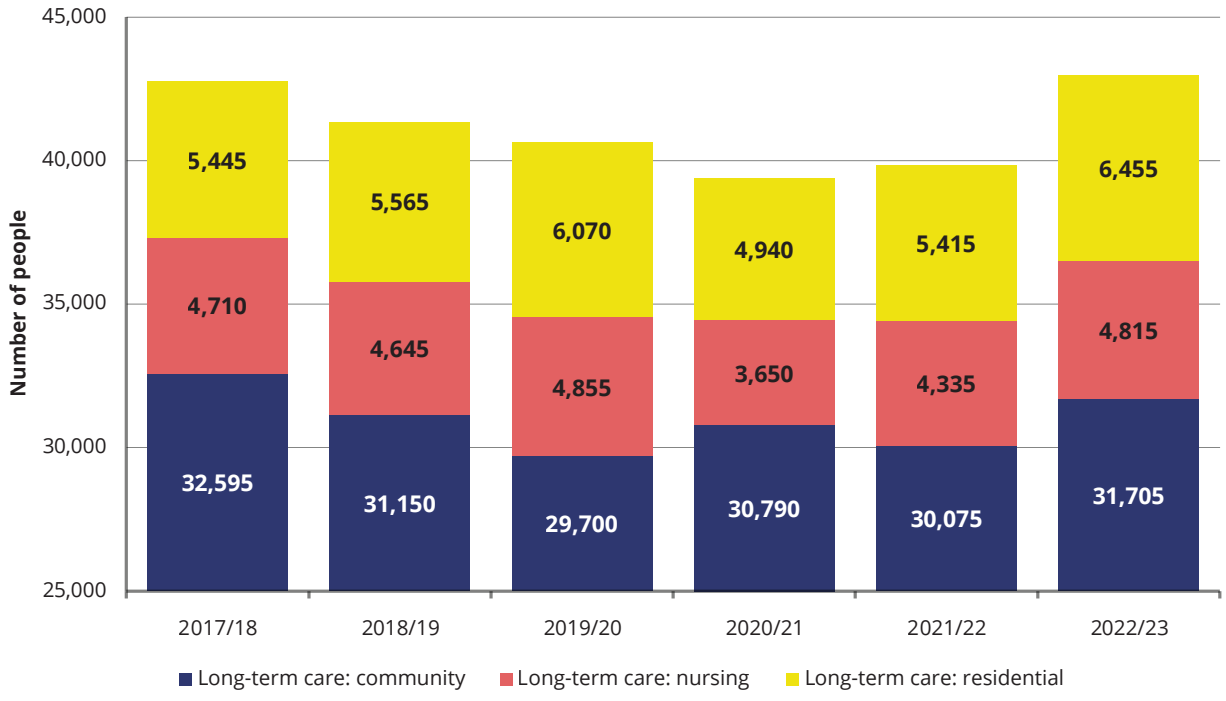


Figure 14. Number of 'new' people being discharged from acute hospitals to long-term care.

Regional variation

This programme's analysis (illustrated in Figure 15) has found that there is significant variation in key performance indicators by region, by ICS, and by individual trust within an ICS.

Clearly some of this variation can be explained by the make-up of the local place, population demographics, system characteristics, and local care supply and pricing. However, this only tells part of the story.

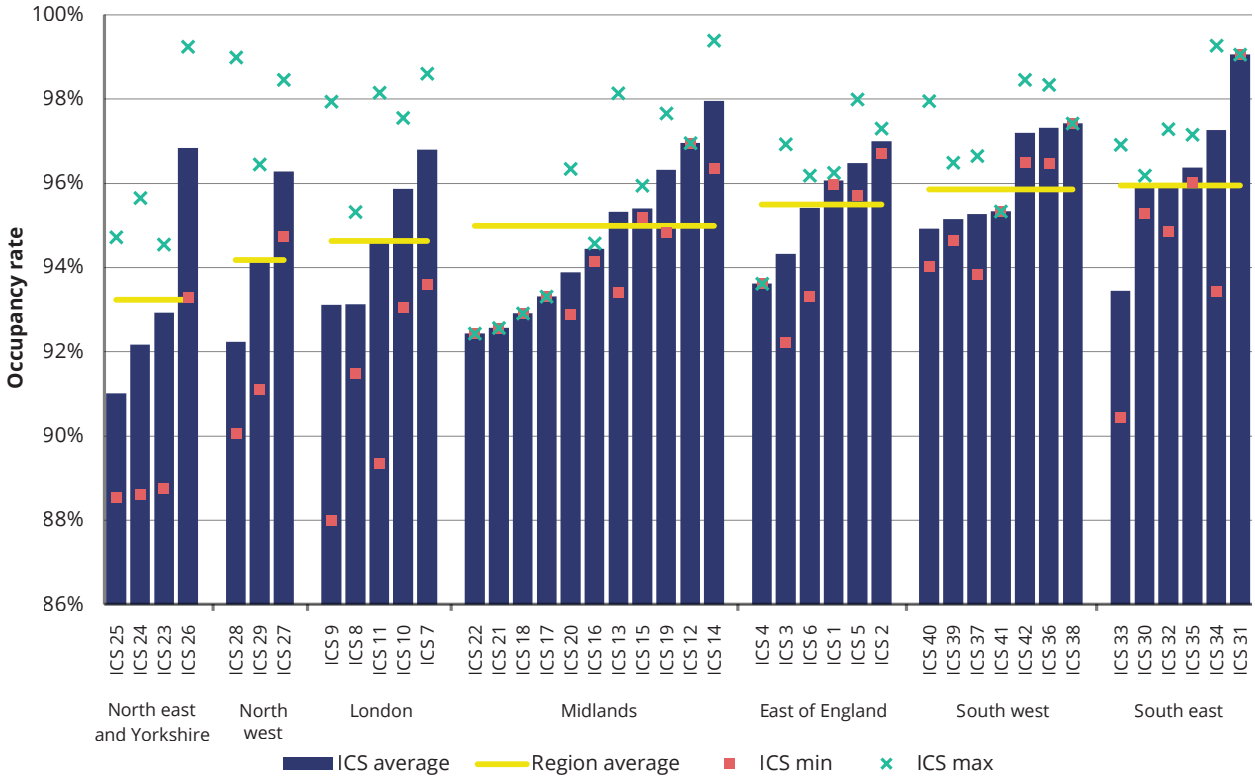


Figure 15. Winter 2022/23 occupancy rates in both adult general and acute, and critical care beds, split by ICS.

At a regional level, further work should focus on the key differences between the northeast and Yorkshire and the southeast, to offer hypotheses on how performance could be improved nationally.

In the southeast, the highest occupancy rates of adult general and acute, and critical care beds are recorded nationally. At an average of 96% across the region, this is 2.8% higher than the lowest occupancy rate (93.2%), observed in the northeast and Yorkshire.

Of particular interest is the variation between individual trusts within the same ICS, with over 6% variation between the highest and lowest occupancy trusts.

This raises questions about how different ICSs function, and the potential for identifying and sharing good practice to drive consistent high performance.

Similar regional variation is observed in length of stay (illustrated in Figure 16), with the lowest average length of stay of 4.1 days observed in the Midlands, compared to the longest average length of stay of 4.9 days observed in the north west. It should be noted that the length of stay figures represent a blended average for elective and emergency admissions for all ages, and so are not directly comparable to other figures presented through this report. However, a variation of 18.6% is notable, and again prompts questions and discussion about the driving forces and the differences in regional practice and what can be learned from this.

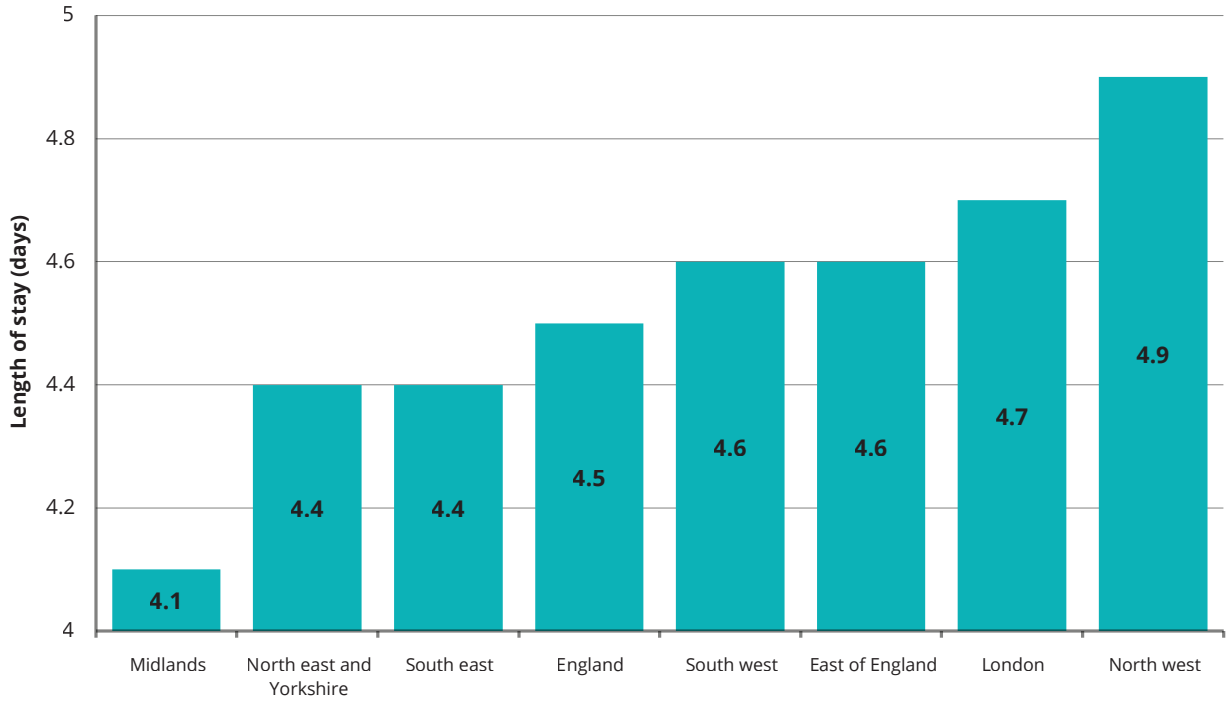


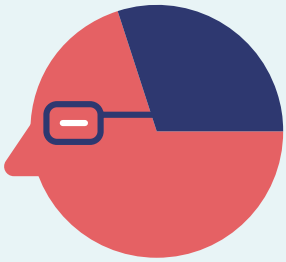
Figure 16. Average length of stay (for emergency and elective admissions combined) for all trusts with type 1 A&E departments by region, in year 2022/23.

07

The driving forces

A summary in numbers of the driving forces and root causes behind a system under pressure, with a specific focus on the flow into and out of acute hospitals. This is explored further through this section of the report.

Avoidable admissions and attendances



31%

of acute hospital attendances by older adults deemed inappropriate or avoidable (by a multi-disciplinary group).

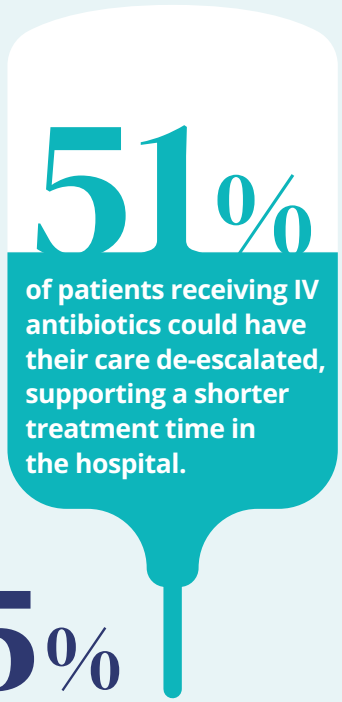
53%

of inappropriate attendances were conveyed by ambulance.

30%

of older adults admitted to an acute hospital deemed inappropriate or avoidable (by a multi-disciplinary group).

Delays before someone is medically fit for discharge



51%

of patients receiving IV antibiotics could have their care de-escalated, supporting a shorter treatment time in the hospital.

35%

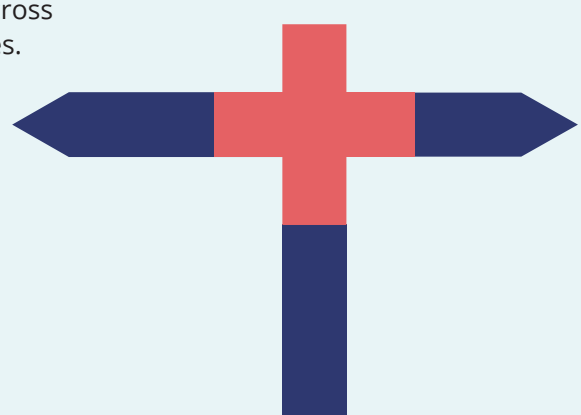
of the total length of stay of an older adult on a non-elective pathway is made up of avoidable delays.

47%

of delays caused by availability of inpatient diagnostic capacity and associated reporting across all modalities.

40%

of delays caused by waiting for a decision from medical staff.



Delays when someone is medically fit for discharge

Simple discharges

One million delayed bed days every year caused by delays to Pathway 0 discharges.

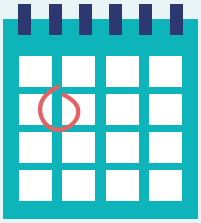
Complex discharges

10.2 days is the average discharge delay for patients on Pathway 3, making it the most delayed discharge pathway.

There is an average delay of

5.5 days

for patients on Pathway 2 and 4.1 days for those on Pathway 1.



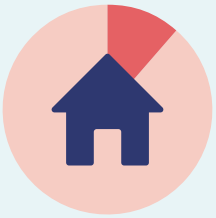
Intermediate care

– community capacity, home-based intermediate care, bed-based intermediate care

40,000

additional people could benefit from home-based reablement and rehabilitation on hospital discharge, if the capacity was available.

Only **11.6%**



of people, on average, are discharged from a short-term bed on time once they are deemed medically fit. The availability of onward care is the most significant cause of delay.

Long-term outcomes

Between **20%** and **45%** of people were not discharged from hospital onto the ideal pathway for their needs.

Introduction

This section seeks to provide an analysis of the driving forces and root causes behind the pressures described in section six. This will lead to exploring potential solutions.

It does so first by examining what an optimised flow and discharge approach looks like, before detailing evidence which demonstrates why this isn't always being achieved. The optimised approach is intended to be person-centred and based on existing good practice and evidence from local systems, recognising that to be achieved consistently across all health and care systems it would require the concluding recommendations be put in place.

a. Avoidable attendances and admissions

An optimised approach: avoiding attendances

Where acute hospital flow and discharge is optimised, only those who really need to attend the acute hospital do so. This is achieved in the following ways:

- A comprehensive offer of alternative services available in the community is in place, which health professionals, including paramedics, have good awareness of and trust in to refer to. This includes primary care, community healthcare, urgent community response services, and virtual wards, along with a thriving voluntary sector.
- There is sufficient capacity and capability in primary care; General Practice has the confidence and capability to manage conditions outside of the acute hospital and the awareness of alternative community-based services.
- Processes and ways of working exist to ensure alternatives to hospital attendance are always considered – where appropriate.
- There is a positive culture around risk management, utilising multi-disciplinary approaches to gain confidence in decision-making.

Barriers to optimisation: avoiding attendances

Based on a sample of 539 instances where an older adult attended an acute hospital across five local health and social care systems, a multi-disciplinary group deemed nearly a third (31%) to be inappropriate or avoidable.[29] This group also determined that these individuals would have been better treated by alternative services in the community such as primary care, community health, and urgent community response. This finding is reinforced by analysis commissioned by the LGA (Efficiency Opportunities Through Health and Social Care Integration), and research recently published in the HSJ which demonstrates that those ICBs that invest more in their community care see up to 15% fewer emergency admissions. This is a significant proportion and plays a large role in pressure observed in A&E departments.

Despite ambulance-related hospital admissions declining overall and ambulance conveyances only accounting for around a fifth of hospital attendances, the most common route for these inappropriate attendances is via ambulance conveyance (accounting for 53%).[30]

When examining the reasons for inappropriate attendance, a lack of knowledge from healthcare professionals of the alternative services available is a key factor, affecting over a third (42%) of inappropriate attendances. Risk aversion in decision-making is also a factor, affecting 32% of inappropriate attendances.

Case study

Leicestershire, Leicester City, and Rutland's unscheduled care co-ordination hub

Leicestershire, Leicester City and Rutland (LLR) partnership comprises a large county with the city it surrounds and a neighbouring small county working collaboratively with local health services (including the acute hospitals) under an Integrated Care Board to build the appropriate types and levels of intermediate care.

LLR's transformation journey began as part of their involvement with the LGA's capacity and demand planning pilot. Through the initiative, they enhanced their understanding of local data, received guidance from an expert geriatrician, and listened to testimonies from individuals with lived experience. As a result, a full change programme was agreed, and a steering group established to oversee the transformation. All new services have been commissioned through the Better Care Fund.

The LLR partners have established an 'Ageing Well' workstream which brings together their health and social care services in the community.

They have developed an "unscheduled care co-ordination hub", where a multi-disciplinary team (including paramedics, GPs, geriatricians, advanced practitioners, social workers, community nurses, therapists, and mental health workers) work together to respond to calls that have been made to the ambulance service and other referrals to address people's needs without the necessity of admission to an acute hospital. They can use the intermediate care services to assist where appropriate, and most people remain in their own home.

This has saved the ambulance service a lot of time and resource, reduced people being transferred to a hospital (85% of people are helped in their own home), and offers an early intervention service for people who are beginning to struggle.

An optimised approach: reducing hospital admissions

In an optimised flow and discharge system, admission to the acute hospital is reserved for those who absolutely need it. Alternative pathways are available to support people out of hospital, and wherever possible at home. There is a positive culture around risk management at the point of deciding when someone is admitted, utilising multi-disciplinary approaches where required.

Barriers to optimisation: reducing hospital admissions

Based on a sample of 591 instances across seven local health and social care systems where an older adult was admitted to an acute hospital, a multi-disciplinary review deemed 30% were avoidable or inappropriate.[31]

As illustrated in Figure 17, lack of knowledge and awareness of the appropriate out of hospital alternative was the key reason why people were admitted to hospital inappropriately, with this affecting 36% of inappropriate admissions. Again, risk averse decision-making was the second most significant factor, affecting 20% of cases.

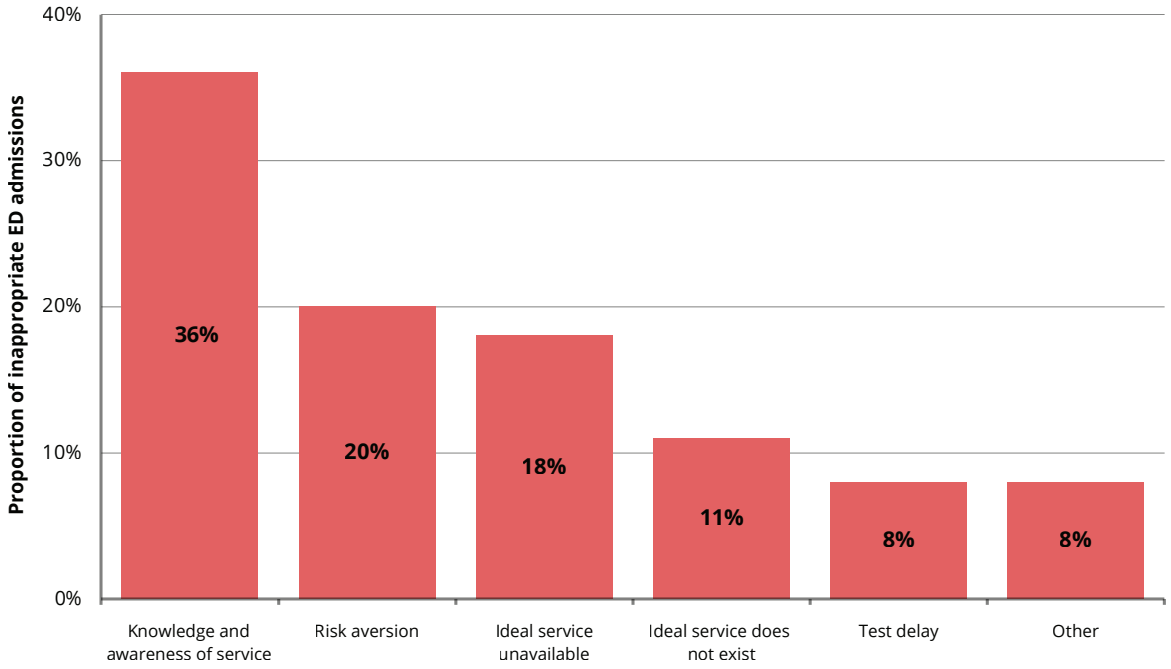


Figure 17. Reasons for inappropriate hospital admissions across seven local health and social care systems where an older adult was admitted to an acute hospital.

Case study

Preventing need through Norfolk's falls prevention programme

Norfolk County Council is working alongside its local partners and using shared data, digital technologies, and AI to radically change how they manage demand.

Joining up their health and care data gave them a new perspective on the needs of their older population and how they could act early to help these people stay in their own homes for longer. Through this approach the Council is now preventing, reducing and delaying the requirement for long-term care and hospital admission amongst their older residents.

The Council and its partners are using innovations in data, digital technologies, and insights to proactively identify and intervene in cases where there is a chance of an individual falling (and experiencing a related injury). Through this approach they identified that they had the opportunity to prevent 1,300 older individuals falling each year (at an annual cost of £5-6m to the health and social care system).

As a result, this insight is now enabling frontline practitioners to make practical adjustments to a person's home and connect them with community-based services to keep individuals mobile and active. Tailored befriending services and appropriate signposting to NHS multifactorial falls assessment teams are also being offered to residents deemed at risk, helping them to maintain their independence in their local community.

By using this insight and tailoring its interventions accordingly, the Council is now supporting individuals at risk at a much earlier stage, and preventing them from a painful fall which would often lead to a hospital admission and subsequent long-term care.

b. Delays before someone is medically fit for discharge

An optimised approach: reducing delays in hospital treatment, to shorten a person's overall length of stay

To prevent deconditioning and maintain a person's mental and physical wellbeing, hospitals with optimised flow and discharge systems ensure that once a person is admitted, they receive their treatment promptly.

To enable this, diagnostic tests are readily available, and the person's journey through the hospital is managed tightly, with robust and insightful flows of information.

Barriers to optimisation: reducing delays in hospital treatment, to shorten a person's overall length of stay

A study of 1,310 resident journeys across three health and social care systems found that an average length of stay for an older adult on a non-elective pathway, before they are deemed medically fit, is 5.4 days. Of this, an average of 1.9 days, or 35% of the total length of stay, is made up of avoidable delays.[32]

Another study reviewed 733 cases across four healthcare systems where older people experienced delays before they were declared medically fit for discharge. As shown in Figure 18, it was found that the availability of inpatient diagnostic capacity and associated reporting across all modalities (especially computerised tomography and magnetic resonance imaging scans) was the most significant root cause, impacting 47% of delays. Waiting for a decision from medical staff was the next most significant cause of delay. Impacting 40% of cases, these delays often included the preparation of discharge paperwork.

Services not being available seven days per week and reduced availability of staff at weekends can be a significant contributing factor to these delays in decision-making. This is explored further on page 64.

There is further potential to reduce length of stay related to the provision of intravenous (IV) antibiotics and fluids. A small sample taken within one acute hospital showed that 50% of patients receiving IV antibiotics could have their care de-escalated, supporting a shorter treatment time in the hospital.

This could be achieved by switching to oral treatment, being able to finish treatment sooner than planned, and receiving treatment at home. In many cases, these stays could be eliminated if there was the ability to provide such therapies in the person's home, potentially as part of a virtual ward service. Recent work with one health and social care system has demonstrated a four-day length of stay reduction can be achieved.

Similarly, IV oxygen therapy accounts for significant days of inpatient treatment, despite the fact that this can be safely delivered in the patient's place of residence.

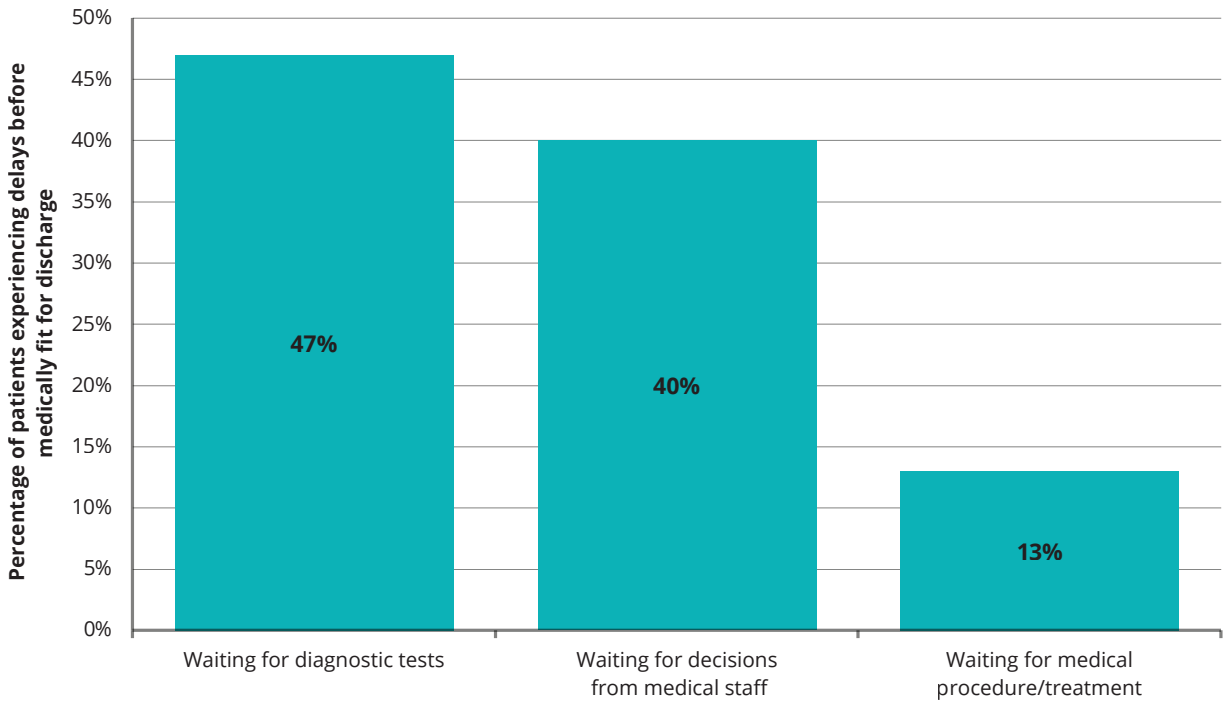


Figure 18. Reasons for delays in hospital treatment, and percentage of people impacted.

c. Delays once someone is medically fit for discharge

Where discharge is optimised, people leave the hospital as soon as they are medically safe to do so, regardless of whether they can go home immediately without further support (simple discharge) or whether they have an ongoing need for care and support in the community (complex discharge).

Summary of discharge to assess pathways[33]

Pathway 0

- simple discharge home
- no new or additional support is required to get the person home or such support constitutes only:
  - informal input from support agencies
  - a continuation of an existing health or social care support package that remained active while the person was in hospital.

Pathway 1

Able to return home with new, additional or a restarted package of support from health and/or social care. This includes people requiring intensive support or 24-hour care at home. Every effort should be made to follow Home First principles, allowing people to recover, reable, rehabilitate or die in their own home.

Pathway 2

Recovery, rehabilitation, assessment, care planning or short-term intensive support in a 24-hour bed-based setting, before returning home.

Pathway 3

For people who require bed-based 24-hour care: includes people discharged to a care home for the first time plus existing care home residents returning to their care setting.

Those discharged to a care home for the first time will have such complex needs that they are likely to require 24-hour bedded care on an ongoing basis following an assessment of their long-term care needs.

1. Simple discharges

An optimised approach: reducing length of stay for simple discharges

For optimised simple discharge, decision-making is timely. Even flow is achieved through the week, enabled by effective seven-day working practices. Criteria-led discharge is effectively implemented, supported by registered healthcare professionals, with discharge criteria clearly set by the clinical lead.

Discharge planning begins at the point of admission, when an Estimated Discharge Date (EDD) is also set and progress is clearly communicated with the person themselves, their family, carers, and other professionals, including care providers, as required.

Barriers to optimisation: reducing length of stay for simple discharges

Based on a sample of two health and care systems, the average delay for a Pathway 0 discharge following someone being deemed to no longer have the criteria to reside in the acute hospital ranged between one and three days. Because of the significant volume of Pathway 0 discharges, these delays are the most significant contribution to overall delays, contributing one million delayed bed days nationally every year.

There is currently significant variation in the national profile of discharges throughout the week. As illustrated in Figure 19, in winter 2022/23 Pathway 0 discharges varied from an average of 9,774 on a Friday to 5,131 on a Sunday.[34] This variation leads to an accumulation of additional bed days required, compared to having a flat profile of discharges through the week (equal to the average of 7,948 discharges per day). This accumulation peaks at 4,612 beds observed on a Monday evening/Tuesday morning – which could be avoided.

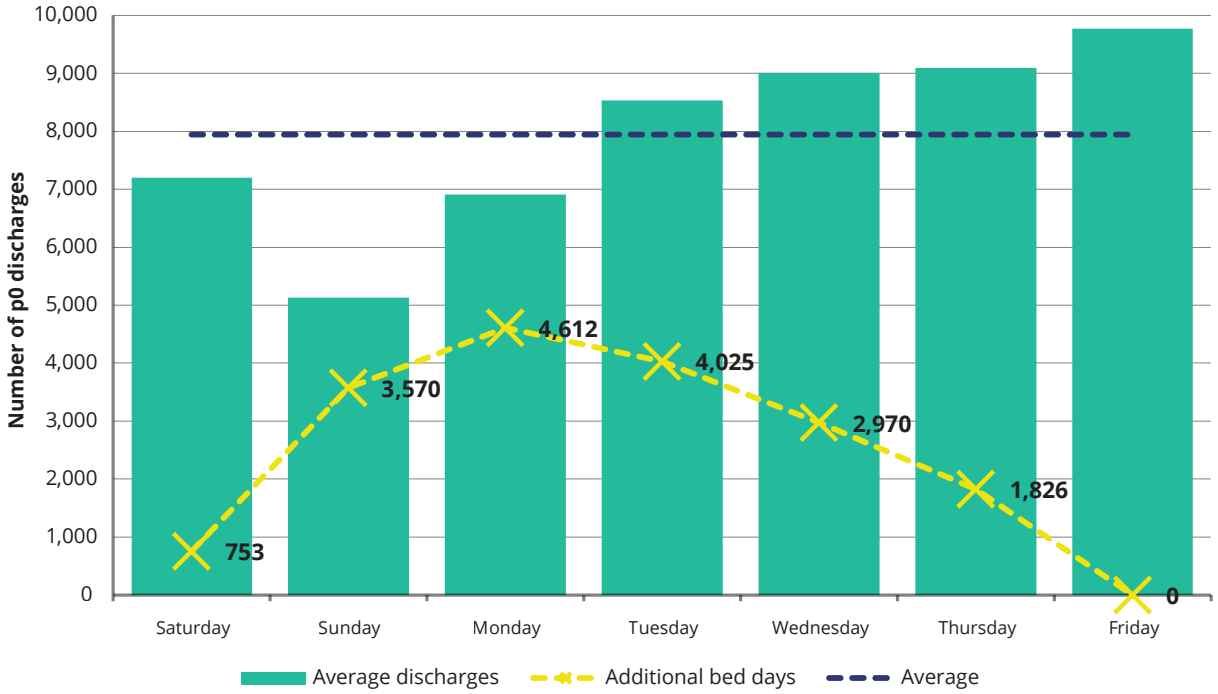


Figure 19. Average Pathway '0' discharges per day in winter 2022/23 and associated bed days impacted.

Case study

Leicestershire, Leicester City, and Rutland's hospital discharge approach

Through LLR's analysis, the partners discovered that five times more bed days were lost in the acute hospital through delays in discharging people on Pathway 0 than those lost because of shortages in other parts of the system e.g., social care. This placed a real onus on the hospitals to re-look at their internal processes to understand what might be improved.

The main finding was that there was a ceiling on the number of patients discharged each day and this number halved at the weekend.

The acute hospitals now have a strong focus on speeding up the processes for those returning home on Pathway 0.

This also helped change the local dialogue away from a blame culture between partners with a new focus on how the system could be improved by working together.

2. Complex discharges

An optimised approach: reducing length of stay for complex discharges

When complex discharges are optimised, the transfer of care between the acute hospital and the community is managed smoothly and without delay through the Care Transfer Hub.

The right capacity and type of intermediate care is commissioned and available. It is also supported by effective demand and capacity planning, and processes, systems, and decision-making are well coordinated across multiple professionals. Discharge to assess protocol is implemented effectively.

This means that assessments for long-term care and support are carried out in the most appropriate setting to understand need (not in the acute hospital and ideally in the person's own home). This results in residents receiving the most appropriate care and in turn promotes their long-term independence.

Barriers to optimisation: reducing length of stay for complex discharges

In addition to the previously stated one to three day delays for Pathway 0 cases, the average discharge delays observed for individuals with no criteria to reside in an acute hospital were:

- **Pathway 1** (where new, additional, or restarted package of support at home/in their usual residence was required): 4.1 days
- **Pathway 2** (where rehabilitation and/or reablement in a temporary bedded setting was required): 5.5 days
- **Pathway 3** (where a new or existing long-term care home placement was required): 10.2 days

These figures are based on a sample of three health and care systems.

The root causes of these delays are a combination of factors within the acute hospital (including decision-making) and delays in the availability of the right community resource and provision.

The data also illustrates that focusing on minimising inappropriate use of Pathway 3 is both the right thing for long-term outcomes for residents, and for reducing pressure in the acute hospital, with Pathways 1 and 2 seeing shorter delays on average.

Analysis of the national hospital discharge situation report data (summarised in Figure 20) demonstrates the combined impact of delays across these pathways. This is both in terms of delays as a result of waiting for the appropriate community capacity to be available, and delays introduced by decision-making within the hospital.

The data clearly demonstrates the need for the right capacity and types of intermediate care. It also highlights the need for the system to work collaboratively in order for local government to build capacity in the domiciliary and bedded care market, ensuring sufficient supply of care is readily available.

Collaboration as a system is crucial; engagement carried out as part of this work programme reported that unilateral decisions made by individual system partners to commission additional capacity, while done with the best intentions, had resulted in confusion and disjointed pathways.

It also had a detrimental impact on economies of scale in the care market, increasing prices where items were not purchased as part of a joined-up commissioning strategy. Those engaged agreed that commissioning decisions should be made jointly and aligned to a shared strategy across each integrated care system.

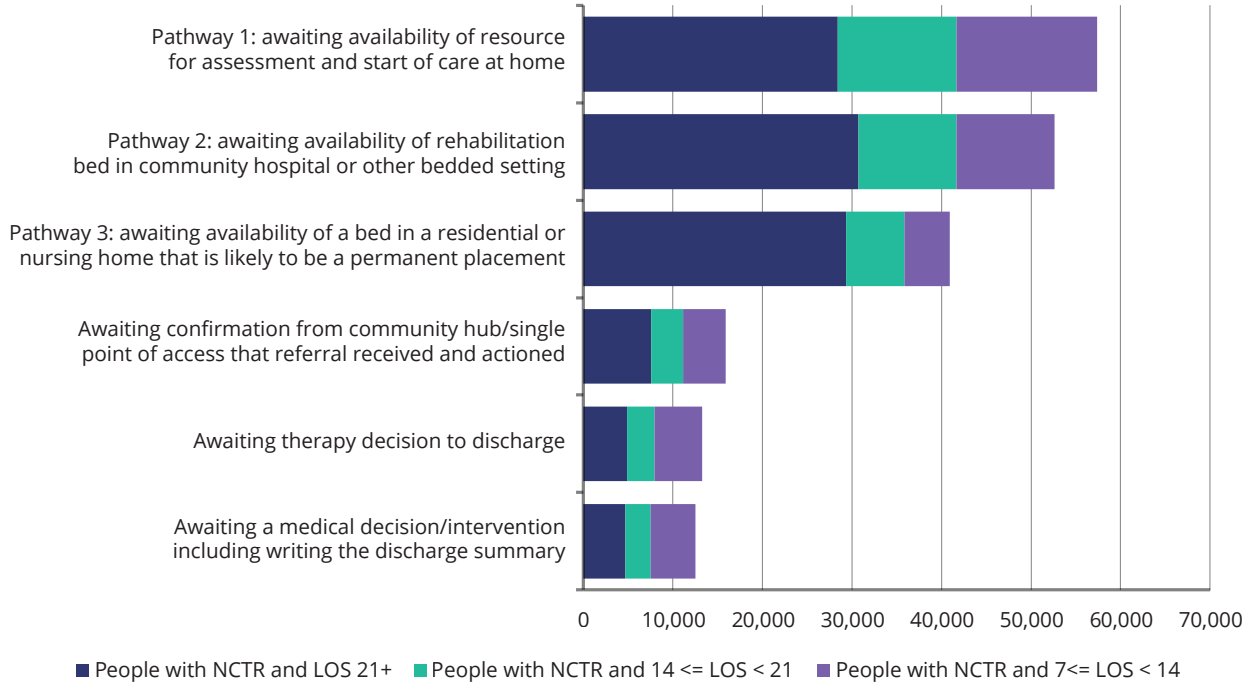


Figure 20. Key reasons why people medically fit (i.e., with no criteria to reside) with different lengths of stay remain in hospital (winter 22/23).

Case study

An integrated discharge model in Buckinghamshire

Buckinghamshire was struggling to get patient flow back on track after the pandemic. The system has dismantled the discharge model developed during the pandemic and replaced it with a more integrated and person-focused approach. Key achievements include:

- **Closing the discharge-to-assess bedded discharge pathway** (180 beds at the peak of the pandemic) and replacing with four Care Home Hubs (26 beds launched) to support complex patients while their assessments are carried out. Clear performance targets and multidisciplinary teams on-site are ensuring good flow and patient experience.
- **Launching an integrated discharge team,** in which social workers and discharge co-ordinators work together with patients and their families on the ward to plan their discharge from the point of admission. Patient information and referrals for discharge are quality assured daily, meaning a better understanding of patient needs and views.
- **Introducing a Transfer of Care Hub,** a single system-wide team meeting twice daily to make informed decisions about the most appropriate discharge pathway for a patient. With the 'Home First' ethos at its core, it ensures discharges are planned and supported in a coordinated and integrated way, and delays are minimised.
- **Opening a new intermediate care centre** for patients who require low intensity rehabilitation to prepare them to return home. They will have clear goals set over a maximum of six weeks. This will prepare patients better for returning home and living independently, resulting in a lower risk of readmission.
- **Trialling a six-month trusted assessor pilot** to evaluate the impact of building strong relationships with Care Home Managers, performing trusted assessments on their behalf thereby reducing delays to discharge.
- **Successfully deploying integrated winter surge capacity,** using a former hotel located in close proximity to the acute hospital to provide up to 32 additional beds to maintain flow during winter. 547 patients were admitted (October 22 to May 23) of which 457 were able to return home, and the average length of stay was 10.4 days.
- **Better performance information;** the new integrated services have interactive dashboards making performance information visible. This is the start of driving a stronger performance culture and data-driven approach to managing discharge which we plan to build on further next year.

The reduction of 593 lost bed days at Buckinghamshire Healthcare Trust alone has delivered an estimated £234k cost avoidance for the system over the last 12 months, and the programme of improvements has been delivered alongside a reduction of £6m in the overall discharge budget for Buckinghamshire.[35] The programme's benefits are summarised in Figure 21.

September 2022	September 2023
101 D2A beds	**26 Care Home Hub beds**
85 days Average LoS in D2A beds	**30 days** Average LoS in Care Home Hub beds
40 MOFD* patients waiting in hospital for a D2A bed **128 MOFD patients (total across all discharge pathways)**	**No patients waiting in hospital for a Care Home Hub bed** **108 MOFD patients (total across all discharge pathways)**
13.6% Readmitted within 28 days	**10%** Readmitted within 28 days
2,250 lost bed days (average across all BHT sites)	**1,657 lost bed days** (average across all BHT sites)

*medically optimised for discharge

Figure 21. Summary of benefits achieved through an integrated discharge model in Buckinghamshire.

This has put the system on a stronger footing ahead of next winter, but there is plenty more to do to achieve the system ambition.

Importantly, this programme of work is part of a broader suite of initiatives in Buckinghamshire focused on keeping people well at home and in their communities (thereby avoiding admission to hospital).

Case study

Optimising discharges in Oxfordshire

Over the last two years Oxfordshire County Council and their local NHS system partners have worked both collaboratively and ambitiously on a transformation programme helping with the flow of patients through health and care services.

The impact of these changes two years later is that the percentage of people on Pathway 0 and on Pathway 1 has significantly increased and the use of bedded facilities has decreased.

The first two arms of the transformation involved:

1. Bringing the leadership of the acute and the community services together (both NHS and County).
2. Gaining a common vision to focus on 'Home First' with a front line multi-disciplinary team empowered to make quick decisions (Transfer of Care Team).

Bringing leadership together

During Covid, senior leaders from the NHS, including from community and ambulance services, had a daily early morning conference call with the leadership of the council. This daily meeting has continued and still meets every morning to review any challenges and opportunities in real time across the system.

It has proved to be a very effective way of supporting decisions and actions about both individuals and services that impact upon system flow. This has bound the range of health and care teams together in a common purpose and enabled a focus on mutual support to resolve difficulties and ensure better outcomes for residents.

Gaining a common vision to focus on 'Home First'

The Transfer of Care team brought together the hospital's own discharge co-ordinators with the MDT (social workers, nurses, and therapists) with a strong vision to enable older people to return home.

There was a strong focus on peer challenge not to over prescribe care (a high risk for discharged patients) but to ensure that the right levels of care were available when a patient was discharged.

The team is encouraged to work together to make the best possible decision for the older person in a speedy and effective way, and they have access to the services that are available. The person's needs are the defining factor in where any person is placed and what support they need.

This transformation has enabled the Oxfordshire system to lessen the pressures on the health and care system with lower numbers of older people in long-term residential care benefitting the council and reduced lengths of stay in the acute hospital benefitting the NHS.

d. Intermediate care

An optimised approach: intermediate care

Where hospital flow and discharge is optimised, the right level of support for recovery and rehabilitation is available in the community and, where necessary, in bedded provision. This both minimises delays on discharge, and promotes the independence of residents, improving their long-term outcomes.

When intermediate care is optimised, adequate capacity exists across bedded and home-based services to deal not only with fluctuations in demand, but also the full potential cohort of individuals who would benefit.

This empowers practitioners across the system to refer individuals confidently, quickly, and easily into these services and helps maximise their quality of life, improve hospital flow, and avoid the need for inappropriate referrals into long-term services.

Crucially, length of stay in these services is minimised, retaining a sharp focus on reablement and rehabilitation. This is particularly important for bed-based intermediate care, avoiding the potential for short-term bedded care to turn into a long-term, permanent need for a bed.

This is primarily achieved by planning for onward care from the beginning of a stay in a short-term bed and retaining grip and visibility over length of stay throughout the support provided.

To achieve the best outcomes, all individuals in receipt of intermediate care will have been at the centre of creating their own specific and clear independence goals, in conjunction with and supported by multi-disciplinary practitioners and other stakeholders. The individual's progress towards these goals is regularly tracked, and the interventions adjusted dynamically to achieve their aims.

Effective bed-based intermediate care requires a multi-disciplinary team, including therapists and other clinical support (geriatrician, doctors, or nurses) working collaboratively with care staff with a shared ethos of prioritising independence. These practitioners are motivating, creative, challenging, and ambitious to help individuals maximise their own outcomes and build strong links to local community-based services, supporting people to move back to their own home. They rigorously evaluate and improve the effectiveness of their service delivery based upon the long-term outcomes achieved.

With all of these components in place, effective bed-based intermediate care can support two thirds of people to return home (as found in '*Measuring and optimising the efficiency of community hospital inpatient care for older people*' by Young, Hume, Smith et al in their January 2020 study).

Case study

Developing home-based intermediate care in Warwickshire

Warwickshire's health and care partners have developed a service (launched in April 2023) which has significantly increased their capacity to support people to be discharged from hospital once they are medically fit to be discharged, so that they can go home with support from a combination of domiciliary care and therapy services.

Like many councils in England, after the pandemic Warwickshire was faced with a greater requirement for support for people to return home from hospital. The council already ran an 'in-house' domiciliary care reablement service which held a prescriptive eligibility criteria but the local commissioners and partners decided that a new fully integrated community recovery service should be commissioned with health and social care working together.

A service specification was drawn up in consultation with local contracted domiciliary care providers. The proposed model included a (up to) six-week package of care to be determined by the domiciliary care providers and the therapists (in consultation with the individual).

The service would operate in a defined area of the county and would guarantee a set number of hours every week for which they would be paid (in advance). The providers were contracted to ensure they could provide any care needed within 24 hours of a request.

In the new service, the NHS offers support from therapists to assist the domiciliary care workers in delivering recovery-based care. The therapists help set the goals with the older person and advise the care workers on how best to assist the person to achieve their goals. The amount of care allocated to each person is determined by the older person and the provider (rather than by the council or the NHS). The provider then works with the customer and together they determine the longer-term package of care (where required).

The service can be partly described as a recovery and then an 'assessment' service. Each person is assessed in an ongoing way as their recovery goals are monitored.

The NHS-run community response team and the council-run reablement service, along with district and community nurses, have continued to provide their services alongside this new community recovery service. The new service has found that it can meet the needs of far more older people than had previously been possible, and is popular with many of the local domiciliary care providers who have greater freedom and guaranteed income.

There are seven local domiciliary care providers from the local care market participating in the community recovery service. They have been helped to train their staff (by the council and the NHS) for this specific recovery-based role and each member of staff has a 'prompt sheet' that helps them to focus on the outcomes needed for each person. The service takes referrals from all three major acute hospitals in the county.

There has been a three-fold increase in older people leaving hospital to return to their own homes. With the increase in older people being helped at home there has been a significant decrease in the use of both Pathway 2 and Pathway 3 beds.

Savings are expected to be made in the following areas:

- reduced length of stay in the acute hospitals
- reduced use of bedded facilities
- reduced social worker time
- reduced transaction costs resulting from the payment model.

These savings have not yet been calculated for the NHS and the county.

Case study

Introducing specialist short-term beds in Northamptonshire

The Integrated Care System in Northamptonshire, like many other places, was struggling to deliver effective Pathway 2 (P2) bedded pathways.

Research found that on average, older people were waiting an additional ten days in an acute hospital before they could be placed in accommodation (either a community hospital bed or a short-term residential care bed). The individual outcomes from these residential placements for older people were poor, with most people never returning home and being readmitted into an acute setting many times.

The health and care commissioners agreed to convert a former council-run care home into a Recovering Independence Beds (RIB) unit – a specialist short-term 51 bedded facility. The main aims are to enable older people to leave hospital more promptly and to help them return home independently. The jointly delivered pilot model between NHFTS and West Northamptonshire Council aims to deliver both speedy discharge and improved outcomes with the aim being to extend the model across the ICS's P2 bed base.

The RIB is fully integrated and is staffed by nurses, therapists, and care workers, each supporting the older person to recover to a level that will enable them to safely return to their own homes. In the first nine months, the unit saw an average of 35 older people admitted each month, and on average 50-60% of individuals returned to their own homes, approximately doubling the number returning home before the pilot. The pilot site is designed to be flexible with its admission criteria and can help a wide range of people including those with dementia, delirium, and other mental frailties, as well as those with physical frailties. There is a bespoke outcome-based performance framework which includes capturing the experience of the older person. The ICS can already demonstrate that they can reduce length of stay in hospital and improve outcomes for older people, reducing longer-term costs.

Through this innovative project, Northamptonshire Health and Social Care has been able to offer individuals with a wide range of medical conditions faster access from acute hospitals. Despite being more expensive to initially set-up (in comparison to purchasing Pathway 2 beds in the care market), they are achieving shorter length of stays than the unit's previous baseline and helping to drive down community bed length of stay by ensuring patients are placed in the most appropriate setting according to their needs. Importantly, most people who are admitted into the unit are able to go back to their own home as soon as they are well enough to do so.

Case study

Improving system visibility to support a new model of intermediate care in Leeds

The Leeds Health and Care Partnership is currently delivering 'HomeFirst'. This is a bold and innovative programme aiming to achieve a sustainable, person-centred, home-first model of intermediate care across Leeds that is joined up and promotes independence – so that individuals can go home with support from a combination of domiciliary care and therapy services.

The programme consists of five core projects which aim to collectively address areas of opportunity to better support older people in Leeds, as identified in a place-wide diagnostic.

Fundamental to the whole programme is a new system visibility tool which combines new ways of working and data visualisation to embed a culture of data-driven decision making in Leeds. This is enabling people at all levels across the system to better manage system pressure, improve the efficiency of services and ultimately deliver services which lead to more independent outcomes for patients.

The system visibility tool

Before the system visibility tool was developed, data visibility within the system was siloed, difficult to access, and not widely trusted. The system set out to create a single source of truth which would enable them to take actions together based on evidence, rather than anecdote.

In the early stages of the HomeFirst programme, work commenced to identify and extract the right data from the different system partners and process it as one complete set. Now, data automatically flows from the acute trust, community trust, and local authority and is combined to give a live view. Numerous views are available, from trends in how the system as a whole is performing on key metrics relating to flow and discharge, to data on different health and care settings, right through to ward and patients.

Leaders can now identify, live, where the pressure is in the system, what is contributing to it, and what outcomes are being achieved. Managers and team leaders can view capacity, flow, delays, next steps, and outcomes down to individual patient level.

Evidence-based decisions can now be made at all levels, for example, to correct downward trends before they become a bigger problem, or to agree better use of resource or capacity across the system.

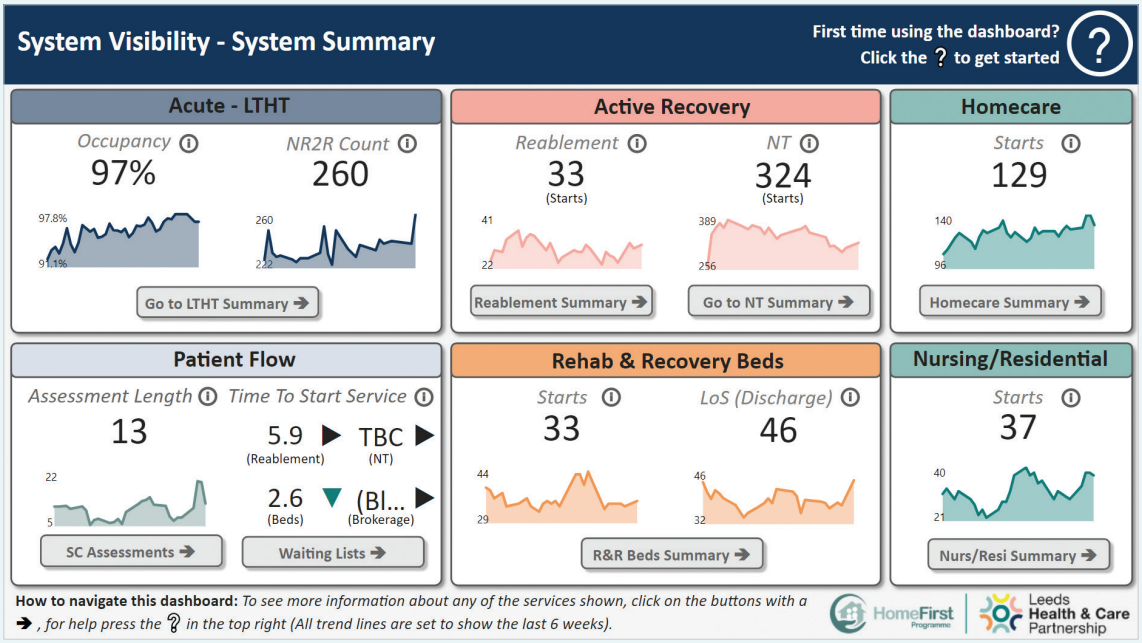
Crucially, the tool enables people to see in real-time the impact of any changes that are made to address issues. This not only helps to build trust in those changes but can also allow further adjustments to be made until the desired impact is achieved.

Impact to date

Many of the changes from the programme are still to be implemented. However, particularly since the roll out of the new tool, the following early improvements have been seen:

- 30% reduction in lost hospital bed days for people with no current reason to reside.
- Reduced reliance on Pathway 2 beds in the community (from 280 beds to 185 beds).
- 11% increase in number of people going home with support.

This is an example view of the system dashboard in Leeds. This view shows an overall summary of system performance focusing on the key metrics for each of the services shown. This dashboard is used in a weekly system-wide meeting, where partners work collaboratively using the data to make evidence-based decisions, enabling them to do the best thing for the whole system.



Case study

Leicestershire, Leicester City and Rutland

Leicestershire, Leicester City and Rutland's analysis at the start of their transformation programme found that far too many older people were being discharged into short-term beds in residential care and as a result were staying in those care homes long-term.

They found that most older people deteriorated further when they were in care homes not supported by intermediate care, and very few were able to return to their own homes.

They were determined to develop a proper and appropriate bed strategy for their intermediate care. To achieve this, they worked closely with their local community hospitals to enable them to build capacity to offer a recovery-based set of beds available for discharged patients.

They found that if therapy staff were available to help guide the recovery programmes for older people in the community hospital, then 77% of patients were able to return to their own homes – most with either no further care or a much lower care package than had previously been anticipated. They have also been in discussions with a care home to provide a similar short-term service supported by nurses and therapists.

A pilot of this scheme resulted in 88% of the older people returning to their own homes.

Barriers to optimisation: home-based intermediate care

By analysing the demand and capacity plans of 19 local authorities, the gap between anticipated demand for intermediate care and the capacity of actual services commissioned can be explored. In Figure 22, positive numbers demonstrate more demand than there is capacity, while a negative number shows more capacity than there is demand. This shows that there is significant anticipated shortfall in capacity in home-based intermediate care, specifically reablement and rehabilitation at home. In contrast, there is a lesser requirement for additional capacity in short-term residential and nursing beds.

Taking this as a representative sample would suggest that some 40,000 additional older adults could benefit from greater capacity in these home-based intermediate care services. Previous work conducted by CCN and Newton demonstrated that reablement at home has a 7:1 return on investment in terms of reducing the need for, and spend on, long-term care and support.[36]

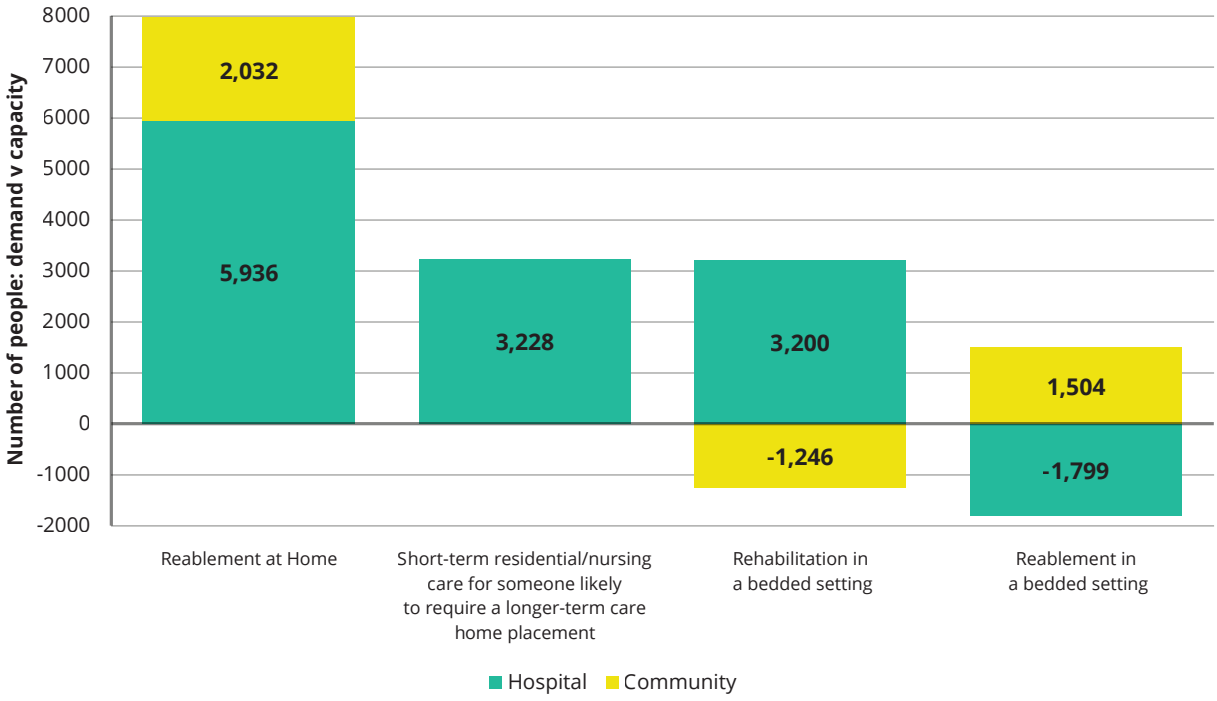


Figure 22. Analysis of social care capacity for hospital discharges in 2022/23.

This is backed up by a separate study showing that home-based intermediate care is often under-utilised. Multi-disciplinary reviews of 1,000 cases across 11 local authorities identified that the number of people who could benefit from home-based reablement was almost double the number who actually received it, with those individuals going on to receive more ongoing care than necessary with reduced independence.[37]

Inefficient scheduling processes, management of travel time, and staff productivity all contribute to this lack of capacity, as well as the need for more provision to be commissioned.

Risk averse decision-making can also be a significant contributing factor, where practitioners are more likely to refer to bedded care, or more intensive packages of care at home, than to home-based intermediate care.

Equally as important as the right people having access to reablement is ensuring the service is delivering excellent outcomes. This is measured by comparing the 'end need' (the amount of long-term care and support required after a short-term intervention) to the 'start need' (the estimated amount of long-term care and support required without the short-term intervention).

Figure 23 illustrates the results from a study of a sample of 11 reablement services across the country. This showed that the most effective service, according to this measure, adds five times the value of the least effective service, demonstrating the significant variation in practice and outcomes achieved across the country.

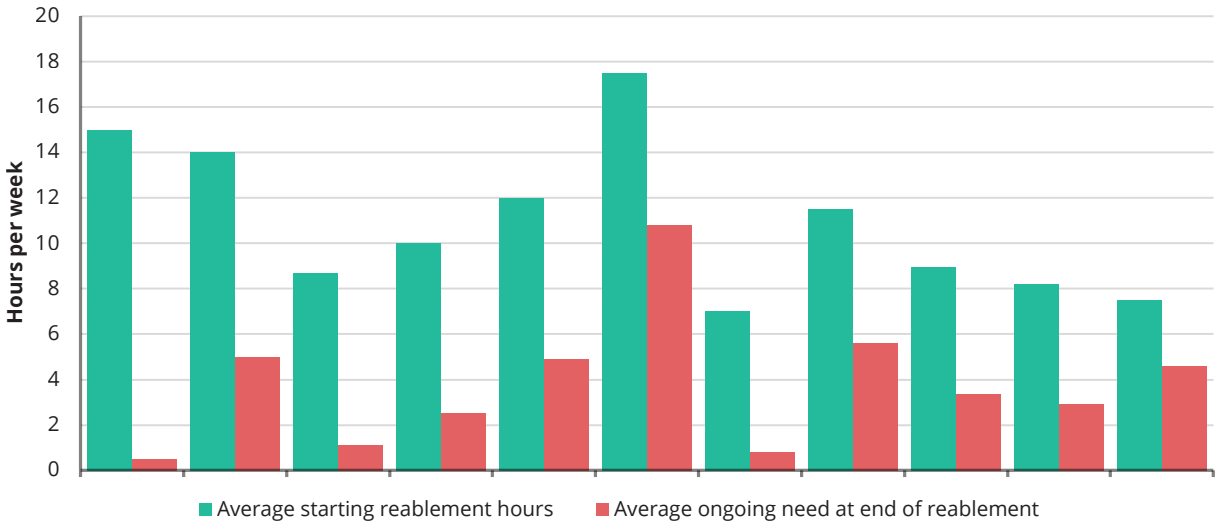


Figure 23. Comparison of effectiveness of 11 different reablement services, comparing start need to end need.

Barriers to optimisation: bed-based intermediate care

Nationally, there is a significant challenge in achieving effective onward flow for residents who are discharged into short-term beds. Figure 24 shows that only 11.6% of people, on average, are discharged on time once they are deemed medically fit (i.e., without criteria to reside in their bed), with the remaining 88.4% experiencing delays.[38]

This analysis was published for the first time in the HSJ in September 2023, drawing increased focus.[39]

This data demonstrates that purely focussing on the acute hospital can often mask a problem whereby residents remain in beds in the community which risk becoming permanent placements. The availability of onward care, specifically domiciliary care (Pathway 1) and residential and nursing care (Pathway 3), is the most significant cause of delay, making up 65% of all delays in short-term beds.

To some extent, this is a hidden problem. It is only recently that national data on performance in this area has been available and published, and often local systems do not have sufficient visibility of performance.

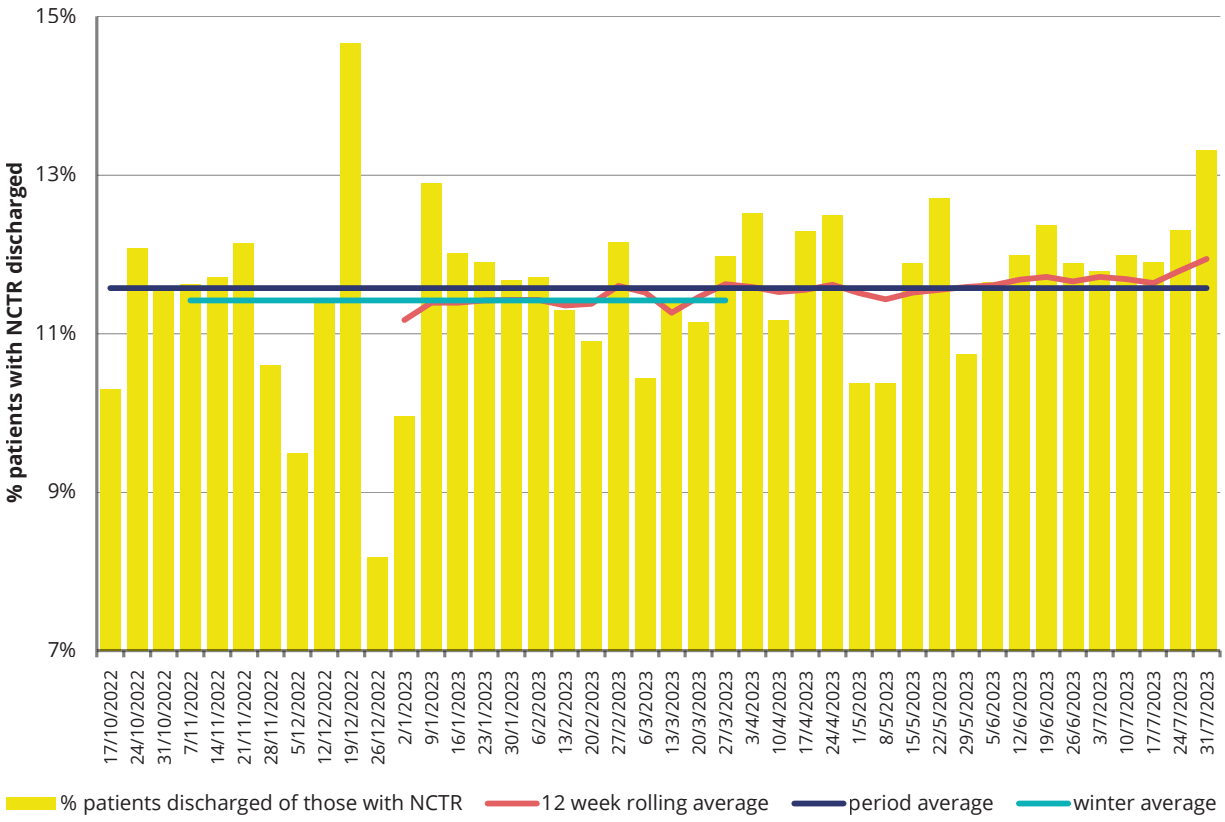


Figure 24. The proportion of people who are medically fit (i.e., who have NCTR) who are discharged on time.

Short-term beds are often commissioned specifically with the aim of improving flow in the acute hospital (and so reducing numbers of patients with no criteria to reside in the acute hospital) without planning for the onward care needs of these residents. As a result, many systems report that the majority of people discharged to bed-based intermediate care do not return to their own home, and their bed becomes permanent. This is in stark contrast to the study '*Measuring and optimising the efficiency of community hospital inpatient care for older people*' by Young, Hume, Smith et al in January 2020 which suggests that, when bed-based intermediate care is optimised, two thirds of people can return to their own home.

A principle adopted by some is that everyone who is discharged into a short-term bed must receive home-based reablement or care following their stay, and so this is planned for from the beginning of their hospital stay. Like reabling people in their home, effectively reabling people in short-term beds to support them to be discharged home is dependent on the availability of a therapy workforce, together with other clinical colleagues, such as nurses, geriatricians, and doctors, who all have a shared focus on promoting independence. This workforce is nationally limited, which can therefore cause further delays and lead to poor long-term outcomes.

11.6%

of people, on average, are discharged from a short-term bed on time once they are deemed medically fit

e. Long-term outcomes

An optimised approach: long-term outcomes

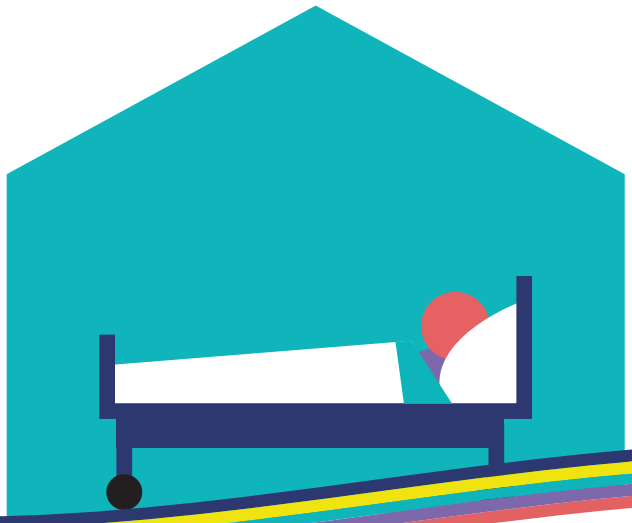
Where hospital flow and discharge are optimised, decision-making around long-term outcomes has an appropriate approach to risk management and prioritises long-term independence as the core principle. In doing so, this focus on long-term independence also supports minimising discharge delays, with fewer people discharged to Pathway 3 where the most significant discharge delays are observed.

In addition to the provision of intermediate care covered above, optimised long-term outcomes are enabled by the right capacity and capability of long-term care in the community, including specialist provision for people living with dementia. This is supported by a robust approach to strategic commissioning, which is joined up across health and social care.

Whilst much of the focus of this work programme has so far looked at the role of NHS trusts, local authorities, and the private sector in the delivery of care, the voluntary sector also plays a crucial role in the delivery of seamless health and social care in England, often complementing the efforts of the public and private sectors.

Where hospital flow and discharge are optimised, voluntary sector partners bring deep sector knowledge and expertise in the delivery of services. Highly effective, multi-agency delivery that utilises the knowledge and expertise of voluntary sector partners has a transformative impact on the experience and outcomes of individuals. Voluntary sector partners bring innovation and flexibility, as well as a deep and values-based connection. They are able to mobilise and deploy capacity to bridge gaps in services with large numbers of well trained, motivated employees and volunteers.

Beyond the immediate benefits for individuals, work undertaken by the University of Durham in conjunction with health and care bodies across West Yorkshire and Humberside identified that the voluntary sector has an even greater multiplier effect upon the local economy, reducing the costs to public sector bodies as well as delivering outstanding value to the immediate recipients of their services. The total economic added value to the region was calculated to be between £3.1bn and £4bn.[40]



Case study

Optimising long-term care options through a commissioning strategy at Oxfordshire

Over the last two years Oxfordshire County Council and their local NHS system partners have worked both collaboratively and ambitiously on a transformation programme helping with the flow of patients through the health and care services.

The impact of these changes two years later is that the percentage of people on Pathway 0 and on Pathway 1 has significantly increased and the use of bedded facilities has decreased.

One arm of the transformation involved a commissioning strategy from the Council which transformed both the on-going care at home support and commissioned new reablement services from strategic partners.

To ensure that getting people home was the default care pathway for residents, Oxfordshire County Council used the re-commissioning of its domiciliary care services to transform local care arrangements. They combined a new contract for domiciliary care at home with a contract for the private sector to run and manage their own reablement-based domiciliary care services.

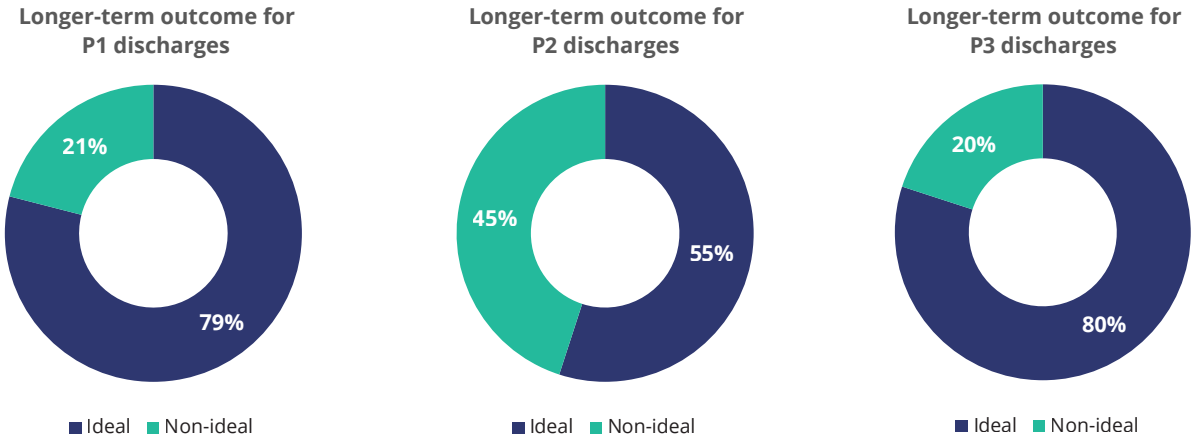
This replaced a local service that had been previously run through the NHS and which had not achieved outcomes required. The new reablement service agreed to pay providers £1,200 per episode of reablement whatever time the recovery took for the older person. This averages out at around 48 hours delivered care per person.

Agreeing this standard price has reduced the bureaucracy and administration costs for both the providers and the County Council. As a result of the new contract, providers were able to increase the number of hours that were available both to the home care (18% increase) and reablement services. In addition to their work on the re-commissioning of the formal care market, Oxfordshire has started to support local community enterprises and use personal assistants to add further capacity to the care and support that is available for those with support needs.

Barriers to optimisation: long-term outcomes

When multi-disciplinary teams reviewed 270 cases across four health and care systems, they found that between 20% (Pathway 3) and 45% (Pathway 2) of discharges were not on the ideal pathway for their needs (as illustrated in Figure 25). When taken together with the typical delays data included above (which demonstrates that delays are typically greater on Pathway 3 than Pathway 2, and Pathway 2 than Pathway 1) this underlines the point that those inappropriately discharged to Pathway 3 are experiencing both a less independent long-term outcome, and an increased delay.

Service capacity is a clear root cause of this. The robustness and consistency of practice and decision-making is also a key factor, with the wishes of the individuals and their families and risk aversion also impacting outcomes. This demonstrates the discharge to assess model is not functioning effectively.



Main reasons for P1 non-ideal outcomes:

- Patient wishes
- Ideal services does not exist
- Family/friends wishes

Main reasons for P2 non-ideal outcomes:

- Ideal services does not exist
- No capacity in service (Intermediate care)
- Family/friends wishes

Main reasons for P3 non-ideal outcomes:

- Patient wishes
- No capacity in service (Intermediate care)
- Risk aversion, decision making (Intermediate care)

Figure 25. Comparison of long-term outcomes depending on the pathway onto which an individual was discharged.

Dementia

At least 25% of general hospital beds are occupied by people living with dementia. On average, people with dementia stay more than twice as long in hospital as other patients aged over 65. Further to this, one study identified dementia as the strongest predictor of a delayed discharge. Not only is this detrimental to overall system performance, but there is a significant body of evidence to suggest that time spent in an acute hospital can cause delirium and worsen the symptoms of dementia, compromising long-term outcomes for people. Therefore, there is an even greater imperative to ensure people are discharged in a timely way.

The data earlier in this section demonstrates that one of the key causes of delay for people once they have been deemed medically fit to leave hospital is the right capacity of care in the community. Taken together with the evidence around dementia, this implies that there is a specific issue in the availability of appropriate dementia care in the community, be that bedded or home-based, along with staff having the right skills and experience to work with people with dementia as they're discharged from hospital.

f. Underpinning challenges

The driving forces explored above focus in on specific systems, processes, and ways of working which need to be in place for discharge and flow to be optimised.

Underpinning these areas are a number of cross-cutting challenges which impact on multiple areas of health and social care pathways. These areas have also been drawn out through specific engagement with system leaders carried out as part of this work.

1. Competing cultures and behaviours

A common theme emerging from the roundtable discussions with health and care leaders was the need for a clear and consistent approach to system leadership at all times, especially "when things get really tough".

Positively, 79% of respondents to a survey of CCN member councils said that they believe leaders across their health and social care system are aligned on the key priorities and challenges facing the system.[43] However, through further engagements as part of this programme, health and care leaders agreed that in the most challenged systems, a belief still exists that "a win for my organisation, even in the context of an overall system loss, is preferable in the short-term". Misalignment of incentives, for example a perceived trade-off between speed of discharge and achieving the right long-term outcome for someone, can play out at every level.

This can be a result of fundamental differences in the philosophies underpinning each organisation, for example a focus on diagnosis, treatment, and safety, compared to a focus on long-term independence. It can also be down to structural differences in that the NHS provides a service free at the point of access, whereas social care is means tested.

There was agreement from those engaged that overcoming these structural, financial, and cultural barriers between organisations within a system is a crucial enabling step to making decisions in the best interests of the residents and staff and that doing so requires strong leadership.

System leaders agreed that where this is observed working well, there is alignment in the narrative from the most senior leaders across each organisation, and consistency in the way this message is both understood and then put into practice within and across organisations.

This requires senior leaders to take visible responsibility for flow and discharge, empowering their teams to collaborate and take a person-centred approach. This must be supported by the right data, processes, performance reporting, and decision-making to ensure all organisations are pulling in the same direction.

2. Lack of trust in data

Health and care leaders engaged in this work programme described facing real challenges in truly understanding both the demand from residents accessing their services, and more critically, the capacity that exists within their organisations to service this demand.

The absence of this understanding means that leaders do not have real-time access to the relevant information and insight to make informed decisions. Even where this data can be made available, it is often inaccurate, or there are competing and conflicting versions, which causes a lack of trust.

One system leader described trying to take system-level decisions as like "flying an A380 without any instruments in the cockpit".

In a survey of CCN member councils, while 84% of respondents said they have witnessed attempts to improve system visibility and insight, only 37% said that the necessary level, quality, and accessibility of data are available to all members of their organisation to perform their roles effectively and only 24% agreed that information and knowledge are easily shared among partner organisations, and there exists a single 'source of truth'.[44]

Where this is observed working well, primary, social, intermediate, and acute care data is integrated to provide an accurate picture of demand at every point in the system, in near real time.

This allows leaders to have access to the necessary and sufficient insight to take optimal decisions about where and how to 'right size capacity' to meet current and predicted demand. This data can be used in 'business as usual' management, for example through place-based and system performance meetings, to allow decisions to be surfaced and actioned including on where short-term investment should be made. It can also inform where longer-term transformation opportunities exist.

The journey towards this position begins with individual organisations building up this understanding of their own data, such that it can be used dynamically to drive day to day operations. Once this is in place, the data can be integrated to create a unified view, which can then be presented at patient, provider, and system level.

The technical challenges to deliver this, such as systems interoperability, information governance, and data accuracy are significant, but not insurmountable. The most critical success factor is having a leadership team aligned on the need for having data that can be used in this way.

3. Unsustainable workforce pressures

System leaders engaged in this work asserted that one of their greatest underlying issues is workforce sustainability, productivity, and wellbeing. In a survey of CCN member councils, just 8% agreed that their workforce capacity within their organisation is suitable for the workload at hand.[45]

The national evidence backs this up; staffing vacancy rates across health and social care continue to be significant with, for example, rates in NHS nursing remaining stubbornly high at 9.9% as of March 2023 in spite of significant levels of recruitment.[46] Somewhat positively, a recent Skills for Care report on the adult social care workforce appears to suggest more starters, reduced turnover, and fewer vacancies in 2022/23. However, it remains to be seen whether this is indicative of a long-term trend.[47]

Whilst high levels of open posts continue to exist, and staff incur significant levels of overtime and take on additional shifts, not only does wellbeing suffer, but health and social care providers are exposed to greater employment costs.

Furthermore, and as a result of these vacancy rates, they must also fund the higher-than-average costs associated with using agency providers.

Beyond the very clear challenge of vacancies within teams working across health and care, frontline workers are often inhibited by clunky processes, systems, and ways of working, which limit productivity. A major part of this is lack of access to timely clinical and operational information, caused by siloed information and poor quality technology. This in practice reduces efficiency, for example by requiring mobile teams to return to offices to update systems, resulting in a much poorer outcome and experience for residents, as well as increased costs.

Where the health and care workforce is observed to be more sustainable and productive, providers are supported to deliver an attractive career structure.

The right practice, processes, and professional supervision are in place to create a safe and stimulating environment for staff, whilst wrapping around pastoral care to help with the emotional demands of working in health and care.

Effective recruitment campaigns are in place to help recruit and develop the right quantity and quality workforce of tomorrow, fully leveraging the strength of the brands of both the NHS and local government in this.

The NHS and local government collaborate to align on a shared workforce strategy, with fairness of remuneration a key component. Staff engagement also features strongly as a key performance indicator; this is measured regularly and reviewed in partnership across the system.

08

Optimising flow and discharge: conclusion and recommendations

Impact of optimised hospital flow and discharge

If the recommendations are fully embraced, and acted upon both nationally and locally, analysis from this work programme shows significant progress can be made towards optimising flow and discharge.

This will require the continued commitment of national policy makers, working together with local health and care system leaders to affect significant change. If this can be achieved, outcomes for people can be improved, operational pressure reduced, and financial sustainability enhanced.

The financial benefit of these improvements in each case is described (net of delivery costs) and therefore represents the realisable impact for the health and care system.

The potential benefits can be outlined in terms of:

1 **Avoiding people being admitted to hospital.**

2 **Reducing unnecessary delays when someone is in hospital.**

3 **Optimising long-term outcomes when someone is discharged from hospital.**

Avoiding people being admitted to hospital

175,000 fewer older adults (aged 65 or above) could be admitted to hospital, and instead supported in the community. This will save the NHS £0.6bn.

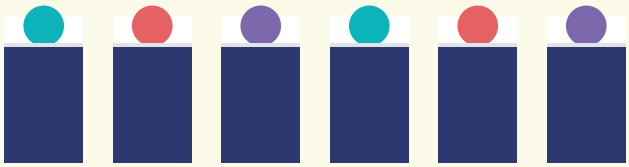
This is achieved primarily by building trust, confidence, and awareness of alternative community resources.

Reducing unnecessary delays when someone is in hospital

Over half a million

bed days are currently lost to delays during treatment that could be saved (before individuals are deemed to have no criteria to reside in the acute hospital). This will save the NHS £220m.

This requires increased diagnostic capacity and improvements to management processes.



500,000 bed days lost to delays with 'simple' discharges (Pathway 0) could be saved. This would save the NHS £200m.

The uneven discharge throughout the week is a major driver of these losses.

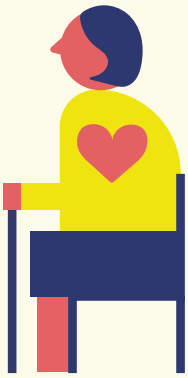
There could be 1.1m fewer bed days lost to delayed 'complex' discharges – primarily as a result of improving capacity in intermediate care and reducing delays in the discharge process.

There could be **440,000 bed days** saved by reducing discharge delays on Pathway 1 – a saving to the NHS of £176m.

There could be **300,000 bed days** saved by reducing discharges on Pathway 2 – a saving to the NHS of £120m.

There could be **400,000 bed days** saved by reducing discharges on Pathway 3 – saving the NHS £160m.

Optimising long-term outcomes when people are discharged from hospital



43,000 people could have a more independent long-term outcome, as a result of being discharged on to the right, more independent pathway – saving local government £575m.

This is primarily as a result of lack of capacity of the right intermediate care, and risk averse decision-making.

40,000 people could have a more independent long-term outcome as a result of receiving effective home-based reablement and the effectiveness of this service could be improved for the 200,000 people already benefiting from it – saving local government £440m.

This is primarily as a result of increasing therapy input into home-based intermediate care.

In total this results in a potential financial benefit of £2.5bn to the health and social care system, of which £1.5bn is benefit to the NHS, and £1bn to local government.

Please see page 101 for more information on the workings behind these statistics.

Overview

There is no doubt that health and social care systems are under increasing pressure.

The average occupancy of G&A and CC beds in acute hospitals averaged 94.8% in winter 2022/23, up from 92.6% in the previous year.

While non-elective admissions are rising, they are only returning to the levels seen before the pandemic. However, the acuity of those admitted, as measured by the number of co-morbidities recorded on admission, suggests that individuals are more unwell.

This is, in part, contributing to individuals spending over a third longer in acute hospitals than before. This increase in length of stay (a rise of 34.8% between 2019/20 and 2022/23) is also caused by a combination of delays whilst patients have criteria to reside in the hospital, and delays on discharge once they no longer have criteria to reside.

In recent years the number of people discharged from acute hospitals to long-term care had started to reduce. Today, however, the data implies this trend is reversing, with 7.9% more people going on to receive long-term care in 2022/23 compared to 2021/22.

All of the above limits patient flow, stretches resources, and increases an individual's reliance on ongoing care services following a stay in hospital – implying compromised long-term outcomes.

However, there is significant variation in performance across the country, with some health and social care systems making progress.

In the south east, the highest hospital occupancy rates are recorded nationally. At an average of 96% across the region, this is 2.8% higher than the lowest occupancy rate (93.2%), observed in the north east and Yorkshire.

Of particular interest is the variation between individual trusts within the same ICS, with over 6% variation between the highest and lowest occupancy trusts. This demonstrates that good practice exists, and raises questions about how different ICS's function, and the potential for identifying and sharing good practice to drive consistent and sustainable high performance across the country.

The pressures described in this report existed before the pandemic, and are further heightened by its ongoing legacy, which makes achieving real change a complex and daunting task.

So far, this report has sought to provide a description of how optimised flow and discharge can be established and maintained. The rest of this section will now examine:

a. Recommendations for central policy makers.

b. Recommendations for local systems.

Recommendations for central policy makers

Despite the clear challenges, many of the individuals who contributed to this programme of work retained a degree of optimism about the potential to improve long-term outcomes for people, reduce operational pressure, and enhance financial sustainability.

Numerous examples of good practice have been observed (and included in this report), which poses the question of how this practice can be consistently and sustainably adopted.

In order to enable and support local systems, there are a set of enablers which need to be put in place nationally to enable good practice to be adopted consistently and sustainably. These enablers require alignment of policy and nationally funded and directed support programmes.

Recognising the immediate pressure faced by health and social care systems, there are three enablers which ought to be put in place as an immediate priority. Each of them will need decisions to be made around appropriate funding, time, and resource alignment – and are not shown in a priority order.

The remaining recommendations are longer-term, enabling improvement over the medium-to long-term.

a. Immediate priorities

1. **Focus any additional funding that is made available for community capacity on councils to expand home-based reablement and recovery and specifically the therapy workforce required to support this.**

Through the analysis of the demand and capacity plans of 19 systems, reablement and rehabilitation at home is shown to be the service where demand most significantly outstrips capacity. The evidence in this report demonstrates that there is the potential for an additional 40,000 older adults to benefit from reablement and rehabilitation at home on discharge from hospital, if the capacity were available.

Therapists and therapies leadership is a critical component of effective home-based reablement and recovery, shown to be a key driver of the variation in effectiveness of home-based reablement services (as demonstrated earlier in this report). Local systems are reporting a significant lack of therapists available to support these services.

Therefore, if additional funding is to be made available to health and social care systems this year for community capacity, it should be directed towards councils to enable the expansion of home-based reablement and rehabilitation (not short-term beds) and specifically support development of the therapy workforce.

2. **Bring national focus to attendance and admissions avoidance, alongside effective hospital discharge.**

The evidence in this report demonstrates the potential to avoid more admissions to acute hospitals. 30% of non-elective admissions of older adults were judged to be inappropriate or avoidable, when a sample of 768 cases were reviewed by a multi-disciplinary team.

The primary cause of these admissions was where the relevant professionals lacked awareness and confidence in the community services already available locally, and risk aversion in professional decision-making. Tackling even a small proportion of these avoidable admissions would have a transformative impact on the pressure across health and social care systems.

Despite this evidence, the vast majority of available support programmes and national guidance is focussed on optimising discharge from the acute hospital and does not deal comprehensively with admissions avoidance. National data collection focusses strongly on figures of people with no criteria to reside in the hospital, with little consideration of those who could have avoided an admission altogether.

Local systems can be supported in their efforts to avoid and reduce hospital admissions through consistent emphasis in national guidance and support. Data collection and reporting could also highlight this opportunity, providing the means to establish good practice. Using a crude measure of emergency admissions per weighted population demonstrates significant regional variation of 51% between the lowest and highest rates of admission (illustrated in Figure 26), indicating the potential for intelligence to be gained from developing a more comprehensive set of indicators.[48 49]

3. Make minimising simple discharge (Pathway 0) delays a national priority.

The evidence presented in this report clearly demonstrates that delays on Pathway 0 are the largest root cause of wasted bed days, resulting in overly occupied acute hospitals, poor system flow, and compromised long-term outcomes for people, causing close to one million bed days per year lost. However, Pathway 0 is rarely the focus of national conversation or support offers, which instead focus on complex discharges (Pathways 1-3).

Pathway 0 delays are one of the few opportunities presented through this report which can be affected by a single organisation, the acute hospital.

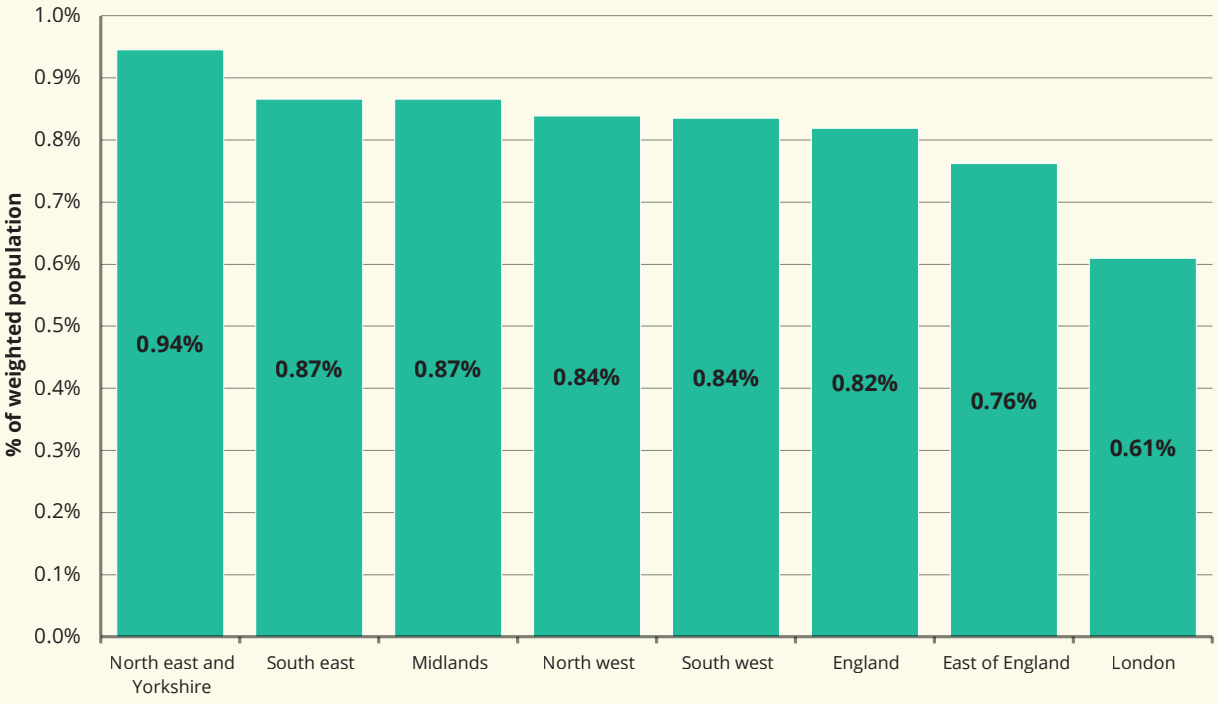


Figure 26. Emergency admissions per weighted population in winter 2022/23.

The majority of delays are caused by the uneven discharge flow throughout the week, specifically with reduced discharges over the weekend, which results in a build-up of delays on Monday and Tuesday. Achieving a more even flow throughout the week, without affecting the overall average, could all but eradicate these delays.

Alongside improved seven-day working patterns, crucially including senor medical discharge capacity, effective implementation of criteria-led discharge offers a means to achieve this even flow. In this approach, discharge criteria are clearly set by the clinical lead, and then followed through and supported by registered healthcare professionals.

Pathway 0 delays must be brought to the top of the national priority list in order to focus resources, support offers, and health and social care system leadership on tackling the issue.

b. Longer-term priorities

1. End short term funding; commit to multi-year arrangements.

The short-term nature of winter funding for health and social care systems effectively prohibits the use of this money for development of home-based support services. Systems cannot commit to paying for and developing the additional workforce required to build this professional skillset when the funding may only be available for a number of months. This stops systems from developing the necessary home-based intermediate care where they report capacity gaps.

It instead forces systems to invest in simple bedded support ('step-down beds'). These beds lack the required therapy input but can be readily commissioned from care providers for short periods of time and can provide some short-term relief in temporarily improving hospital flow.

To truly address the capacity gap demonstrated earlier in this report, which would in turn support an additional 40,000 older adults to benefit from reablement and rehabilitation at home on discharge from hospital, funding must be guaranteed for longer periods of time, and provided with more notice. This would enable the workforce development required to build capacity in these crucial services.

2. Develop good practice and capability development for system strategic commissioning arrangements, in particular for the commissioning of intermediate care and demand and capacity planning.

As explored in section seven, effective demand and capacity planning for intermediate care is a critical area of development for local systems. Whilst much progress can be made on this locally, support from central policy makers will achieve a more significant impact.

Tactically, simpler tools and a simpler template for producing demand and capacity plans, along with improved guidance on how to interpret local data, would support better quality outcomes. This would be reinforced by consistent messaging from government, in terms of the need to work in partnership to jointly develop effective intermediate care services (as per the Hospital Discharge and Community Support Guidance issued in 2022) rather than urgently commission short-term beds without the required workforce to support effective reablement and recovery.

More fundamentally, the capability of health and care systems to commission these services effectively is limited, as evidenced throughout this report. To some extent, this is hampered by the lack of a single, trusted source of data, as well as conflicting guidance on priorities.

However, the case studies shared through this report demonstrate that despite this, where the leadership and capability of strategic commissioners is sufficient, these barriers can be overcome and significant progress can be made.

Building trusting relationships with providers, clear communication, and bringing them in as valued partners in the health and social care system have been shown to be a key driver of success.

Supporting strategic commissioning capability development through a national academy or accreditation would both recognise the complexity of this role and provide vital tools, training, and career development opportunities. Having a clearly designated lead commissioner at a senior / board level in the integrated care system would provide the necessary visibility and leadership.

3. Develop a transparent and extensive national data and performance framework, to more readily identify good practice and areas for improvement.

As demonstrated by the number of different data sources analysed to produce this report, there is no single, comprehensive framework which provides an analysis of the end-to-end performance of health and social care systems. Analysis of the best and worst performing systems tends to be focussed on a small number of specific metrics, for example the numbers of those with no criteria to reside in the hospital but who continue to do so. This can make it challenging to identify true good practice, as well as to direct support and intervention to those systems in most need of it. There are also known issues in the quality and completeness of the data making up some of these submissions and metrics.

Developing a comprehensive and single set of indicators, incorporating end-to-end resident flow through an acute hospital, would provide a strong basis for identifying good practice and supporting improved performance, including developing an improved evidence base for key services, such as reablement. Critically, this framework should include clear metrics around long-term resident outcomes, including short-term beds and long-term care, to act as a balancing measure to the figures on no criteria to reside, helping to better identify good practice.

This could include:

- acute hospital admissions levels
- length of stay, both before and after someone is deemed to have no criteria to reside in the hospital
- use of discharge pathways and associated delays, including Pathway 0
- intermediate care demand and capacity
- length of stay and outcomes from short-term beds
- long-term resident outcomes.

The most insightful data presented in this report, identifying the root causes of key issues, is generated through substantial diagnostic activities carried out 'on the ground' with local health and social care systems. In order to replicate and standardise some elements of this insight, which would further support performance improvement, significant focus would need to be given to systems, standards, and ways of working around local data capture and reason coding. This would require significant systems and capability development.

4. Reform information governance and data standards to enable effective and efficient data sharing across systems.

A common issue identified by almost every system engaged in this work programme, with a handful of notable exceptions, is the availability of a single, trusted source of data. What good looks like for this locally is highlighted in section seven of this report. This is identified as a key enabler of optimised flow and discharge, alongside effective demand and capacity planning and continuous performance improvement.

As it stands, it is incredibly challenging to arrange for effective data sharing between system partners. This can often take many months of concerted effort and requires strong leadership to align partners on the purpose and requirements.

Further to this, a lack of clear data standards can mean data is often reported or interpreted differently between different organisations, making it challenging to draw meaningful comparisons and undermining the trust of the leadership team in using this data to make decisions.

Integrated care systems provide the ideal structure to facilitate effective data sharing and common definitions of key data and metrics. The Federated Data Platform programme, led by NHS England, is designed to achieve this outcome and will see a provider selected in autumn 2023 to provide all ICSs with software which is intended to support the creation of this single source of data. This programme should be considered a high priority and should be given full support to ensure timely procurement and mobilisation.

In order to realise the benefits of such a solution, the software deployment also needs to be supported by:

- consideration of information governance requirements to facilitate data sharing between organisations
- data quality and completeness
- standards of data collection and metric preparation to ensure consistency
- capability development in local systems to manage the data asset
- capability in local systems to use operational data to drive strategies and decisions.

5. Develop a comprehensive strategy for out of hospital dementia care.

The evidence presented in this report clearly indicates that a lack of availability of appropriate care and support for people living with dementia, and discharge processes that are not supportive of people with dementia, are key drivers of delayed discharges. The National Audit of Dementia offers further valuable insight into the current state of care for people with dementia, both within hospital and on discharge to the community.[50] Building on this, there is an opportunity for a national strategy to be developed for support in this area, which should aim to outline a core offer of support, as well as share good practice for both in and out of hospital and transfers of care.

Such a strategy would need to provide the necessary enablers in terms of funding and support for workforce development.

A core offer for out of hospital dementia care in the community could include:

- support at home offered and delivered by care workers who have received additional training in how to support people with dementias
- the use of assistive technology including safety gadgets, tracking devices, alarms, and cameras to ensure a person is safe and has good engagement with local communities
- support for family carers and other informal carers who may support a person with a dementia living in their community
- intermediate care services which focus on helping those with a diagnosis and their carers to learn how to best live with and manage their way safely with the condition.

Unfortunately, and as is a core theme of this report, whilst many older people with dementia can do well in their own homes with the benefit of such a community offer, where this is lacking, many places have had to resort to specialist bedded care. However, there is also a shortage of specialist bedded care, especially places that are able to support older people who have more challenging symptoms such as higher level of confusion, aggressive behaviours, or levels of delirium.

This shortage can mean that people are forced to remain in an acute hospital bed. Therefore, any dementia strategy must involve the development and commissioning of this type of provision.

Lastly, it is necessary to address the skills and experience of the workforce with a workforce development plan. It is often the case that specialist skills are required to manage, for example, transfers of care. Commissioners also need to develop skills and experience in developing and commissioning the appropriate community and bedded provision.

Recommendations for local systems

Nationally, there are numerous examples of good practice throughout the health and social care system, many of which are referenced in this report.

However, as demonstrated, this practice is not universal, nor consistently adopted across the country. The recommendations for central policy makers, explored above, are designed to create the conditions to achieve consistent adoption of this good practice.

With the national enablers in place, the evidence base presented in this report leads to a set of actionable recommendations for local systems which, if successfully implemented, will help to achieve higher and more consistent performance. Again, recognising the immediate pressure faced by health and social care systems, there are five recommendations which ought to be put in place as an immediate priority. The remainder enable improvement over the medium to long-term.

a. Immediate priorities

1. Ensure system-wide visibility of the community support offer, especially with paramedics.

The evidence gathered through this report demonstrates that nearly a third (31%) of older adult emergency attendances were deemed to be inappropriate or avoidable and 30% of older adult emergency admissions could have been avoided. It has also shown that more than half of these avoidable admissions come via ambulance conveyance. The most significant reason observed was where professionals did not have the awareness of or trust in alternative services already available in the community. There are three specific actions that can be taken to support in rectifying this:

i. Training and educating paramedics, clinicians, and other health and care professionals on the alternative options to attendance and admission that are available.

ii. Ensuring that alternative services (including primary care, community healthcare, and urgent community response) are available seven days per week, and that they have sufficient capacity to meet demand.

iii. Having an effective multi-disciplinary team assessment in A&E to identify patients that are suitable for alternative services. These multi-disciplinary teams must include colleagues from the voluntary and community sector.

These actions can be supported by the sharing of demand and service capacity data across the system, putting this in the hands of clinicians, paramedics, and other health and care professionals at the point that they interact with residents. Digital tools can support professionals by visualising the full range of alternative services available, and what capacity is available. Coupled with the training, knowledge, and experience of alternative services, this can help ensure that people are efficiently supported into appropriate services, avoiding an acute hospital admission.

2. Bring focus to tackling delays for simple discharges (Pathway 0) by smoothing discharges through the week.

As outlined in this report's analysis, one million bed days are lost every year because of delays to simple discharges, with every simple discharge being delayed by between one and three days on average. This is primarily driven by the uneven rates of simple discharges observed across the seven days of a week (with lower rates of discharge over the weekend).

Whilst seven-day working practices will vary from place to place, a smoother flow can be achieved by effective implementation of criteria-led discharge.

This requires planning for discharge from admission, and for the final discharge for the vast majority of patients to be supported by registered healthcare professionals, with the criteria having been set by medical colleagues.

3. Re-focus on the delays contributing to length of stay before patients are 'medically fit' for discharge.

Analysis of acute provider length of stay within this report shows that the length of stay both before and after someone is deemed medically fit for discharge is increasing (0.7 days and 0.5 days on average respectively), in part linked to the fact that people are also more unwell on admission to hospital. There is a significant opportunity to reduce the delays associated with diagnosis and medical optimisation of patients for whom acute hospital admission is necessary. These include:

- improving availability and inclusion criteria for interventions which can be delivered out of hospital, through enhanced care at home, including IV anti-biotics/therapy, virtual frailty, and respiratory services
- rigorous application of ward and board rounds including 'Red to Green' adoption
- seeking to increase the capacity of inpatient diagnostics to match demand
- elimination of delays to discharge from access to pharmacy and other enabling services.

All NHS leaders who contributed to this work acknowledged that the adoption and application of these critical services and approaches remains inconsistent. They recognised that without an on-going focus (due to the high volumes of patients involved), this can quickly result in a significant impact on overall acute occupancy.

4. Prioritise building the capacity of home-based intermediate care.

The evidence in this report has demonstrated that the most significant area where demand exceeds capacity for community services is in home-based intermediate care. This is supported by the data in Figure 20 which demonstrates that awaiting home-based support (Pathway 1) is the most significant cause of delays for complex discharges, once someone no longer has criteria to reside in the hospital. Moreover, when people are unable to benefit from this support, their long-term independence is compromised, with more intensive ongoing care being required. Too often patients who have been placed in inappropriate non-therapeutic care beds (who with the right reablement and recovery support could have regained their independence), spend the rest of their lives in long-term residential care.

Wherever possible, additional funding should be invested to grow the capacity of these services. A particular focus should be placed on the role of therapists, to lead the delivery of home-based reablement and rehabilitation. Whilst this can be challenging to achieve with short-term funding, the investment case is compelling.

Alongside investing in growing capacity, significant progress can be made to optimise the capacity already available. Tackling staff productivity, the efficiency of scheduling processes, and staff rotas and travel time optimisation can lead to significant gains.

5. Unblock and optimise bed-based intermediate care.

The evidence presented in this report demonstrates that, nationally, just 11.6% of people in short-term beds leave these beds on time once they are deemed to no longer need to be there. It is commonplace in health and social care systems to see people who are discharged from the acute hospital to short-term beds who are then unable to get home in a timely way – this leads to further deconditioning and ultimately a temporary bedded placement becoming permanent.

Timely discharge from these beds maximises the likelihood of going home after a stay in a short-term bed, with a smaller overall package of care to meet ongoing needs. To achieve this, and to maximise the effectiveness of the service, it is important that along with any physiotherapy and occupational therapy support, the person also receives a targeted and stretching package of recovery and reablement. To enable this, it is critical that there is appropriate supply of ongoing care and support.

Effective bed-based intermediate care can help around two-thirds of its population to return home (as found in '*Measuring and optimising the efficiency of community hospital inpatient care for older people*' by Young, Hume, Smith et al in their January 2020 study). This requires a multi-disciplinary team, including therapists and other clinical support (geriatrician, doctors, or nurses) working collaboratively with care staff with a shared ethos of prioritising independence. These bed-based facilities need to have good links to local community-based services so that people can move to their own bed and readily have the support they require.

Some systems are beginning to report that they are seeing improving capacity in ongoing care and support, partly due to the efficacy of recruitment drives. However, delays remain in short-term beds whilst this care is sourced. To mitigate this, the assumption should be that anyone being discharged into a short-term bed will always need some form of further support afterwards (either home-based support or a permanent bed) and as such the sourcing of this should begin from the point of admission to the short-term bed.

b. Longer-term priorities

1. Ensure comprehensive data visibility across the system.

One of the most common issues raised by those engaged in this programme of work was the lack of trusted data available to support decision-making. By contrast, those systems that have been able to design, deploy, and actively use timely digital insight about the demand and capacity of each service have seen marked improvements in performance, even when services and pathways have not been optimised.

While there are complexities in achieving this, including navigating information governance and the responsibilities to use personal data appropriately, the benefit of getting this right is significant. Importantly, this data needs to be supported by appropriate skills development for the individuals using it, so they have the confidence to make data-driven decisions.

There are three situations where this insight can add real value:

i. **Clinical workflow:** clinicians need to be able to understand their current clinical workflow – who are their patients, where are they now, what do they need, and where do they need to go next?

ii. **Tactical management:** service management teams need to be able to see the demand facing their services now, and up to three months into the future. With this information they can take decisions about where and how to use their resources, where they need to flex to meet spikes in demand and how to do so in a way that is operationally and financially sustainable.

iii. **Strategic commissioning (and demand and capacity planning):** insight from system visibility tools can be used to build richer pictures of longer-term trends. This can inform strategic commissioning decisions including, the nature and scale of services, the impacts on the provider market, workforce requirements, funding streams, and patient and population outcomes.

2. Optimise demand and capacity planning.

DHSC issued guidance in April and July 2022 which suggested that health and social care commissioners should consider how capacity across the system is being used and how it is built up to meet local demands.[51]

As explored in section seven, most health and care systems have a mismatch in demand for, and capacity of, critical intermediate care and community services, implying that this guidance is not currently being consistently followed. In part, this has been influenced by the additional £200 million announced in January 2023 which was specifically for buying care beds ("to ease the NHS crisis"). This has hindered the development of an evidence-based view of the right capacity of services to meet local demand.

Optimising system demand and capacity plans is the mechanism by which this mismatch can be resolved, enabling commissioners to understand demand from the flow of patients out of hospital (and from admission avoidance) so that the right level of service is commissioned to meet local needs.

The basics of an optimised demand and capacity plan are:

- Understand the demands from the current population; this can be achieved by a combination of looking at the current patterns of the needs of discharged patients and discussing with the multi-disciplinary discharge team how many patients each week have moved onto a different care pathway than initially proposed.
- Understanding where there is a shortage in the capacity from those arranging the discharges.
- An analysis of the current patterns, to take a view on what the future patterns of demand might look like and how the supply needs to change to meet predicted need.

It is also important to recognise that, in some places, changing commissioning decisions and building a new set of intermediate care services may take several years.

A short-term plan may be needed to sit alongside a long-term plan to meet the competing needs of the here and now and future requirements.

For local systems to develop their capacity and demand plans it is essential that:

- There is a common and trusted set of demand and capacity data (as explored in the previous recommendation).
- The strategic commissioning team is a joint team between health and social care.
- Strategic commissioners are skilled in interpreting this data and have appropriate local knowledge of what services might be best to meet the needs of the local population.

3. Support effective practice and decision-making through the discharge process.

A consistent theme observed throughout this report is the impact of risk averse decision-making, which results in people receiving more intensive care and support than they need, limiting their long-term independence and often exacerbating delays in the hospital. All those involved in transfers of care must work to ensure people leave the hospital as soon as it is safe for them to do so, and that their independence is maximised.

Optimised systems invest time and resources to review, improve, and where necessary redesign systems, processes, and ways of working such that this is achieved. There are several practice principles which enable this, which require behavioural and cultural development to embed sustainably across the workforce:

- **Home first:** home must be the default decision. There should be an opportunity to challenge on 'why not home' for anyone awaiting Pathways 2 or 3, to allow space to encourage more independence-focussed decisions, and to better understand gaps in service provision to feed demand and capacity planning.
- **Goal-based recovery:** to achieve the best outcomes, all individuals in receipt of intermediate care will have been at the centre of creating their own specific and clear independence goals, in conjunction with and supported by multi-disciplinary practitioners and other stakeholders.
- **Decisions in the right place:** long-term support decisions taken outside of a hospital setting will lead to more independent outcomes. Describing someone's needs building on their strengths rather than prescribing specific support can enable better independence-focussed decision making.
- **Right people involved at the right time:** community practitioners being involved in discharge decisions leads to more independent outcomes as they better understand risk management in the community. Multiple people involved in decision-making leads to a better outcome, including social workers with strong relationships in wards and who can challenge during multi-disciplinary team reviews, along with occupational therapists.

4. Develop and deliver effective and targeted prevention.

The notion of prevention has been around for some time, whether that is public health concepts around universal interventions to improve the health of the population, or more targeted and specific interventions to pre-empt a crisis. However, clear evidence and a solid business case have often been lacking.

A more robust evidence base is now beginning to emerge around targeted and proactive prevention. Advancing use of data and artificial intelligence is enabling sophisticated modelling to identify specific cohorts of individuals who are at future risk of being admitted to hospital, or who require a significant intervention from health and care services. The same technology can also allow more reliable evaluation of the efficacy of interventions.

The case study included in this report from Norfolk County Council in section seven demonstrates emerging evidence of the potential to use this technology to identify and prevent 1,300 older adults falling each year (and subsequently being admitted to hospital) by better targeting existing community services. The financial impact of this in Norfolk alone is £5-£6m per year, with myriad further use cases still to be explored.

It is important that local systems begin to act now to capitalise on this opportunity and build a local strategy around effective and targeted prevention. This will require partnership working, a trusted source of data, and people with the right capabilities and skills working in the system to work with the data and lead the required operating model and service model re-design. Developing this capability now will result in sustainable outcomes and operational and financial improvements over the medium to long term.

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Workings behind the infographic on 'Impact of optimised hospital flow and discharge' on pages 10, 11 and 86, 87.

Avoiding people being admitted to hospital

30% of 1.6m admissions of older adults could be avoided every year.

The interventions outlined in this report are anticipated to affect around a third of these avoidable admissions.

Reducing unnecessary delays when someone is in hospital

The average observed delay for older adults during treatment is 1.9 days.

For 1.6m admissions, this equates to three million bed days.

The interventions outlined in this report are anticipated to affect around a sixth of this opportunity.

Approximately 18,000 bed days are lost each week due to the uneven profile of Pathway 0 discharges through the week, equating to nearly one million days per year.

The interventions outlined in this report are anticipated to affect around half of this opportunity.

There could be 440,000 bed days saved by reducing discharge delays on Pathway 1 – a saving to the NHS of £176m.

- 273,000 people are discharged on Pathway 1 each year.
- The average discharge delay observed on Pathway 1 is 4.1 days.
- This gives a total number of days lost of 1m, and the interventions outlined in this report are anticipated to affect around 40% of this opportunity.

There could be 300,000 bed days saved by reducing discharges on Pathway 2 – a saving to the NHS of £120m.

- 137,000 people are discharged on Pathway 2 each year.
- The average discharge delay on Pathway 2 is 5.5 days.
- This gives a total number of days lost of 750,000, and the interventions outlined in this report are anticipated to affect around 40% of this opportunity.

There could be 400,000 bed days saved by reducing discharges on Pathway 3 – saving the NHS £160m.

- 100,000 people are discharged on Pathway 3 each year.
- The average discharge delay on Pathway 3 is 10.2 days.
- This gives a total number of days lost of 1m, and the interventions outlined in this report are anticipated to affect around 40% of this opportunity.

Optimising long-term outcomes when people are discharged from hospital

21,000 people could be discharged on Pathway 0 instead of Pathway 1 each year.

15,000 people could be discharged on Pathway 1 instead of Pathway 2 each year.

7,000 people could be discharged on Pathway 2 instead of Pathway 3 each year.

If you would like to discuss the findings of this report or have any questions, please contact:

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