**Notice of a public meeting of** — **Care and Independence and Housing Overview and Scrutiny Committee**

**To:** **Councillors Caroline Dickinson, Karl Arthur, Heather Moorhouse, Karin Sedgwick (Chair), Roberta Swiers, Nigel Knapton, Andy Brown, Pat Marsh, Robert Heseltine, Jack Proud, Eric Broadbent (Deputy Chair), George Jabbour, Andy Paraskos, Phillip Barrett and Peter Lacey.**

**Jillian Quinn & Mike Padgham.**

**Date:** **Thursday, 7th December, 2023**

**Time:** **10.00 am**

**Venue:** **Brierley Room, County Hall, Northallerton, DL7 8AD**

Members of the public are entitled to attend this meeting as observers for all those items taken in open session. Please contact the Democratic Services Officer whose details are at the foot of the first page of the Agenda if you would like to find out more.

This meeting is being held as an in-person meeting.

Recording is allowed at Council, committee and sub-committee meetings which are open to the public, please give due regard to the Council's protocol on audio/visual recording and photography at public meetings. Anyone wishing to record is asked to contact, prior to the start of the meeting, the Democratic Services Officer whose details are at the foot of the first page of the Agenda. We ask that any recording is clearly visible to anyone at the meeting and that it is non-disruptive.

## AGENDA

**1. Welcome and Introductions**

**2. Minutes of the Meeting held on 22nd June 2023** **(Pages 5 - 10)**

**3. Apologies for Absence**

**4. Declarations of Interest**
All Members are invited to declare at this point any interests they have in items appearing on this agenda, including the nature of those interests.

**5. Public Participation**

Members of the public may ask questions or make statements at this meeting if they have given notice to Christine Phillipson of Democratic and Scrutiny Services (contact details below) and supplied the text by midday on Monday 4th December, three working days before the day of the meeting. Each speaker should limit themselves to 3 minutes on any item. Members of the public who have given notice will be invited to speak:-

- at this point in the meeting if their questions/statements relate to matters which are not otherwise on the Agenda (subject to an overall time limit of 30 minutes);

- when the relevant Agenda item is being considered if they wish to speak on a matter which is on the Agenda for this meeting.

If you are exercising your right to speak at this meeting, but do not wish to be recorded, please inform the Chair who will instruct anyone who may be taking a recording to cease while you speak.

**6. Chair's Statement - Correspondence, communication or other business brought forward by the direction of the Chair of the Committee.**

**7. Adult Social Care Pressures and Charging Reform (Trailblazer) - Report from Anton Hodge, Assistant Director Resources, Resources Management Team.** **(Pages 11 - 18)**

**8. Suicide Prevention - Presentation from Dr Victoria Turner, Public Health Consultant & Dan Atkinson, Public Health Manager.** **(Pages 19 - 30)**

**9. Housing Strategy Update - Update from Sharon Graham, North Yorkshire Housing Strategy Manager.** **(Pages 31 - 62)**

**10. Dementia Care - Update from Abi Barron, Assistant Director, Prevention and Service Development & Mike Rudd, Head of Housing Market Development Accommodation.** **(Pages 63 - 74)**
For Information - Welcome to Dementia Forward, Dementia Forward, North Yorkshire's leading dementia charity

**11. Kirkwood Hall Visit Feedback - Committee Discussion following the visit to Kirkwood Hall on 21st November.**

**12. Development of the Integrated Care Systems and Partnerships that cover North Yorkshire - Presentation from Richard Webb, Corporate Director of Health and Adult Services.** **(Pages 75 - 78)**

**13. Work Programme** **(Pages 79 - 86)**
Report of the Democratic Services and Scrutiny Officer

**14. Any Other Items**
Any other items which the Chair agrees should be considered as a matter of urgency because of special circumstances

**15. Report for Information - Finding a Way Home - County Council's Network Report** **(Pages 87 - 190)**
How health and social care can optimise hospital flow and discharge this winter to improve outcomes and performance.

**16. Date of Next Meeting**
The next Committee meeting is on Thursday 28th March 2024 at 10am in the Brierley Room, County Hall, Northallerton.

**Members are reminded that in order to expedite business at the meeting and enable Officers to adapt their presentations to address areas causing difficulty, they are encouraged to contact Officers prior to the meeting with questions on technical issues in reports.**

Barry Khan
Assistant Chief Executive
(Legal and Democratic Services)

County Hall
Northallerton

Wednesday, 29 November 2023

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# North Yorkshire Council

## Care and Independence and Housing Overview and Scrutiny Committee

Minutes of the meeting held on Thursday, 22nd June, 2023 commencing at 10.00 am.

Councillor Karin Sedgwick in the Chair plus County Councillors Caroline Dickinson, Karl Arthur, Heather Moorhouse, Roberta Swiers, Nigel Knapton, Andy Brown, Robert Heseltine, Jack Proud, Eric Broadbent, George Jabbour, Andy Paraskos and Phillip Barrett.

Councillors Bridget Fortune, Joy Andrews and Pat Marsh attended remotely.

Officers present: Christine Phillipson, Principal Democratic Services and Scrutiny Officer, Mike Rudd, Head of Housing, Technology & Sustainability, Prevention and Service Development, Claire Bell, Service Manager, Technology Enabled Care, Cath Ritchie, Business Relationship Manager, Beckie Dukes, Strategic Service Development Manager, Cath Simms, Head of Targeted Prevention, Toya Bastow, Team Manager, Direct Payments, Andrew Rowe, Assistant Director, Housing.

Other Attendees: Councillor Michael Harrison joined remotely.

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**Copies of all documents considered are in the Minute Book**

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**1 Minutes of the meeting held on 2 March 2023**

That the minutes of the meeting held on 2 March 2023 be taken as read and confirmed by the Chair as a correct record.

It was noted that at item 5, climate change training had been opened out for voluntary and community sector participation by Jill Quinn and it was asked if this had been undertaken ?. This will be followed up with Jill and an update given at the next meeting.

It was noted By Cllr Andy Brown that at agenda item 9 of the minutes, performance measures were requested for review. It was confirmed that these are regularly reviewed by the Executive and were available for the Committee to review should they require.

**2 Declarations of Interest**

There were none.

**3 Public Questions or Statements**

None were received.

**4 Chairman's Remarks - Correspondence, communication or other business brought forward by the direction of the Chairman of the Committee.**

The Chair noted that as all information had been published in the agenda already,

presentations would only cover this briefly therefore allowing more time for Members questions and discussion.

**5 Next Generation Extra Care - Update from Mike Rudd, Head of Housing, Technology & Sustainability, Prevention and Service Development, North Yorkshire Council.**

Considered – An Update from Mike Rudd, Head of Housing, Technology & Sustainability, Prevention and Service Development Beckie Dukes, Strategic Service Development Manager, North Yorkshire Council.

This covered the following main points;

- Celebrating 20 years of extra care housing in North Yorkshire
- What extra care is and how it is delivered across the County
- How the programme works and how it varies depending on location
- The Team and their success
- Demand and financial implications
- Extra care providers and the commissioning model
- Community schemes to add value
- The way forward.

There then followed a discussion with the following points being raised;

Congratulations on the delivery of the 5 new schemes and the positive feedback from residents.
The suggestion of a site visit to Kirkwood Hall for Members in the near future.
How information on facilities and schemes can be distributed to rural areas.
Whether there was currently a higher demand than supply for extra care.
Commissioning an independent report to look at areas, catchment, data and statistics and trend information.
The scope of land required to build a new facility being 2-3 acres.
The challenge of rural planning and escalation of costs.
An ageing population in certain areas of the County.

Resolved –

1. The Chair thanked Mike and Becky for their update and discussion.
2. That the possibility of a visit to Kirkwood Hall for the Committee be looked into.

**6 Digital Lives - Update from Mike Rudd, Head of Housing, Technology & Sustainability, Prevention and Service Development, North Yorkshire Council.**

Considered – A presentation from
Mike Rudd, Head of Housing, Technology & Sustainability
Cath Ritchie, Business Relationship Manager
Beckie Dukes, Strategic Service Development manager
Claire Bell, Service Manager, Technology Enabled Care

Claire updated the Committee on the digital aspect within the Health and Adult Social Care Directorate covering, Technology and Transformation, Adult Social Care, Public Health and Stronger Communities.
Key points to note were;

- The digital network and the vast areas this covers
- Funding and strategy

- Success in different forms, not simply computers
- Getting the basics right
- Proactive and preventative services
- Examples of the services in use.

The Committee were then introduced to some of the different types of digital assistance in use such as brain in hand, GPS tracking, GEO fence and Oysta.

There then followed a discussion which covered the following points;

Current work with Sheffield University is successful and will ensure ethics are adhered to and prevent poor copies of digital items being re produced.
Consent and understanding from the individual or family is absolutely paramount and the utmost priority in the use of any digital enablement.
How do the survey results compare, are they improving and how many individuals are using the service and is there a waiting list?
There are approx. 1800 units currently in operation and no waiting list.

Resolved –
The Chair thanked the team for the presentation.

**7 Support for Unpaid Carers - Report from Cath Simms, Head of Targeted Prevention, Care and Support, Health and Adult Services, North Yorkshire Council.**

Considered – Presentation from Cath Simms, Head of Targeted Prevention, Care and Support.

Cath gave the Committee a presentation around the work that North Yorkshire Council does to support unpaid carers. This focused on the Carers assessment and Support Plan, information and guidance and the different types of support available.
The number of unpaid carers in England and Wales is approx. 5 million, of which 53,723 are in North Yorkshire. Likely lines of enquiry by the Care Quality Commission were discussed and the priorities identified in an improvement plan, those being:

- Leadership, Practice and Performance
- Co – Production, engagement and strategy
- Commissioned services for carers.

There followed a discussion around the following points of issue:
Budget reductions being reflected in care packages
Are we aware of family members that don't necessarily see themselves as carers ?
How do we check on the wellbeing of the "looked after" person, how does safeguarding fit here ?

Resolved –

1. The Committee is asked to note the report
2. The Chair thanked Cath for the presentation and invited her to return to a future Committee meeting with an update.

**8 Direct Payments - Report from Cath Simms Head of Targeted Prevention, Care and Support and Toya Bastow, Team Manager, Direct Payments, Care and Support, North Yorkshire Council.**

Considered – Presentation from Cath Simms, Head of Targeted Prevention, Care and Support, and Toya Bastow, Team Manager Direct Payments, Health and Adult Services.

Toya gave an update to the Committee that covered:

- What a direct payment is
- Who can access these payments
- How direct payments can be used
- Comparative data with regional neighbours and England
- The statistics in relation to North Yorkshire Councils position
- Improvement plan to increase the uptake of direct payments
- Some of the changes already made and other planned activities going forward.

The Committee gave its support in helping to raise awareness of direct payments and how the whole organisation can promote this.

Resolved – The Chair thanked Cath and Toya for the update and suggested they return to the Committee in the future with a further update.

**9 Living Well - Update report from Cath Simms, Head of Targeted Prevention, Care and Support, Health and Adult Services, North Yorkshire Council.**

Considered – A presentation from Cath Simms, Head of Targeted Prevention on Living Well.

This reminded the Committee of the background to living well and the team having an overall aim of preventing reducing or delaying the need for social care.
Annual referrals continue to increase and now stand at 3930 for April22 to April23.
Cath covered the performance outcomes and key developments and gave a statistical summary of activity.
The Homes for Ukraine scheme (HFU) continues to receive support with 1287 arrivals since March 2022.

Priorities for the next 12 months are:

- Domestic abuse
- Falls
- Community collaboration
- Autism accreditation.

Resolved – The Chair thanked Cath for the update.

**10 An Overview of Housing - Verbal Update from Andrew Rowe, Assistant Director, Housing, North Yorkshire Council.**

Considered – Andrew Rowe, Assistant Director, gave a verbal update on Housing and how this now sits in the Community Development Directorate.

Andrew updated the Committee on the Council's acquisition of 8.5k council homes following the cessation of the 7 District and Borough councils. Housing covers a number of aspects including:

- Homelessness
- Prevention and accommodation
- Regulation of landlords
- Houses of multiple occupation
- Disabled facility grants
- Retro fitting and energy efficiency
- Enforcing standards.

Many of these areas are statutory and will receive scrutiny from Central Government.

The Committee then discussed in some detail their view on their remit and responsibility within Housing and that the care and independence specific did not suggest that all of the housing remit would be covered by this one Committee.
This led to a discussion raising the following questions:

- Where does it sit?
- What is the Committee's remit?
- How do we help the Directorate?
- What are the requirements of the Committee?.

The Committee is keen to help and make a difference. The Committee suggested that a recommendation is made to the Executive that a separate Housing Overview and Scrutiny Committee is created.

Resolved –

1. Clarification is sought on the way forward and the remit of this Committee in relation to its housing responsibility.
2. The Committee liaises with relevant Officers and/or Constitution Working Party to seek clarity on the remit of Housing within the Care and Independence Committee.

**11 Work Programme**

Considered – The Committee's work programme.

- The objective is to enable the Committee to review the work programme and make suggestions on areas of scrutiny for inclusion for the remainder of the year and prioritise accordingly.

The Committee discussed the work programme and as well as the items on the programme the following was suggested;

- The possibility of the Member visit to Kirkwood Hall
- Report presenters having relevant statistical and performance data to accompany their reports in future.

**12 Other business which the Chairman agrees should be considered as a matter of urgency because of special circumstances.**

There was no further business.

The meeting concluded at 12.50 pm.

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**NORTH YORKSHIRE COUNCIL**

**CARE AND INDEPENDENCE AND HOUSING OVERVIEW AND SCRUTINY COMMITTEE**

**7 DECEMBER 2023**

# HAS FINANCE PRESSURES UPDATE, including update on work relating to ASC Charging Reform

## 1.0 Purpose of Report

1.1 This paper highlights the Q2 financial position facing HAS as at December 2023, the management action that is being taken in response to ongoing pressures, and also sets out some of the background to the financial pressures being faced by the council and the social care sector as a whole. The paper also notes that the government's proposals to change the way and amount that people pay for care for social care have been stood down for the time being.

## 2.0 The Health and Adult Services Budget

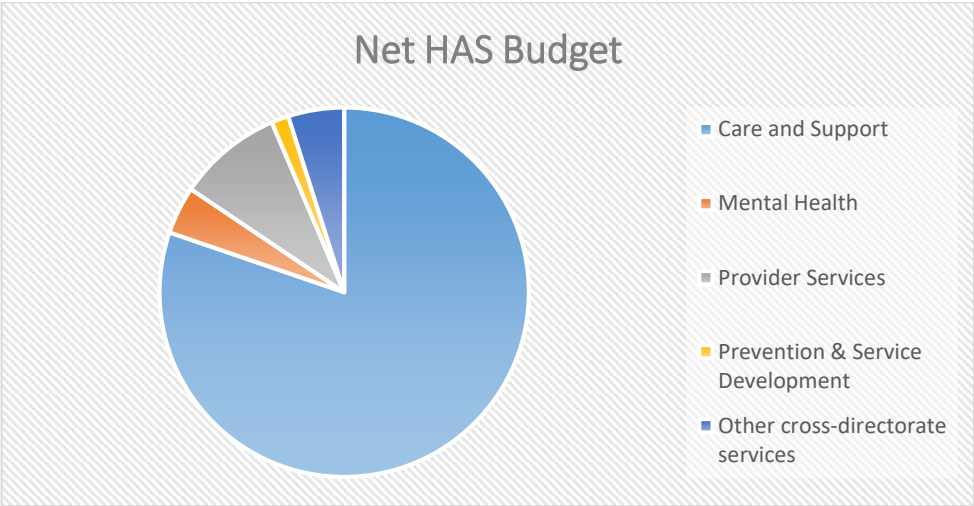
2.1 The HAS Directorate budget includes Adult Social Care, Public Health and some whole directorate costs.

2.2 In 2023/24, the current gross budget is £341m as shown below:

| | **2023/24 £m** |
|---|---|
| Net Directorate Budget | 223 |
| Public Health | 24 |
| Other income and grants | 94 |
| Directorate Gross Budget | 341 |

2.3 Of the net budget, the largest area of spend is on Care and Support as shown below:

| | |
|---|---|
| Care and Support | 80.2% |
| Mental Health | 4.2% |
| Provider Services | 9.2% |
| Prevention & Service Development | 1.5% |
| Other cross-directorate services | 4.9% |
| | 100% |




## 3.0 HAS Financial Pressures

3.1 The latest figures for the Health and Adult Services Directorate shows that an overspend of £2.2m is expected in the current financial year. This is a worsening position from Q1, where the directorate was forecasting to overspend by £0.5m, and this is after the Council's receipt of additional one-off Market Sustainability and Improvement Workforce Funding of £3.7m in the quarter, of which £2.9m is supporting the increased costs.

3.2 It is important to note that to arrive at the Q2 position, the directorate will need to utilise all of the additional growth and contingencies set aside as part of the budget setting process.

3.3 The impact of the implementation of the new Approved Provider Lists (APL) is continuing to cause budget pressures within the service. The new rates charged by providers are generally higher than before and while those new rates only apply to new placements or packages of care, the numbers are showing a more rapid conversion to them than expected. Work is therefore being undertaken to understand this pattern and to ensure that rates are being correctly applied.

3.4 We are continuing to see increasing high-cost packages of care and average costs are continuing to increase each quarter. For example, 27 new high cost residential and nursing packages have been identified in the quarter, increasing gross costs by around £2.9m. Containing such costs is one of the Directorate's key financial priorities over the next few years, as well as ensuring that we receive the right level of NHS funding when care costs cover both health and social care needs and we have incorporated our assumptions about Continuing Health Care (CHC) income. Work is already underway with a new CHC team to ensure consistency of practice and approach and that all eligibility of funding is achieved; this will be followed up with a Deep Dive into CHC practice in December.

3.5 Increased Discharge Costs. We continue to see very high levels of hospital discharge activity, with an average of 14.2 per day in Q2. This is a small improvement since Q1 but we note that activity in September averaged 15.4 per day. On some days (one in four), there were over 20 discharges. The critical factor continues to be localised

surges in the number of discharges, which can quickly use up available domiciliary care capacity necessitating use of short-term care beds instead.

3.6 The headline figures mask some areas of progress. For example, another key priority for the service is to manage down the number, length, and therefore cost of, short-term placements. Work has already started on this, and we are estimating a reduction in-year of around £0.8m as other types of support are implemented. We expect this trend to grow and costs to reduce more in future years.

3.7 We are also seeing a significant reduction in one-off support to providers. While inflationary pressures arising from cost of living and recruitment issues in the provider market remain, the number of requests in the quarter for such support have decreased considerably in the past twelve months. Those approved in quarter have resulted in additional annual costs of around £0.2m. This compares with a figure of £1.8m this time last year.

3.8 Many of the financial pressures are arising from issues in the market and these are illustrated further in the next section.

The Social Care Market

3.9 There are two major issues which are impacting on what we pay providers. The first of these is the continuing impact of implementing the Actual Cost of Care (ACOC) Exercise for residential and nursing care. Transition towards this began in April 2022 and this meant that the new rates are to be implemented for existing (legacy) packages over three years. As all new placements are guaranteed to be paid at the ACOC rate, we will have full ACOC coverage by April 2024. The rates for 2023/24 are:

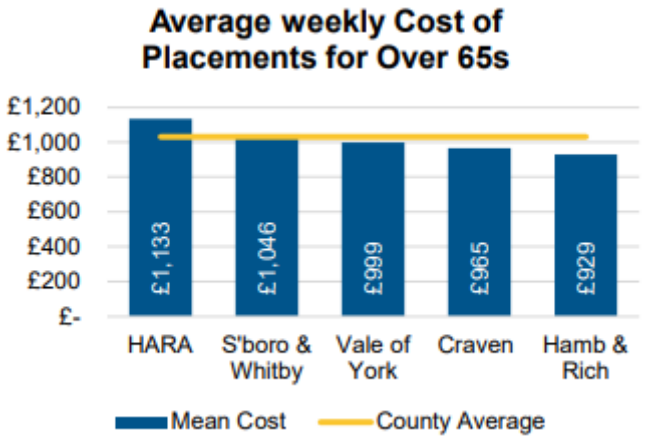
- Residential: £812
- Residential with Dementia: £854
- Nursing: £896
- Nursing with Dementia: £903

3.10 To recognise the significant cost of living pressures and high inflation, these rates were increased by up to 9.4% this year.

3.11 The second issue, as mentioned above is the implementation of the new Approved Provider Lists (APLs) for all types of residential, nursing, and homebased care, and Supported Living.

3.12 These changes, and other market pressures, continue to have a financial impact, and there are significant variations across local care markets. The greatest cost pressure continues to be evident in Harrogate.

3.13 The average cost of a care home placement for someone aged 65+ increased to £1,032 per week at the end of Q2, up by £20 per week compared with Q1. That represents a 14% (£130 per week) increase compared with the end of Q2 in 2020/21. These rates, shown by locality below, are clearly higher than ACOC.




3.14 For Home-based care, the APL rates charged by providers reflects the diverse market we have in North Yorkshire. We specify three types of rates:

- Urban
- Rural
- Super-rural

3.15 Currently, generic homecare rates range from £24.20 per hour (in the former Craven District area) to £28.96 (in Harrogate and Rural Alliance). Enhanced rates range from £25.43 (in the former Hambleton and Richmondshire district areas) to £29.21 (Harrogate and Rural Alliance). In each case the lower rate is Urban, the higher is Super-rural.

3.16 These rates are among the highest in the country. In July 2023 the Department of Health and Social Care (DHSC) published a report "Market Sustainability and Improvement Fund (MSIF): provider fee reporting 2023 to 2024[1]" which stated that the average rates paid nationally compared with North Yorkshire rates were:

| | England | North Yorkshire |
|---|---|---|
| Residential 65+ (per week) | £804 | £960 |
| Residential with Nursing 65+ (per week) | £937 | £1,213 |
| Residential 18-64 (per week) | £1,155 | £1,817 |
| Residential with Nursing 18-64 (per week) | £1,253 | £1,498 |

[1] https://www.gov.uk/government/publications/market-sustainability-and-improvement-fund-2023-to-2024-care-provider-fees/market-sustainability-and-improvement-fund-msif-provider-fee-reporting-2023-to-2024

| | | |
|---|---|---|
| Homecare (per hour) | £22.55 | £27.57 |
| Supported Living (per hour) | £20.06 | £24.37 |

3.17 In November 2023, the Homecare Association published its report: The Homecare Deficit[2]. In that it argued that many Local Authorities were not paying its recommended minimum hourly rate of £25.95 and that the average was in fact £21.59. North Yorkshire was one of few councils above this rate. The HCA's estimate for North Yorkshire, based on a sample week, was £27.80.

3.18 The extra cost in North Yorkshire is in part due to a rural premium that we have to pay. We have calculated that key ASC workers in the county spend 45 minutes on average as "downtime" – for each visit in rural areas. This compares with 20 minutes in urban areas. This is reflected in the rates we charge where costs in super-rural areas can add £4.50 to the hourly rate.

3.19 We have lobbied for many years about this cost and most recently, in our Market Sustainability Plan noted that sourcing packages of care in rural areas is particularly challenging. Delivering services in rural and super rural area is becoming unprofitable, resulting in providers refusing or handing back packages, and removing rural areas from their service footprint. Key factors include increasing fuels costs; workforce shortages; inability to secure office bases or create sustainable runs; and concerns about the safety and welfare of lone workers.

3.20 Some actions are being taken, as explained above, to reduce the reliance on (and therefore higher cost of) short-term placements. Our key priority over the next few years will be develop capacity in the market to ascertain if we can reduce the costs of care to a level closer to those seen elsewhere.

3.21 For example, and as set out in more detail in the Q2 Performance report to Executive on 28 November, we are continuing to explore options for Extra Care to increase the range and spread of alternative options to care home placements across the county. Where appropriate, Extra Care can support people at a lower cost in a setting that provides them with greater independence with access to care and support in response to their changing needs.

3.22 We are also exploring the possibilities of creating a Specialist Care approved provider list and undertaking a Specialist cost of care exercise. Currently, the authority does not have a tool to provide analysis and a standard evidence base to support its negotiations when challenging the care costs being put forward by providers. The exercise incudes discussions with other local authorities for their views on a regional tool to aid negotiation with regional providers, and a review of the available options, including Care Cubed, a system that brings together local demographic, economic, property and care market data to support decision-making.

3.23 We have also recently agreed membership of a Joint Commissioning Group with the local Integrated Care Boards (ICBs). The board, which reports to the local Health and Care Management Group has a particular remit around market development and joint procurements.

[2] https://www.homecareassociation.org.uk/resource/the-homecare-deficit-2023-pdf.html

3.24 Further details of how we might be able to arrest the high levels of cost growth in the market seen in recent years, and which cannot continue in the current financial constraints, are being explored for conclusion in the discussions around the future MTFS.

3.25 Despite the constant financial pressures, the Directorate is aware that it makes up 40% of the Council's budget and therefore needs to contribute where it can to the MTFS Savings programme. To ensure we have a good grip on financial management we have implemented the following areas of work and these continue to be maintained:

- Revised Scheme of Delegation and Approvals Process
- Budget Management Skills
- Improved Forecasting and other business processes
- Improved data monitoring and budget tracking
- Development of a budget performance and activity dashboard
- Practice Review meetings
- Introduction of training materials
- Professional Reasoning checklist
- Closer scrutiny of adult social care activity, practice and performance
- Clear exit strategies for temporary funding and projects
- Ensuring the correct split of costs between NYCC and NHS (especially Continuing Health Care) and people who use our services

## 4.0 ASC Charging Reform

4.1 In 2021, the government published proposals to reform how much individual people contributed towards the cost of social care. This would have meant that anyone with assets of less than £20,000 would not have had to pay anything towards the cost of care either at home or in residential care from October 2023. The proposals meant that people with more than £100,000 in assets would pay all such costs until they reached a maximum of £86,000. Those with assets of £100,000 or less would pay a means-tested proportion towards their care costs, again until they reached a maximum of £86,000.

4.2 North Yorkshire had agreed to be one of six "Trailblazers" for the new proposals and has been working with those other councils and the DHSC to look at the impact of the proposals.

4.3 In November 2022, the government confirmed that the reforms would be delayed for at least two years (until October 2025). Our concerns about the cost of the reforms have been well documented, however we agreed that there were some areas of work, begun as a Trailblazer, we could build on to bring improvements and cost savings to the service.

4.4 For example, we had determined that the extra workload created by the proposals (including a significant increase in the number of social care and financial assessments required) would mean an increase in staffing which would have been

difficult to recruit. Therefore, progress towards more digital self-service models – where appropriate – would greatly assist this. This is one area we have continued to pursue as it will deliver savings which will be much needed in the current financial climate.

4.5 In particular, the work to implement an online care act self-assessment and to improve the existing online financial assessment was identified as vitally important to help address ongoing issues with waiting lists and staff capacity. Online assessments will reduce the time required to identify eligibility for both care and financial support for an individual (see benefits) and help to manage demand at the front door.

4.6 Work has continued which focusses on the introduction of new technologies and processes to support better demand management, including the launch of an online self-assessment for care act eligibility, and a refresh of the online financial assessment tool. A business case was approved with the following objectives:

- Improve the customer experience of assessments and charging
- Introduce more effective systems and processes to manage demand for care act and financial assessments at the front door
- Contribute to the overarching HAS priority 'people get the right support at the right time'
- Ensure that assessments are relevant and proportionate
- Support customer channel shift to online self-assessment wherever it is appropriate to do so

4.7 At this stage the project has mostly achieved the milestones set out in the business case, with the governance approvals progressing as planned, as well as the online financial assessment (OFA) and client finance portal (CFP) launching within tolerance of the agreed Go Live date in August 2023. The launch of the Liquidlogic Adults and Delegation portals is scheduled for early next year.

4.8 Although it is still early days, initial data is showing an increase in the number of Online Financial Assessments being completed with the number in October (67) being more than double that of September (31). This performance will be closely monitored and will feed into further discussions around resources and impact on staff time.

## 5.0 Recommendations

5.1 Overview and Scrutiny Committee is asked to note the contents of the report.

RICHARD WEBB
Corporate Director, Health and
Adult Services

*Report Prepared by Anton Hodge, Assistant Director – Strategic Resources*

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# Suicide Prevention update

**7th December 2023**

Dr Victoria Turner – Public Health Consultant
Dan Atkinson – Public Health Manager

# Suicides in North Yorkshire

All sudden deaths that are **suspected** to be death by suicide are collated by local Coroner Officers and shared with Public Health. This enables epidemiological monitoring of patterns, trends, clusters or contagion and the completion of regular audits.

All suspected suicide deaths are monitored by Public Health, with quarterly, anonymised updates to key colleagues via the Safeguarding Adults Board and North Yorkshire Strategic Suicide Prevention group.

This information informs local priorities and actions, in addition to the ongoing development of the North Yorkshire Suicide Action Plan managed by the Strategic Suicide Prevention Group.

# Context

As part of the Suicide Prevention work that sits within the North Yorkshire Public Health team, we lead on the following:

- Establishment, and maintenance, of an Information Sharing Agreement with the local Coroner's Office
  - The information shared today is in accordance with that agreement
- Analysis of weekly suspected suicide data received from the Coroner's Office
  - This is not real time surveillance but includes data provided by the coroner using the Suspected Suicide definition (slide 4)
- Regular Coronial file audits and reports
- Management of the North Yorkshire Suicide Prevention Strategic Group to bring together the wider system on this topic
  - A Suicide Action Plan sits under this group that Public Health lead on the development and implementation of actions

# Definition

## Suspected Suicide – as agreed between Public Health and Coroner's Officer

- A sudden death identified by staff within the Coroner's Office as a suspected suicide as part of the **pre-inquest** process using information from a range of sources to help build **an initial understanding of circumstances of a death**.

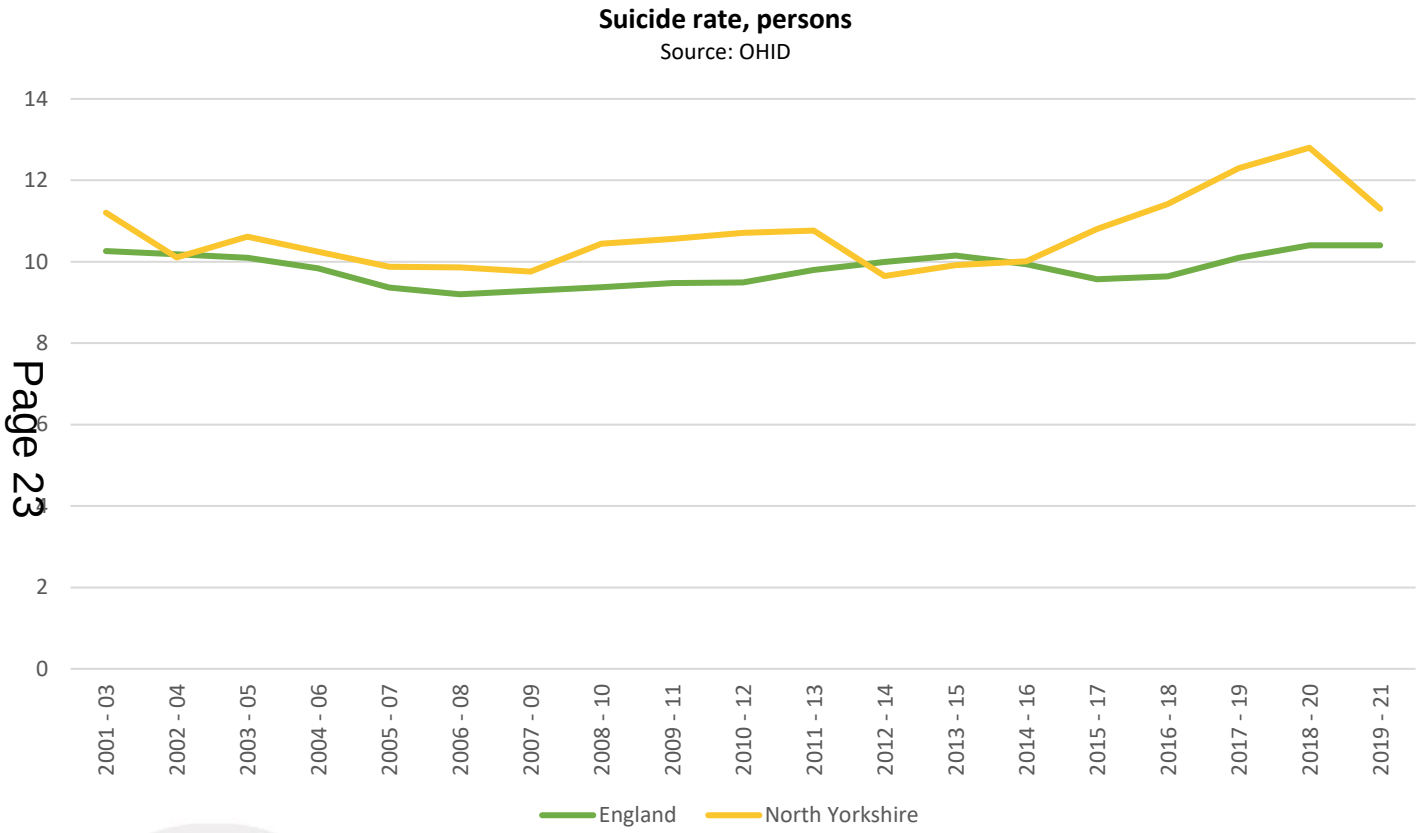


## Suicide

- A death in which a conclusion of suicide has been reached at Inquest. On the **balance of probabilities**, the Coroner is satisfied that they have died as a result of their own actions and that it was their intention to die.

NORTH YORKSHIRE COUNCIL

# Data - Suicides




The total number of suicides has decreased in North Yorkshire between 2018-20 and 2019-21.

The suicide rate has fallen from 12.8 per 100,000 in 2018-20 to 11.3 per 100,000 in 2019-21; similar compared to the England average.

There are a higher proportion of male than female suicides which is in line with the national trend.

# Local Developments

- North Yorkshire Suicide Prevention Strategic Group continues to meet quarterly with representation from key partners working across North Yorkshire.
- Public Health worked closely with partner organisations working in communities across the county to support development of funding ideas for the recent Government-led VCS Suicide Prevention Grants.
- Worked closely with key national partners within Suicide Prevention to strengthen local links and presence (e.g. Samaritans, Papyrus and SOBs).
- Supported organisations working within communities on specific projects to offer advice and guidance based on best practice and evidence.
- Postvention support offer continues to be made for any person bereaved by suicide to provide timely support and intervention.
- Development of a localised cluster response plan in line with national guidance

# Audit Process

- Most of the work undertaken by Public Health for Suicide Prevention occurs pre-Coronial inquest around suspected suicides (as per definitions)
- In line with national guidance, audits should be conducted of deaths in which a conclusion of suicide has been reached at inquest to inform local prevention work and action plans
- Audits allow a comparison of local suicide data and trends with those identified nationally and regionally, as well as highlighting local risk factors, "at risk" groups or areas of higher incidence
- The last audit was completed in 2021 for a review of deaths by suicide in 2017. Currently developing plans to conduct an audit of the intervening, full calendar years completed since the last audit was completed – likely to be 2018-2021.

# National Strategy

- New cross-government strategy published in September 2023 to lead on Suicide Prevention efforts across England from 2023 to 2028.
- Reflects that considerable progress has been made since the last strategy in 2012, and whilst the national suicide rate is not significantly higher than in 2012, it is not falling.
- Therefore, the aim of this cross-government strategy is to bring everybody together around common priorities across the NHS, local government, the voluntary, community and social enterprise (VCSE) sectors, employers and individuals.
- It sets out actions that can be taken to:
    - reduce the suicide rate over the next 5 years – with initial reductions observed within half this time or sooner
    - improve support for people who have self-harmed
    - improve support for people bereaved by suicide

# National Strategy – continued...

To achieve these aims, a range of priority areas for action have been developed including:

- The improvement of data and evidence to ensure that effective, evidence-informed and timely interventions continue to be adapted
- Provide tailored, targeted support to priority groups, including those at higher risk.
- Address common risk factors linked to suicide at a population level by providing early intervention and tailored support.
- Promote online safety and responsible media content to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm
- Provide effective crisis support across sectors for those who reach crisis point
- Reduce access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides
- Provide effective bereavement support to those affected by suicide
- Make suicide prevention everybody's business so that we can maximise our collective impact and support to prevent suicides

# Action Plan

- Underneath this new cross-government strategy there is a comprehensive action plan that sets out how this strategy will be put in to action, in addition to how it will be monitored across the course of its timeframe
- The recent VCS Suicide Prevention Grants were one of the key actions to stimulate activity within voluntary organisations who often lead community-based work
- Another announcement was the development of a new nationwide near real-time suspected suicide surveillance system that, once launched, will improve the early detection of and timely action to address changes in suicide rates or trends. Led by OHID, it launched on 30th November 2023
- The only actions where local authorities are cited as the lead agency reflect the need to ensure robust information is collated locally to inform interventions, as well as making use of local near real-time suicide surveillance systems to connect families, friends, carers and loved ones to bereavement support.

# Real-time Suicide Surveillance

- To establish a real-time suicide surveillance system in line with current international best practices, we conclude that the following criteria should be met:
  - a rapid, routine collection of provisional data sourced from at least one reliable data source to facilitate timely prevention efforts
  - ongoing data review to ensure high sensitivity
  - the development of a core, automated machine learning system to assist rapid data entry and quick transition to analysis
  - visualization
  - reporting of emerging spatial, temporal or spatio-temporal clusters, as well as risk factors and vulnerable populations on a need-to-know basis.
- Work is underway to review our current surveillance system in place to look at how to bring it in line with recommendations from the new strategy
- The development of the new national, near real-time dashboard will be considered as well to look at utilising existing data sharing routes to inform local practice



NORTH YORKSHIRE COUNCIL

# Questions

# North Yorkshire Council

## Care and Independence and Housing Overview and Scrutiny Committee

## 7 December 2023

## Draft North Yorkshire Housing Strategy 2024-29 Consultation

## Report of the Corporate Director Community Development

### 1.0 PURPOSE OF REPORT

1.1 The purpose of this report is to present progress on the Draft North Yorkshire Housing Strategy 2024-29 and to seek comment from the Care and Independence and Housing Committee as part of the official period of consultation, prior to consideration by the Executive on 19th March 2024.

### 2.0 BACKGROUND

2.1 A housing strategy is one of the fundamental strategic documents a local authority will adopt. Whilst there is no longer a statutory duty to do so, local authorities are encouraged to have an overarching strategic document which outlines their ambitions, priorities, and targets, a plan for how they will fulfill their role as a strategic housing authority. This enables the authority to demonstrate to residents, partners, funding bodies and government its strategic planning and organisational governance.

2.2 A housing strategy is separate to the Local Plan, it does not deal with the designation of land for housing development, nor does it set any directives on what housing development should look like or town planning considerations.

2.3 A housing strategy should provide a high-level evidence-based set of priorities and framework for how the local authority will improve housing conditions, access to housing and enforce standards across all tenures, how new homes will be enabled, how it will deliver landlord services and how residents will be supported to stay in their own homes.

2.4 This framework then provides the basis for the Housing Service and others, to conduct service planning, to develop specific actions plans to address identified priorities and to develop policy which supports its ambition.

**NORTH YORKSHIRE**

2.5 Alongside the housing challenges of delivery and household economic pressures faced at a national level, North Yorkshire contains diverse housing markets with varying housing needs and specific local challenges, such as:

- an ageing population,
- significant inequalities in health and social outcomes,
- sparsely populated rural communities and pockets of deprivation,
- a low wage economy,
- Increasing reliance on temporary accommodation for homeless households and associated spend.
- housing affordability and access to good quality homes,
- improving the energy efficiency of our housing stock and reducing fuel poverty,

- the impacts of Climate Change on our population and communities.

2.6 These challenges are accompanied by a raft of opportunities which exist across the county; to deliver housing growth through expanding our council housing stock and working in partnership on a Housing Growth Plan that links in with the housing aspirations of the Devolution Deal for York and North Yorkshire. Devolution presents opportunities to deliver housing at pace and meet our wider economic growth ambitions. The creation of a Mayoral Combined Authority and the new powers that this will bring, will also be a driver for our housing and economic growth ambitions.

2.7 As a result of Local Government Reorganisation, with effect from 1st April 2023 North Yorkshire Council became responsible for delivery of the full range of housing services across the county, including management of c8500 council homes. To meet the diverse housing needs of North Yorkshire, deliver the housing services required and to ensure that we take full advantage of the opportunities presented, the council will need to have a housing strategy in place.

## 3.0 THE STRATEGY

3.1 Prior to Local Government Reorganisation local authorities across North Yorkshire, York and East Riding had a shared YNYER Housing Strategy, this was last reviewed in December 2021 and that review formed the evidence base for the draft North Yorkshire Housing Strategy 2024-29 Appendix A.

3.2 The draft strategy sets out a vision to deliver: 'Good quality, affordable and sustainable homes that meet the needs of all of our communities.'

3.3 The ten priorities identified have been refined and grouped under three themes:

'Our People' is about meeting the housing needs of our population and particularly our older households, homeless households, those threatened with homelessness, and households with support needs. It also includes specific groups such as Gypsies and Travellers, Refugees, and Asylum Seekers.

Our key priorities for this theme are:

- Preventing and tackling homelessness
- Meeting the needs of our ageing population
- Meeting supported housing needs and the needs of specific groups

'Our Places' is about our towns, villages and neighbourhoods and the housing market challenges they face, and what we can do to tackle them.

Our key priorities for this theme are:

- Growing the supply of affordable and available housing
- Addressing the rural housing crisis
- Supporting communities through neighbourhood renewal and regeneration

'Our Homes' is about the challenges with our housing stock and how we can improve housing to ensure it is decent and affordable. We face huge challenges in ensuring that existing homes are decent, energy efficient, and can contribute to meeting our wider Climate Change aspirations. We also need to ensure that all new build housing meets the highest standards, and actively contributes to meeting our Climate Change aspirations.

Our key priorities for this theme are:

- Decarbonising homes
- Ensuring that new housing supply contributes to our net zero ambitions
- Addressing stock condition issues
- Ensuring that Council stock remains decent and continues to improve

3.4 Alongside adoption of the strategy, individual action plans will be developed for each theme to detail how delivery will be achieved, performance indicators introduced to monitor effectiveness of the interventions and a dashboard of key indicators developed to monitor the health of the local housing market.

3.5 Monitoring of delivery against the action plan and performance targets will be monitored by the Assistant Director for Housing on a quarterly basis and reported to the Executive Member for Housing Growth annually. The strategy will be reviewed after three years, or sooner should there be any significant change in national policy direction.

## 4.0 HOUSING STRATEGY CONSULTATION PROCESS

4.1 A programme of consultation is being undertaken, commencing 2nd October 2023 and ending on 11 December 2023. The public consultation is targeted at key partners and stakeholders, Registered Providers, Government agencies (such as Homes England) the Council's tenants and residents, and other key council services so that the strategy can be honed to ensure that it is relevant, ambitious and deliverable.

4.2 The outcomes of the consultation will shape the final version of the North Yorkshire Council Housing Strategy 2024-29. This will then be taken to the Executive for approval in early spring 2024, with a view to being adopted by the Council in May 2024.

## 5.0 RECOMMENDATIONS

5.1 It is recommended that:

- The Committee note the work undertaken preparing the Draft Housing Strategy 2024-29
- The Committee provide comment on the draft document, to be included in the summary of consultation responses to the North Yorkshire Council Executive in March 2024.

Nic Harne: Corporate Director, Community Development

Report Author: Vicky Young, Housing Policy and Strategy Officer

## BACKGROUND DOCUMENTS:

- Appendix A: Draft North Yorkshire Housing Strategy 2024 to 2029

- YNYER Housing Strategy Review 2021: YNYER-Housing-Strategy-Review-2021-to-2023_2.pdf (nycyerhousing.co.uk)

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# North Yorkshire Council Housing Strategy 2024 - 2029

## DRAFT

# 1. Introduction

This is the first housing strategy of the new North Yorkshire Council (NYC). It outlines our vision for housing across North Yorkshire, our priorities and the actions we will take. It provides a framework for the housing policies and projects we will deliver over the next five years.

North Yorkshire contains diverse housing markets, with varying housing needs and many challenges. Local Government Reorganisation has given us a once in a generation opportunity; to transform services, drive innovation and improve outcomes for our communities and the people who need it most.

We will take a proactive approach to housing delivery, and we will develop a bold plan to deliver more homes, including more affordable homes, working with partners, across North Yorkshire over the next five years.

Our strategy demonstrates how we will use the new combined strength of the unitary authority and the advantage of being a stock holding Council to unlock greater resources, access funding opportunities and accelerate housing growth and regeneration, ensuring that we deliver sustainably, and develop inclusive places.

We are an ambitious Council, keen to deliver excellent housing services and to be an exemplar social landlord.

We will lead by example, driving up standards across our Council housing stock and taking enforcement action where we find landlords who are failing to meet safety requirements, ensuring decent and safe homes for all residents.

## 1.1 What does North Yorkshire look like?

North Yorkshire is the largest county in England and Wales, at over 8,000 square kilometres. The population is approximately 620,000, similar to major cities such as Leeds and Sheffield. However, the population density is 77 people per square kilometre, compared with the national average of 432 per square kilometre – this means that we are mostly rural with only two towns (Harrogate and Scarborough) having a population of over 50,000.
Here are some more key housing facts:

**Population: 619,542**

**Population grown by 2.85% since 2011**

**25% of the population aged 65 or over**

**Working age population has fallen by 2.6% since 2011**

**Number of households: 274,381**

**Average No. of persons per household: 2.24, down from 2.33 in 2011**

**27% of housing stock built before 1919**

**18.7% of households rent privately**

**Average house price: £284,000**

**Average household income (after housing costs): £28,448**

**Average rent: £730 per calendar month**

**Over 108,000 residents limited by health and disability**

## 1.2 Strategic Context:

Housing and access to good quality affordable housing is critical to individual and community wellbeing. In strategic terms for the Council, housing is also:

- a driver for sustainable and inclusive economic growth,
- central to ensuring that our communities are sustainable and inclusive,
- vital to delivering our climate change ambitions and our net zero targets.

Within the North Yorkshire Council Plan (2023-2027), delivering "Good quality, affordable and sustainable housing that meets the needs of our communities" is a key ambition of the new Council. The Housing Strategy aligns with other key strategies within North Yorkshire including:

**Climate Change Strategy**

**Economic Development Strategy**

**Health and Wellbeing Strategy**

**Current Local Plans and future North Yorkshire Local Plan**

**York and North Yorkshire's Devolution Deal**

How we link with our strategic partners and work together is crucial to the Council meeting its housing objectives. We have a wide range of key partners including Homes England, the emerging Mayoral Combined Authority (MCA), Registered Providers (RPs), alongside our local voluntary and community sector, delivery partners, and communities.

Homes England has recently published its new Strategic Plan (2023-28) which puts a strong emphasis on levelling up, regeneration and on building a 'housing and regeneration sector that works for everyone, driving diversification, partnership working, and innovation'. We will work alongside Homes England to develop action plans that deliver for our communities.

## 1.3 Challenges

There are some big challenges in North Yorkshire that affect our residents and communities, and impact on housing:

- an ageing population,
- significant inequalities in health and social outcomes,
- sparsely populated rural communities and pockets of deprivation,
- a low wage economy,
- housing affordability and access to good quality homes,
- improving the energy efficiency of our housing stock and reducing fuel poverty,
- the impacts of Climate Change on our population and communities.

Additionally, the Covid pandemic harmed our housing markets, exacerbating housing availability and affordability challenges.

It also highlighted long-term pressures linked to entrenched deprivation, the erosion of support infrastructure and the lack of supported housing.

We now face a 'cost of living' crisis, the impact of which we are only just starting to feel.

## 1.4 Opportunities and Aspirations

Despite the challenges, there are some great opportunities available to us. We have an opportunity to deliver housing growth both through working in partnership and by expanding our council housing stock. Working alongside partners through the York and North Yorkshire Housing Partnership we will look to develop a Housing Growth Plan and shared housing pipeline for the partnership area that links in with the housing aspirations of the Devolution Deal for York and North Yorkshire. Devolution presents opportunities to deliver housing at pace and meet our wider economic growth ambitions. The creation of a Mayoral Combined Authority and the new powers that this will bring, will also be a driver for our housing and economic growth ambitions.

Our aspirations for housing over the next five years, include:

- Consolidating the Housing Revenue Accounts - bringing together Council owned homes, sites and landlord services; putting high management standards, safety, and involving our tenants at the heart of what we do.
- Developing a Housing Growth Plan, which will include growing our own Council housing stock.
- Exploring the housing development potential of publicly owned land, including Council owned sites.
- Working with the York and North Yorkshire Housing Partnership to deliver the right homes in the right place, retrofit our homes, and invest in employment opportunities, including green skills.
- Delivering on our commitment to be carbon neutral by 2034 and the economic opportunities that brings.
- Realising the potential efficiencies of being one council; in particular, working with Health and Social Care colleagues to meet the needs of vulnerable residents, enable capacity and reduce pressure.
- Using our capacity as a landlord and housing enabler to tackle inequalities, especially around health, social and digital exclusion, by coordinating and targeting resources, intervention, and support to best effect.

Whilst acknowledging that there are risks, we are confident that by working together with our partners we can realise these aspirations. We have:

- A combined reputation for developing and delivering quality affordable homes.
- A strong track record of partnership working with Registered Providers to deliver affordable homes that meet a variety of needs.
- Demonstrable success in attracting Government funding to deliver homelessness prevention, private sector housing improvements, enable rural housing, and rough sleeping reduction.
- Experience in working closely, through our locality structures, with communities and community led organisations to provide housing to meet local needs.

# 2. Our Vision and Key Themes

Our Vision is to deliver:
'Good quality, affordable and sustainable homes that meet the needs of all of our communities.'

**To do this we will work across three themes:**

- **Our People**
- **Our Places**
- **Our Homes**

These themes represent what housing is all about; it's not just about the bricks and mortar. It is about our people and places, and how we can as a Council, with our partners, use our resources to support them.

# 3. Theme 1: Our People

'Our People' is about meeting the housing needs of our population and particularly our older households, homeless households, those threatened with homelessness, and households with support needs. It also includes specific groups such as Gypsies and Travellers, Refugees, and Asylum Seekers.

**Our key priorities for this theme are:**

- **Preventing and tackling homelessness**
- **Meeting the needs of our ageing population**
- **Meeting supported housing needs and the needs of specific groups**

## 3.1 Preventing and tackling homelessness

Homelessness is a growing problem across North Yorkshire, exacerbated by the pandemic, and the on-going cost of living crisis. In addition, the supply of affordable housing in both the private rented and social rented sectors has significantly declined in the last three years. Despite these challenges we have achieved some successes in preventing homelessness, by taking proactive approaches to prevention and seeking innovative accommodation solutions.

As significant pressure remains, with sharp rises in the number of homeless assessments in some areas (Craven locality: increased by 71% from 2021 to 2022; Richmondshire locality: increased by over 250% from 17 to 60 in same period).

By far the biggest impact has been on the increased use of temporary accommodation for homeless households and the consequent increase in spending. As an example, within Scarborough, the cost of providing temporary accommodation increased from £281,000 in 2019/20 to £1.1 million in 2021/22. The use and cost of temporary accommodation is likely to continue to rise, as more households are threatened with homelessness and a reduced supply of "move-on" accommodation in both the private and social rented sectors.

### We will meet these challenges by:

- Bringing together homelessness prevention and support services across North Yorkshire to tackle homelessness, using a range of prevention tools, best practice, and interventions to prevent homelessness.
- Delivering new, innovative and existing accommodation solutions, including new temporary housing, and improving support and access to services.
- Doing all we can to reduce rough sleeping in North Yorkshire as much as possible, helping people live independent lives off the street.
- Undertaking a full Homeless Review, leading to a new Homelessness Strategy by 2025.

## 3.2 Meeting the needs of our ageing population

Currently one in four of our residents is aged 65 and over. The proportion of over 65s is predicted to increase further, with one in three of our residents expected to be 65 and over by 2035. Crucially, the number of over 85 year olds, who are more likely to use our services, is expected to grow by over 50% during the same period. We will need to develop our housing offer to ensure that it meets the needs of our growing older population.

We have had a successful Extra Care programme over the last 20 years, which has seen the provision of new Extra Care schemes in virtually all of our main settlements. We need to continue to develop similar services and also look at new models of Extra Care and other specialised housing for older people. We recognise that we cannot meet all needs through the provision of new specialist accommodation and many older households will choose to remain living in their own home. Our Home Improvement Agencies (HIAs) will be essential ensuring that as many older residents as possible are supported to live independently.

We know that some of our Council housing stock, which was developed specifically for older people, is not fit for purpose anymore and is becoming hard to let. We will update this stock to ensure that it meets the needs of our older households.

### We will meet these challenges by:

- Updating our extra care offer to meet changing needs, including developing new models of extra care to accommodate smaller schemes in rural areas, supporting those with complex needs, including working age people with learning and physical disabilities, as well as people with dementia,
- Working with Health and Social Care colleagues to ensure a holistic approach to meeting the needs of older people,
- Updating our own homes to provide improved specialist and adaptable housing for older people.

## 3.3 Meeting supported housing needs and the needs of specific groups

Supported housing needs vary across North Yorkshire and include the needs of those with physical and learning disabilities, and residents with mental health issues. 17.5% of residents in North Yorkshire were limited in some way by a health or disability. Whilst some residents with support needs will seek some form of specialist accommodation, many will want to remain living in their own homes.

For those with physical disabilities the Council's Home Improvement Agencies (HIA) in conjunction with Health and Social Care are well placed to support people living independently, including through the use of Disabled Facilities Grants (DFGs). Better integration with Health and Social Care is key to ensuring that we meet other supported housing needs, including learning difficulties and mental health needs, as well as families with children with disabilities. The Council now has a great opportunity to marry up its resources to meet all supported housing needs.

The retention of a structured housing pathway for care leavers through a joint partnership with Children and Young Peoples Services is a priority; ensuring that this is resourced effectively going forward.

We will continue to meet the housing needs of our Gypsy and Traveller communities, through the provision of both high quality and easily accessible sites and support services.

A more recent challenge has been the resettlement of refugees and asylum seekers across North Yorkshire. In parts of North Yorkshire, refugees and asylum seekers have been located in hotels and other temporary accommodation. As these communities begin to settle in local neighbourhoods, there is a need to support them to secure more permanent accommodation and provide on-going support services.

### We will meet these challenges by:

- Ensuring better integration of health and social care in line with the Start Well – Live Well – Age Well approach community based preventative pathways.
- Enhancing home improvement services to ensure that homes can be adapted to meet the needs of residents.
- Working together to deliver a more efficient and effective Young Peoples Housing Pathway.
- Helping residents to live independently with the aid of assistive technology, including undertaking an options appraisal of all available service delivery models.
- Supporting refugee resettlement pathways and support services via a dedicated refugee resettlement team.
- Ensuring that the housing needs of Gypsy and Traveller communities are met.

# 4. Theme 2: Our Places

'Our Places' is about our towns, villages and neighbourhoods and the housing market challenges they face, and what we can do to tackle them.

**Our key priorities for this theme are:**

- **Growing the supply of affordable and available housing**
- **Addressing the rural housing crisis**
- **Supporting communities through neighbourhood renewal and regeneration**

## 4.1 Growing the supply of affordable and available housing

Parts of North Yorkshire have some of the least affordable housing outside the South East of England, with property price/household income (after housing costs) ratios averaging 10 times across the whole of North Yorkshire in 2021, even reaching 13 times in the Harrogate locality. The average house price in North Yorkshire had risen to £284,000 in October 2022, an increase of over £100,000 in 12 years.

Affordability is exacerbated by North Yorkshire's low wage economy; median annual pay is as low as £20,000 in some locations, significantly below the national average of £26,000. This means that fewer local households can afford to purchase a home on the open market and are reliant on other forms of tenure. We understand that a lack of access to affordable housing acts as a barrier to economic growth, as well as putting pressure on the delivery of essential services as those on lower income struggle to access housing within our high value constrained housing market and we are committed to increasing the availability of affordable housing.

Home ownership levels are high in North Yorkshire with almost 70% of households owning their own home (England: 63.75%). By contrast social rented housing accounts for less than 12% of our households (England: 16.6%). In some localities (Craven, Harrogate) it is less than 10%. As a result, we have a chronic lack of affordable housing, particularly in some of our most expensive places to live.

We understand that a lack of access to affordable housing acts as a barrier to economic growth, as well as putting pressure on the delivery of essential services as those on lower income struggle to access housing within our high value constrained housing market.

"Our Places" are also affected by growing shortages of affordable private rented housing. The attractive nature of North Yorkshire makes it a popular holiday destination. Since the Covid pandemic the demand for 'staycations' has risen, which has resulted in an increase in the levels of short-term holiday lets.

Decreasing numbers of private rentals result in higher demand and rising rents, making private rented homes less affordable to would be renters on low incomes. It is also severely affecting the overall supply of residential housing in locations such as Whitby, Filey, coastal villages and much of our National Parks. As a result, we urgently need to increase the supply of affordable housing.

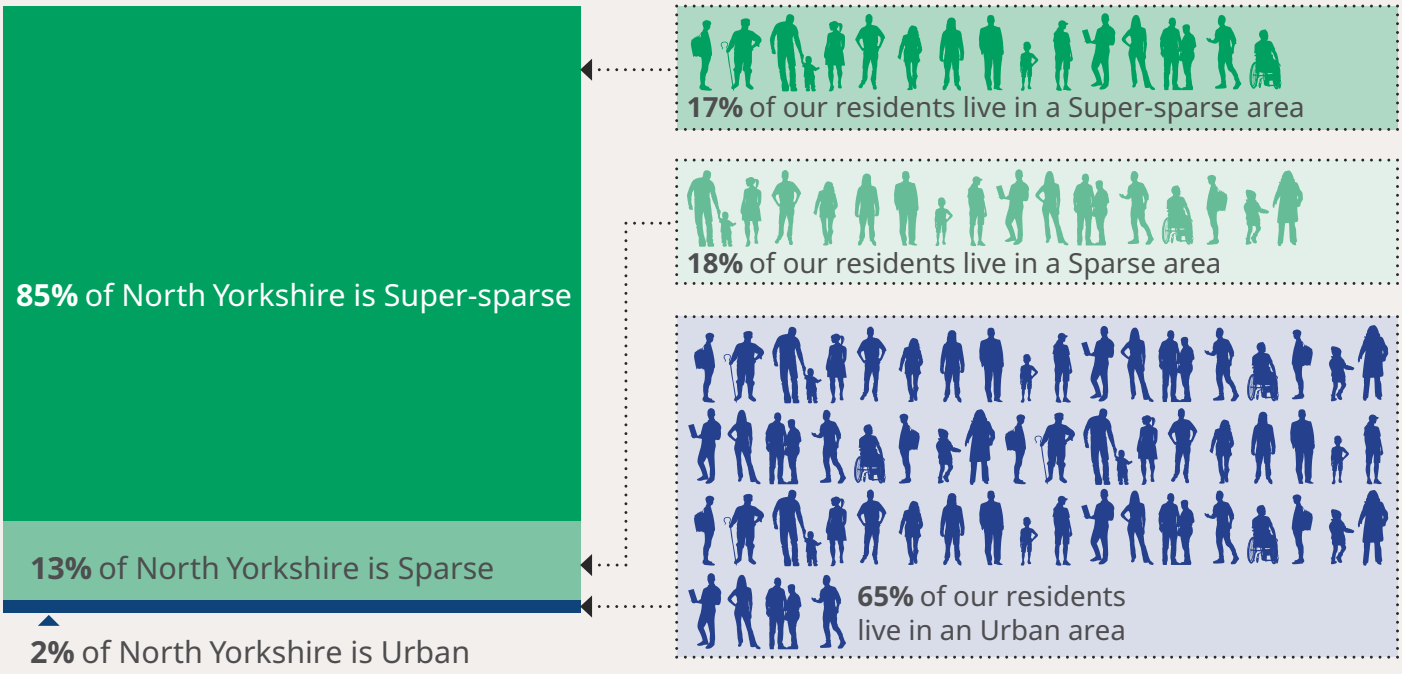
## We will meet these challenges by:

- Delivering at least 2,537 new homes per year across all tenures, including a minimum of 802 new affordable homes each year*. We will also look at how we can work with our partners through the York and North Yorkshire Housing Partnership to deliver the affordable homes that we need.
- Developing an ambitious Council Housing (Housing Revenue Account) Business Plan, which will include growing the Council's housing stock.
- Working with the Mayoral Combined Authority and City of York Council to develop a Housing Growth Plan and supply pipeline, as well as deliver the Brownfield Housing Fund allocation.
- Pursuing opportunities to bolster housing supply (temporary and permanent) in the medium to long term by working with new partners such as the Ministry of Defence, and One Public Estate.
- Maximising all sources of funding to support affordable housing viability and boost delivery.
- Reviewing all our land assets to identify land that could be used for new housing (affordable and market homes).
- Developing our affordable housing delivery model, ensuring that we capture the best delivery models and develop them further to enhance affordable housing supply.
- Working with partners, including the Mayoral Combined Authority, to better understand the need for key worker accommodation across North Yorkshire.

*NOTE: Figures are indicative and subject to review through the Local Plan process as we develop a new Local Plan for North Yorkshire

## 4.2 Addressing the rural housing crisis:

North Yorkshire is the largest geographical county in England covering 3,000 square miles of predominantly rural terrain, where 35% of our population live. Only 2% of our localities are urban but these areas accommodate 65% of our population. There are only two towns with a population in excess of 50,000. All other towns have a population of less than 25,000.




Sparsely and super-sparsely populated communities present a challenge in terms of inclusion and community sustainability, as well as service delivery. In sparsely populated rural areas people can experience physical and digital isolation with difficulty accessing services, jobs and transport links.

Housing is more expensive within these areas, both to rent and to buy, and affordable housing supply is limited. We know that rural poverty is often hidden and the financially vulnerable are dealing with higher cost of living increases, fuel poverty and insecure employment. a lack of digital connectivity and the persistence of 'not spots' exacerbates exclusion and disadvantage in our rural areas. More rural affordable with better connectivity is essential to ensuring inclusion and the sustainability of our rural communities.

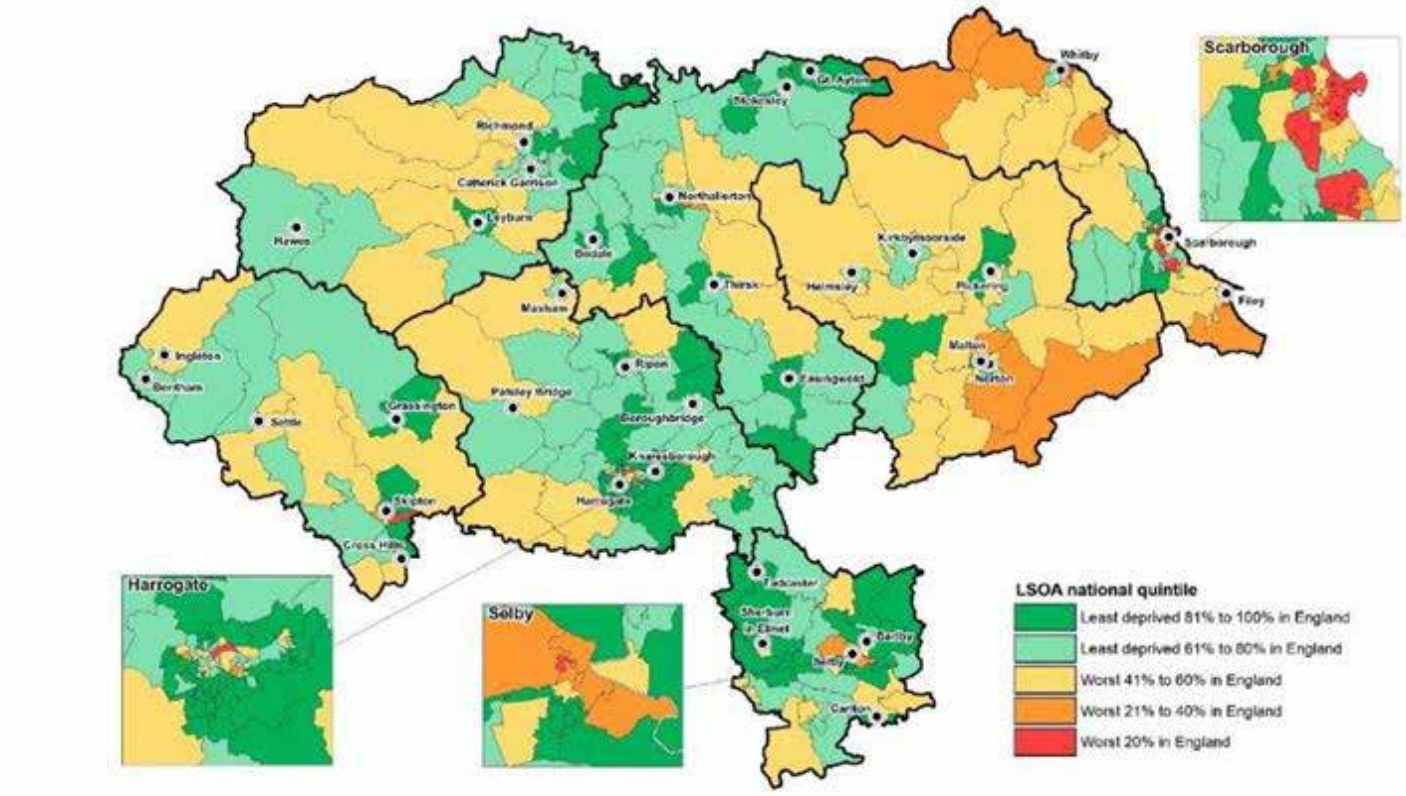
### We will meet these challenges by:

- Supporting the Rural Housing Enabler Partnership and Community Led Housing groups – to ensure a supply of housing is maintained, of the right quality, type and tenure in rural areas.
- Keeping sufficient focus on affordable housing supply in our rural communities.
- Working with key partners to ensure that rural affordable homes are digitally enabled.
- Working with the York and North Yorkshire Housing Partnership, the Mayoral Combined Authority, and Homes England to develop an enhanced rural affordable housing supply pipeline, and ensure that there is sufficient investment to deliver the homes needed.

## 4.3 Supporting communities through neighbourhood renewal and regeneration

Whilst most of North Yorkshire is relatively affluent with low levels of deprivation, there are some very high concentrations of deprivation. A significant part of Scarborough town is within the most 10% deprived neighbourhoods in the country and 85% of North Yorkshire's most deprived residents reside in Scarborough, with further pockets of high deprivation in Selby and Harrogate. The levels of deprivation are in line with those of inner-city metropolitan locations.

**Index of Multiple Deprivation (IMD) - Indices of Deprivation 2019**
**North Yorkshire LSOAs by National Quintile**




Notes
1. Source: Indices of Deprivation 2019, MHCLG
2. Ordnance Survey Map Data: © Crown Copyright 100017946. (2019)
3. Compilation & Analysis: Strategy & Performance (HAS), NYCC

Contributing to the levels of deprivation are:

- A low wage economy.
- High levels of households reliant on benefits.
- Low educational and skill levels.
- A poorer physical environment.
- Significantly high concentrations of private rented properties (over 50% in inner Scarborough).

There is a need to develop a holistic neighbourhood renewal approach to address these issues in partnership with other key service areas (Planning, Economic Development, Environmental services, Health) and external partners.

North Yorkshire has some major strategic regeneration projects and priorities, including the redevelopment of Catterick Town Centre, where £19m Levelling Up Fund investment is regenerating the town centre. This investment has the potential to unlock significant future brownfield housing sites within Catterick. There are significant regeneration projects within Selby and new settlements being created at Maltkiln (between 3,000 and 4,000 new homes), and Ripon Barracks (1,300 new homes). These projects are catalysts, not just for the delivery of housing but generating economic growth and key infrastructure improvements that will benefit the whole of North Yorkshire.

Tackling empty homes will also support regeneration in local neighbourhoods and will provide more homes for local households, including more affordable homes.

Whilst the proportion of long-term empty homes across North Yorkshire is roughly similar to the national average at just over 1%, this is still over 3,000 empty homes. There are slightly higher proportions of empty homes around Skipton and Malton.

### Regeneration in Selby

The latest census data shows Selby had the highest percentage increase in population of any local authority in Yorkshire and Humber between 2011 and 2021 with over 10% growth.

Within Selby itself are two major brownfield housing allocations at the former Rigid Paper site (330 homes) and ICL (450 homes), together with the adjacent Selby Station Quarter regeneration area, which also has scope for redevelopment for residential uses. This suite of sites can provide a new urban village of around 1000 homes next to the town's rail and bus stations, which themselves are being transformed through the £28m Selby Station Gateway project.

Heronby (south west of Escrick) is the proposed new settlement in the most recent Selby District Local Plan (3387 homes by 2065). At Eggborough, an allocation remains for 1500 dwellings by 2048. This mixed use development will comprise of residential, open space and education.

In addition, the Cross Hills Lane site at Selby is allocated for 1270 dwellings by 2043 This will be a mixed use development, comprising: residential, open space, community and local shopping facilities and education.

### We will meet these challenges by:

- Developing an approach to neighbourhood renewal for our most deprived neighbourhoods.
- Working with key partners to support communities through projects that will improve their local environment.
- Working in partnership with the Mayoral Combined Authority and Homes England to drive strategic regeneration projects across North Yorkshire.
- Developing a new Empty Homes Strategy to bring long term empty properties back into use.

# 5. Theme Three: Our Homes

Our Homes is about the challenges with our housing stock and how we can improve housing to ensure it is decent and affordable. We face huge challenges in ensuring that existing homes are decent, energy efficient, and can contribute to meeting our wider Climate Change aspirations. We also need to ensure that all new build housing meets the highest standards, and actively contributes to meeting our Climate Change aspirations.

**Our key priorities for this theme are:**

- **Decarbonising the whole housing stock, including our Council homes, making them more energy efficient and affordable to live in, reducing fuel poverty**
- **Ensuring that new housing supply of all tenures contributes to our net zero ambitions**
- **Addressing stock condition issues, improving poor quality housing in all tenures**
- **Ensuring that our Council housing stock remains decent and continues to improve**

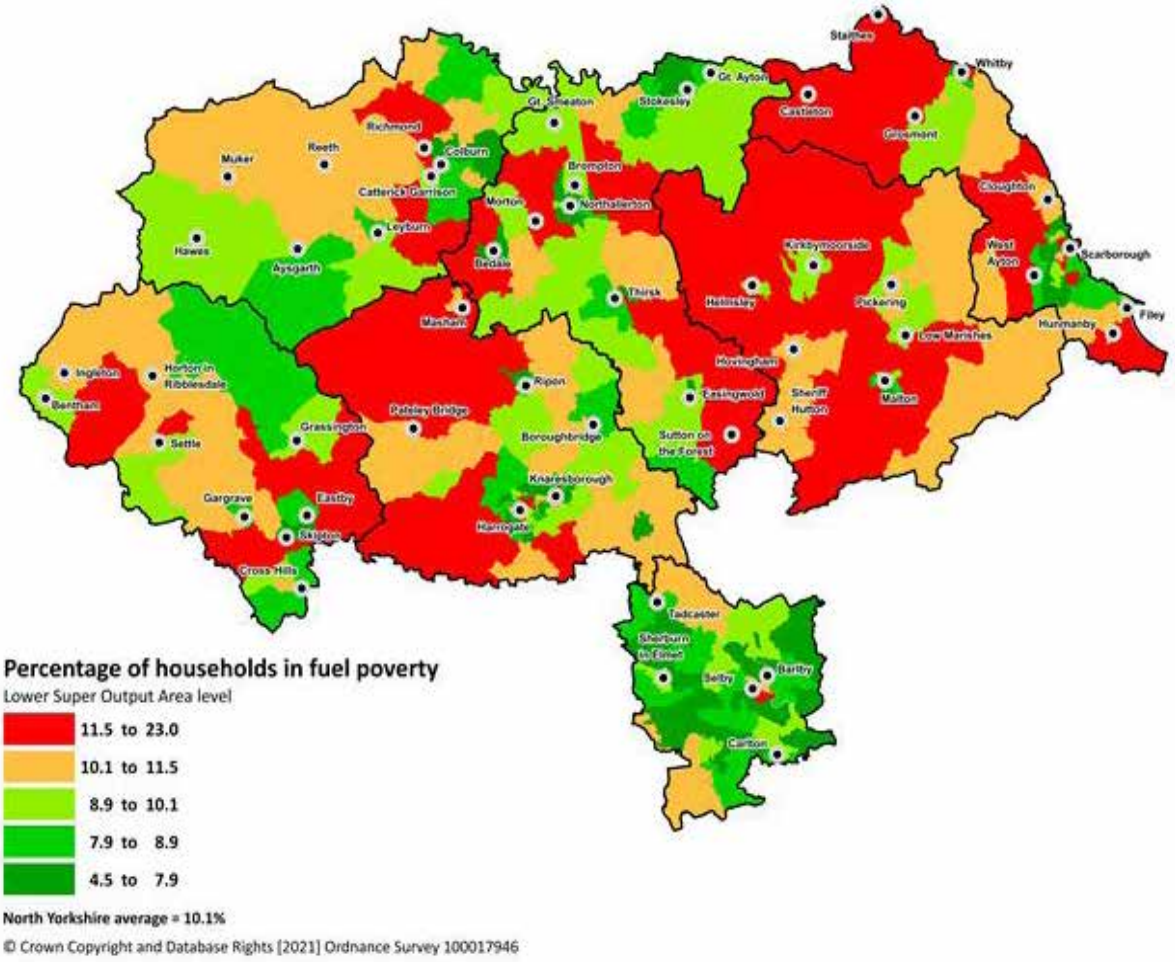
## 5.1 Decarbonising the whole housing stock

In North Yorkshire over 27% of the housing stock was built before 1919 (England: 21%). Older housing stock is often less well insulated and less energy efficient due to its construction, making it more difficult to improve.

This in turn is a contributory factor to fuel poverty - over 15% of our households were recorded as being in fuel poverty in 2020. With rising energy costs and wider costs of living increases, the proportion of households experiencing fuel poverty is likely to rise.

In North Yorkshire, 18.7% of households privately rent their home, which is just below the national average of around 19%. There are higher levels of privately rented properties in Richmondshire (21%) and Scarborough (22%), with very high concentrations (over 50%) in parts of Scarborough. Privately rented stock tends to be older, has a higher rate of non-decent homes, and a higher proportion of lower income households. There will also be higher rates of less energy efficient privately rented stock and, consequently, higher proportions of households in fuel poverty.

North Yorkshire Residents, % of Households in Fuel Poverty
2018, Low Income High Cost (Source DECC)




Work has already started to retrofit the council's housing stock, with work underway in the Harrogate locality to retrofit homes with an EPC E or F rating to bring them up to an EPC C. However, a comprehensive plan for all our council homes needs to be developed to ensure all properties meet EPC "C".

## We will meet these challenges by:

- Developing a social housing decarbonisation plan, with the aim of getting all our council homes to achieve EPC C and up to Decent Homes Standard (when the target date is announced by Government).
- Working with our Registered Provider partners and Homes England to implement investment plans to make their homes warmer and more affordable to live in.
- Attracting Government funding to improve and decarbonise our private sector housing homes.

## 5.2 Ensure that new housing supply of all tenures contributes to our net zero ambitions

Ensuring that all new homes are built to high energy efficiency standards and contribute to our net zero ambitions is also crucial to achieving our Climate Change aspirations. Whilst progress has been made in recent years in uplifting the energy efficiency of new homes built, the recent introduction of Part L (conservation of fuel and power) of the Building Regulations, which came into force in 2022, and the proposed implementation of the Future Homes Standard in 2025, should contribute positively to these aspirations. Ensuring new homes are built to high energy efficiency standards will help ease energy costs during the current cost of living crisis.

### We will meet these challenges by:

- Implementing new Design Codes to ensure an increase in the quality of new housing, working towards the Future Homes Standard and Nationally Described Space Standards.
- Ensuring that all new Council homes are built to Future Homes Standard and meet EPC C as a minimum with a net zero carbon aim.
- Supporting our Registered Provider partners to meet net zero carbon ambitions in the delivery of new affordable homes.

## 5.3 Address stock condition issues, improving poor quality housing in all tenures

The English Housing Survey (2021-22) shows 14% of all homes were deemed non-decent. Within the private rented sector the proportion is higher at 23%. Based on these figures, it is estimated that approximately 38,500 of all our homes are non-decent, of which almost 12,000 will be privately rented.

The level of resources needed to tackle the issue is challenging, especially in the private rented sector. We have successfully bid for Government funding to set up a Pathfinder project to increase resources in our Private Sector Housing Renewal teams, with special focus on locations where resources have been scarce previously.

We will undertake an assessment of the private rented sector across the whole of North Yorkshire, in the form of a "State of the Nation" report. This will provide an overall assessment of the private rented stock and market, which will inform future strategic planning and help us to target resources appropriately.

### We will meet these challenges by:

- Producing a private housing stock condition baseline and a retrofit action plan to inform future investment.
- Tackling stock condition issues, improving poor quality housing across all tenures.
- Working with the Mayoral Combined Authority to deliver the Carbon Abatement Pathway.
- Using our legal powers to enforce and raise standards in the private rented sector - taking a consistent and firm approach to raising housing standards, including the further development of selective licencing schemes.

## 5.4 Ensuring the Council housing stock remains decent and continues to improve

Managing 8,500 council homes, we are a major social housing landlord. We want to ensure that all of our residents live in a decent home. Whilst the vast majority of our stock meets the Decent Homes Standard, we know that just over 200 of the homes within our stock are classed as Non-Decent (LAHS: 2021/22).

As well as bringing the current non-decent homes up to the Decent Homes Standard we will invest in an improvement programme to ensure that our homes are the highest standard possible. We know that some of our housing stock may no longer be fit for purpose. We need to appraise the stock and ensure that it meets modern standards, including installing digital technology to suit modern needs.

The recent case of a child's death, elsewhere in the country, caused by damp and mould in their social home, has led to increased regulation of safety in social housing. We will tackle any mould and damp issues in our properties effectively and ensure that we have a plan and resources in place to respond to all complaints of damp and mould within set timescales.

We aim to become an exemplar landlord, providing high quality tenancy services. We will meet the expectations of the Charter for Social Housing Residents and look to develop our key policies in line with this and the new Social Housing Regulations 2022/23.

### We will meet these challenges by:

- Implementing a robust investment plan for all our Council housing stock over the next 30 years.
- Putting tenant safety first and fully meeting our regulatory responsibilities, including the eradication of mould and damp issues within set timescales.
- Developing a new Tenancy Strategy and establishing clear and high standards for the delivery of tenancy services.
- Appraising our Council housing stock and re-purposing where required.

# 6. Addressing our Equality Objectives

The North Yorkshire Council Plan has set a range of key equality objectives for the Council:

- To understand the needs of our communities and work with them to meet those needs
- To demonstrate commitment to equality, diversity and inclusion as an organisation, show leadership across the county and work in partnership to improve equality, diversity and inclusion
- To provide responsive services and effective customer care to all
- To have a diverse and engaged workforce and fair and inclusive employment practices

We will meet these objectives through the following actions and approaches:

- We will ensure equality of service to all our tenants, residents, customers and partners, including improving our equality monitoring arrangements.
- We will identify and address the needs of any specific groups including ethnic minorities, the LGBTQ community, Gypsy and Traveller community
- We will identify and address the needs of vulnerable households and groups such as older people, people with physical disabilities, people with learning difficulties and all other people with supported housing needs
- We will ensure that our policies are fair and non-discriminatory and equally accessible to all residents
- We shall meet the requirements of the Armed Forces Covenant and new due-regard duty, with respect to all our Housing Services and ensure that it is reflected within all of our housing policies, with specific regards to the Allocations Policy, Tenancy Strategy, Disabled Facilities Grant Policy and Homelessness Strategy.

# 7.Key performance indicators

Setting out our high-level housing ambitions and priorities is just the start of the strategic planning process. A key tool in delivering our strategy is monitoring our performance and tracking trends which may impact on that performance. We will publicly monitor performance against the following Key Performance Indicators. These will be backed up by a wider dashboard of performance measures and market trends.

## 7.1 Theme One: Our People

| Measure | Frequency |
|---|---|
| Number of new homes specifically developed for older people | Annual |
| Number of homeless assessments | Quarterly |
| Number of successful homeless preventions and reliefs | Quarterly |
| Number of households in temporary accommodation | Quarterly |
| Number of rough sleepers | Quarterly |
| Number of Disabled Facilities Grants completed | Quarterly |
| Number of refugee households resettled into permanent accommodation | Annual |

## 7.2 Theme Two: Our Places

| Measure | Frequency |
|---|---|
| Overall new housing completions | Annual |
| Number of Housing Revenue Account new builds (direct delivery) | Annual |
| Number of Housing Revenue Account acquisitions (buy back and S106) | Annual |
| Affordable housing completions | Annual |
| Number of empty homes brought back into use | Annual |
| Community-Led Housing completions and engagements | ½ Yearly |
| Rural Housing Enabler programme completions | ½ Yearly |
| Units delivered through the Development Partnership | ½ Yearly |

## 7.3 Theme Three: Our Homes

| Measure | Frequency |
|---|---|
| Number of Council owned homes improved through retrofit initiatives | Annual |
| Number of private homes improved through energy efficiency initiatives | Annual |
| Number of homes achieving EPC C or above | Annual |
| Number of private sector enforcement notices served | Annual |
| Number of new homes built to Future Homes Standards | Annual |
| Number of Council homes improved through Improvement Programme | Annual |

## 7.4 Strategy Review

Progress on the delivery of this strategy will be monitored by the Assistant Director for Housing on a quarterly basis and reported to the Executive Member for Housing Growth annually. The Strategy will be reviewed after three years.

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# Dementia in North Yorkshire

# Dementia in North Yorkshire


There are an estimated **9,272 people over 65 living with dementia** in North Yorkshire[2]

**15,002 people will be living with dementia** in North Yorkshire by 2030[3]

By 2030, it is estimated that there will be **9,617 of people living with severe dementia** in North Yorkshire[4]


It is predicted that the cost of dementia care in North Yorkshire by 2030 **will be £662m**[6]


Currently, the annual cost of dementia care in North Yorkshire **is £403m**[5]


Currently there are **15,006 people under the age of 65 living with dementia** in England[7]



Source: North Yorkshire Local Dementia Profile – Alzheimer's UK

# Diagnosing well in North Yorkshire

**The dementia diagnosis rate for North Yorkshire is 58%**, the average for England is 61.7%[9]

**5,376 people have received a dementia diagnosis** in North Yorkshire[10]

**3 ⇨ 34 weeks**

is the range of time **between referral and diagnosis of dementia** in England, meaning that many people wait over six months to receive a diagnosis[13]

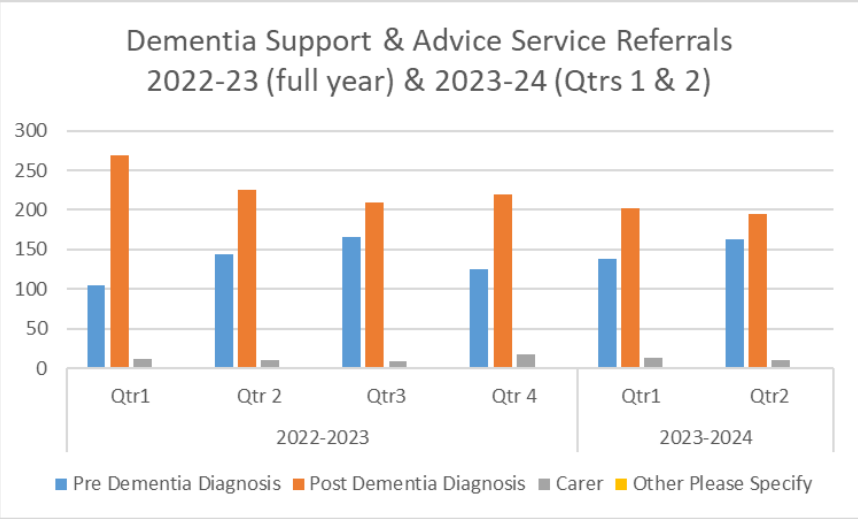
The national target for **diagnosis rates in England is 66%**[11]

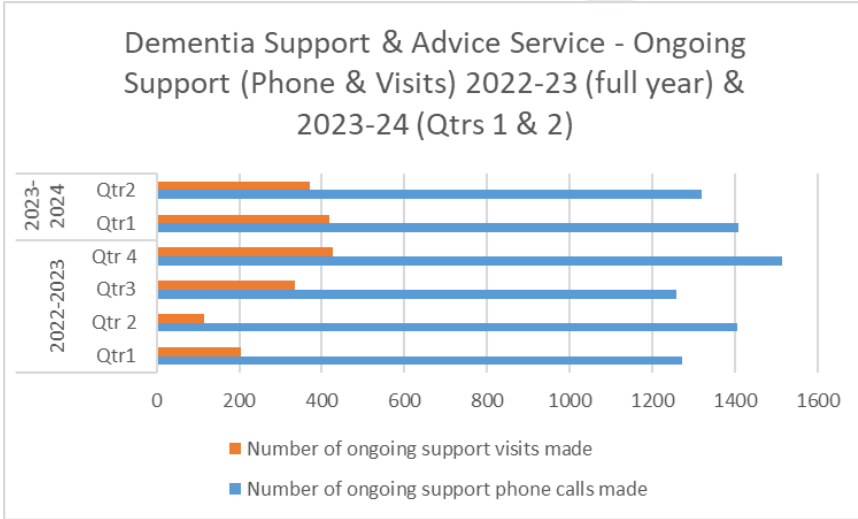

**is the average wait time between a referral and an initial appointment** at a memory clinic in England[12]

**58.5% of people are diagnosed in the mild/early stages** of their condition in England[14]

Source: North Yorkshire Local Dementia Profile – Alzheimer's UK

# Dementia Support & Advice Service Data




| Dementia Support & Advice Service | 2022-2023 | | | | | 2023-2024 | |
|---|---|---|---|---|---|---|---|
| New Referrals | Qtr1 | Qtr 2 | Qtr3 | Qtr 4 | Year End | Qtr1 | Qtr2 |
| Pre Dementia Diagnosis | 105 | 144 | 165 | 125 | 539 | 138 | 163 |
| Post Dementia Diagnosis | 269 | 226 | 210 | 220 | 925 | 202 | 195 |
| Carer | 12 | 10 | 8 | 17 | 47 | 13 | 10 |
| Other Please Specify | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **386** | **380** | **383** | **362** | **1511** | **353** | **368** |

| Dementia Support & Advice Service | 2022-2023 | | | | | 2023-2024 | |
|---|---|---|---|---|---|---|---|
| Support | Qtr1 | Qtr 2 | Qtr3 | Qtr 4 | Year End | Qtr1 | Qtr2 |
| Number of ongoing support phone calls made | 1274 | 1405 | 1260 | 1514 | 5453 | 1409 | 1319 |
| Number of ongoing support visits made | 205 | 116 | 334 | 426 | 1081 | 418 | 371 |
| **Total** | **1479** | **1521** | **1594** | **1940** | **6534** | **1827** | **1690** |

# Dementia Care in the Community

## Community Based Support

- Hub Clubs & Well being Cafes
  - 200 places per week
  - Additional 40 places for Young Onset Dementia
  - Potential for further development/sharing peer support and good practice
- Education Awareness Sessions

## Training

- Dementia Strategy Workforce Priority (internally and externally)
- LGR Opportunities – Taxi Driver Licensing/Leisure Services etc
- NYC Providers (Residential & Nursing/Home Based/Community Based Support
- Dementia Friendly Communities and Champions

# Dementia Care in the Community

**Extra care**

There are 67 specially designed dementia apartments within Extra Care schemes along with specially trained staff, these units are open plan to reduce disorientation.

The supportive environment of Extra Care can also reduce stress for both the person and carers who know that help is available whenever it is needed

Future schemes will include dementia friendly design and environments

**Technology**

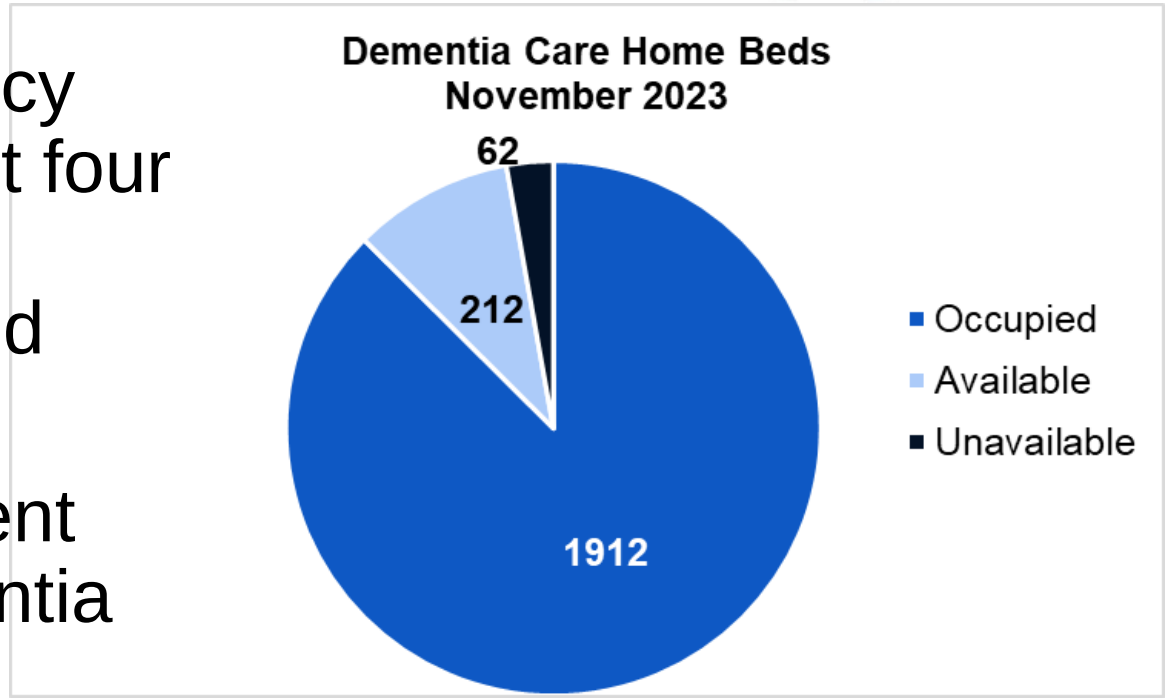
A wide range of TEC solutions can support people living with dementia. Simple products that provide reminders or location based support can assist in the early stages, whilst more complex products that monitor and react to physical or behavioural changes can support people and carers as their dementia progresses.

These are all available through NYC's commissioned service following an assessment

# Care Market Capacity

There are 2,186 dementia beds recorded in North Yorkshire on the national Capacity Tracker. Occupancy has been running at 90% for the last four months. Nursing bed occupancy is higher at 93% in the Vale of York and 92% in Craven.

992 (41%) of the people in permanent care home placements are in dementia specific provision.



# Dementia Care in Residential and Nursing Settings

**Root Cause Analysis**

- **'OP Resi/Nursing Root Cause Analysis'** case mapping exercise looked at 194 cases in our highest cost specialist provision across the county.
- **Interrogation of information** to identify reason for current 'high cost' specialist placement admission, understanding of care needs including any specific additional/specialist needs and/or 1:1 care needs, details of previous care and support/placements, admission refusals, current details of cost, funding stream, care needs, future reviews planned etc.

**Provider Engagement**

- Provider Engagement Events **co-hosted with ICG, TEWV and Dementia Forward** held in Scarborough and Northallerton. 32 partners attended across the two events with 21 provider representatives with a cross-section of providers from different localities.
- **Positive solution-focussed discussions** with providers on challenges, barriers and solutions of delivering dementia care to meet the changing/emerging needs.
- Clear feedback themes and proposed programme of works developed.

**Common Theme** – **Need & opportunity to work more closely as a 'system' with providers on developing dementia care services**, to build skills and capacity in the residential & nursing care sector in order that we can meet the needs of people in moderate and advanced stages of dementia.

**Action – Taskforce/Working Group** set up with key partners to develop and take forward **shared programme of work/action plan**

# Programme of Work to Upskill / Build Capacity

| | |
|---|---|
| **Workforce – Capacity & Training** | Develop a rolling bespoke dementia training programme co-designed with providers to meet identified gaps in skills and improve recruitment and retention of the care workforce through building of confidence, empowerment and skills development. |
| **Culture** | Work with health and social care colleagues across the system to develop and embed a shared positive risk management approach from pre-referral through to admission and continued care planning, in particular for s117 cases, addressing cultural issues in some practice relating to incidents and safeguarding. |
| **Assessments** | Work with health and social care colleagues across the system to improve quality and accuracy of assessments and support plans (including TAFs) provided to care providers at the point of referral to enable informed and more efficient decision making of admissions. |
| **Commissioning** | Explore alternative commissioning approaches for specialist dementia care. |
| **Environment** | Develop a mechanism for holding more detailed information on each dementia care setting, including staffing ratios, environment and staff capacity & skills to enable more effective and efficient commissioning of packages of care. |
| **Wraparound/Crisis Support** | Review the information, advice and support available to care homes across the county in a crisis and/or when a person's care needs or behaviour escalates, and ensure a robust and consistent accessible offer is available across the county. |

# Dementia Strategy

A series of engagement events have taken place to look at what is working well and what further action is needed:

- overwhelming support for the renewed focus on dementia and the need to work in partnership on the strategy
- positive about the breadth of support offered by Dementia Forward, although concerns about capacity due to increased demand;
- concerns around the length of time for diagnosis (up to 2 years and even longer for young onset);
- the need for more specialist training for professionals, particularly in care settings;
- the need for stronger links to primary care;
- support for carers and in particular the lack of short stay respite;
- restarting work on dementia friendly North Yorkshire to challenge the stigma associated with dementia

# Visit to Kirkwood Hall

Any thoughts or reflections?

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# Health and Adult Services

## Working with the NHS Integrated Care Systems

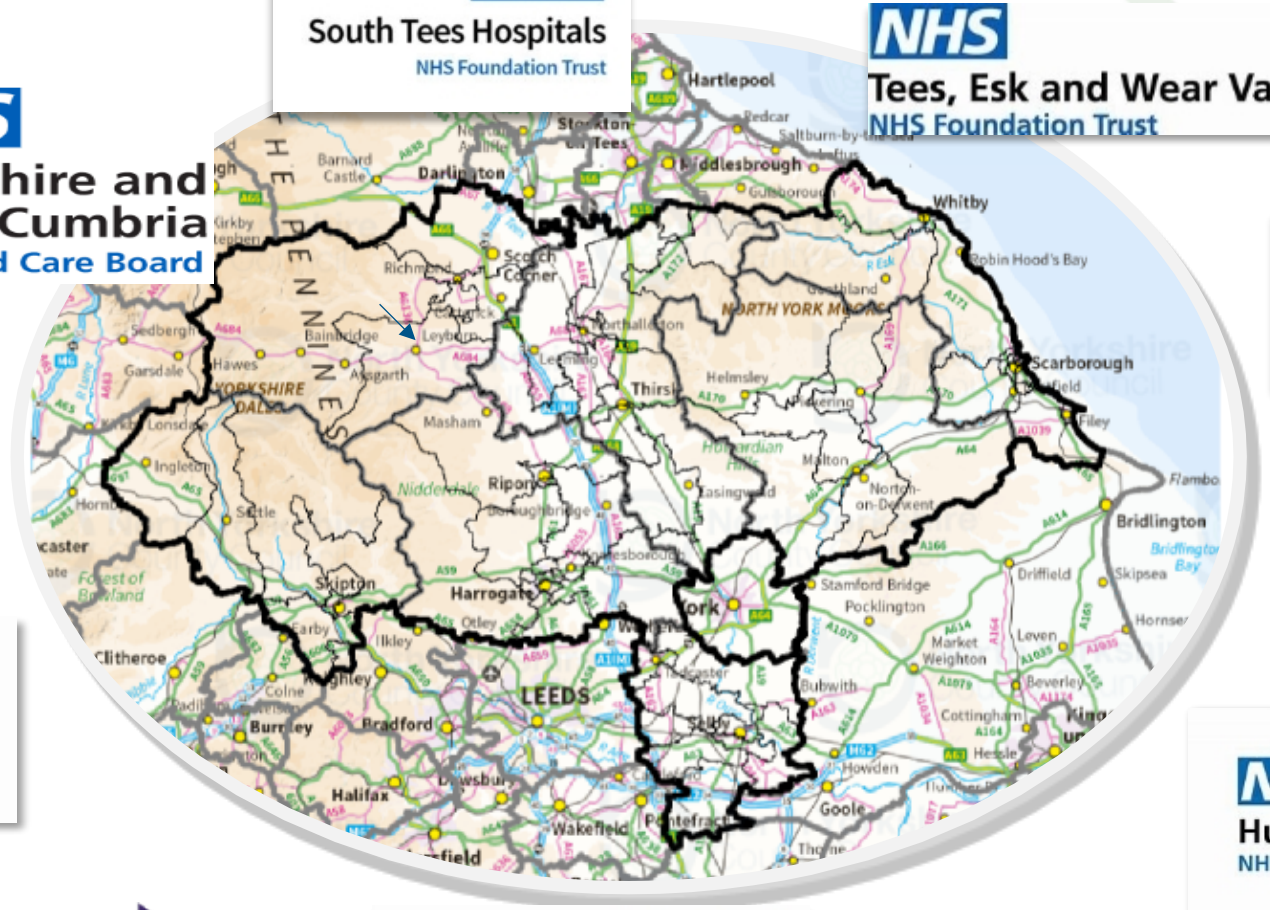
# Working with the NHS

NORTH YORKSHIRE COUNCIL

NHS South Tees Hospitals NHS Foundation Trust

NHS Tees, Esk and Wear Valley NHS Foundation Trust

NHS Lancashire and South Cumbria Integrated Care Board




NHS York and Scarborough Teaching Hospitals NHS Foundation Trust

NHS Bradford District Care NHS Foundation Trust

Humber and North Yorkshire Health and Care Partnership

NHS Airedale NHS Foundation Trust

NHS Humber Teaching NHS Foundation Trust

West Yorkshire Health and Care Partnership

NHS Harrogate and District NHS Foundation Trust

## Primary Care

# Progress

Active role in HNY and WY and good links with Lancs/South Cumbria

Executive Member and DPH play an active role in HNY ICB and ICP

NY Place Board chaired by NYC Chief Executive

Strong North Yorkshire Place team – good “can-do” relationships

Active involvement in/joint working with Bradford and Craven partnerships

New NHS investment in health inequalities and tobacco control

Integrated Quality Team

Better Care Fund has doubled since its inception

# Areas for development

- Home First response
- Intermediate Care
- Continuing Health Care
- Mental Health/Dementia/Autism
- NHSFTs facing challenges

**NORTH YORKSHIRE COUNCIL**

**Care and Independence and Housing Overview and Scrutiny Committee**

**7 December 2023**

# Work Programme Report 2023/2024

| | |
|---|---|
| **1.0** | **Purpose of Report** |
| 1.1 | The committee has agreed the attached work programme (Appendix 1). |
| 1.2 | The report gives Members the opportunity to be updated on work programme items and review the shape of the work ahead. |

## 2.0 Background

2.1 The scope of this committee is defined as 'The needs of vulnerable adults and older people and people whose independence needs to be supported by intervention from the public or voluntary sector".

## 3.0 Scheduled Committee dates and Mid-Cycle Briefing dates for 2023/2024

3.1 Committee Meetings

- Thursday 7 December 2023 at 10am
- Thursday 28 March 2024 at 10am

3.2 Mid Cycle Briefing Dates

- Thursday 2 November 2023 at 10am
- Thursday 8 February 2024 at 10am

3.3 Please note that the Mid Cycle Briefings are not public meetings and are attended by the Chair, Vice-Chair and Spokespersons for the political groups. These meetings are used to develop the committee work programme and determine the scheduling of key items.

## 4.0 Recommendations

4.1 The committee is recommended to consider the attached work programme and determine whether any further amendments should be made at this stage.

Author of Report: Christine Phillipson
Contact Details: Tel: 01609 533887 E-mail: christine.phillipson@northyorks.gov.uk

27 November 2023

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**NORTH YORKSHIRE COUNCIL**

**Care and Independence and Housing Overview and Scrutiny Committee**

**Work Programme 2023/24**

**Meeting dates**

- Scheduled future Committee Meetings: 7th December, 28th March 2024
- Scheduled mid cycle briefings: 2nd November, 8th February 2024

| Meeting | Subject | Aims/Terms of Reference | Lead/Current position |
|---|---|---|---|
| **Thursday 2 March 2023 at 10am** | Local Account | A review of the published account | Louise Wallace/Shanna Carrell |
| | Adult Social Care, Public Health and Climate Change | A response to issues and themes raised by Cllr Andy Brown | Richard Webb (Mike Rudd and Victoria Turner) |
| | Safeguarding | Annual NY Safeguarding Adults Board Report | Louise Wallace |
| | Care Market pressures | | Abi Barron |
| **Thursday 22 June at 10am** | Extra Care - next generation | Revisit of Extra Care 12 months on as requested by the Committee. Update on progress and statement on ambition to see Extra Care in all key towns in 2023. | Mike Rudd |
| | Unpaid Carers – support for Carers | Overview item to help assess the support provided to adult carers of adults in North Yorkshire. | Cath Simms |

| | | | |
|---|---|---|---|
| | Direct Payments | Revisit how NYCC is ensuring that Direct Payments enable more choice and control over the support people receive and how their social care needs are met (can use previous slides as basis of report)<br>Content and timing of item may be affected by ongoing HAS developmental work | Cath Simms and Toya Bastow |
| | Living Well | Update on service activity (overall approach/content as previous) | Cath Simms |
| | Digital Lives | Introduction to Technology enabled care, online care, financial assessment and brokerage. Tech Enabled Care – supporting and enhancing the experience of people and their independence in their own homes. Activity, Initiatives etc | Mike Rudd Cath Ritchie. |
| | Housing | An overview of housing and how this fits into the Overview and Scrutiny Committee | Andrew Rowe |
| | Intermediate Care/Discharge to Assess | Discharge arrangements.<br>Including possible briefing on introduction of Pilot scheme for short-term care beds. | Abi Barron |
| **Thursday 28th September 2023 - Cancelled** | | Items moved to 7th December | |
| **Thursday 7th December at 10am** | Adult Social Care Pressures and Charging Reform (Trailblazer) | Update on financial pressures<br>Trailblazer - anything on timetable, any further learning etc | Anton Hodge |

| | | | |
|---|---|---|---|
| | Suicide Prevention and Audit | Update on activity, prevalence and action | Vic Turner/Public Health |
| | Housing | Update to the Committee on the Housing Strategy | Sharon Graham |
| | Dementia Care | Report on progress business case and development https://www.dementiaforward.org.uk/ | Abi Barron |
| | Development of the Integrated Care Systems and Partnerships that cover North Yorkshire | What does this mean for social care, what are the risks etc | Richard Webb |
| | Kirkwood Hall Visit | Feedback and discussion following the visit on 21st November | All |
| **Thursday 28 March 2024 at 10am** | Annual Report of the Older People's Champion | | Cllr Caroline Dickinson |
| | Report of the Director of Public Health | | Louise Wallace |
| | Supported Housing | Transforming Care and current supported housing service overview | Abi Barron |
| | Update on Care Provider Services | Overview with focus on how the pandemic has changed demand for these services and how that influences commissioning arrangements in place to deliver | Rachel Bowes |

| | | | |
|---|---|---|---|
| | | personalisation and choice and meet current service and business requirements.<br>Progress on a transformational approach to short breaks | |
| | Shared Lives Scheme | Approval to re-procure or in-source the Shared Lives Scheme | Jo Waldmeyer |
| | Local Account | A review of the published account - Confirmed | Louise Wallace/Shanna Carrell |
| | Annual Report of the Adults Safeguarding Board | | Chair of the Board |
| **Future Items** | Transformation | Update on the market transformation | Abi Barron |
| | Specialist Provision | Care and Accommodation update | Abi Barron |
| | Extra care | | Mike Rudd |

## ITEMS FOR MID CYCLE BRIEFINGS

| DATE | POTENTIAL ITEM |
|---|---|
| Thursday 27th July at 10.00am (in respect of the Committee meeting on 28th September) | Discussion with Andrew Rowe and Daniel Harry around the remit of the Committee in relation to Housing.<br>Discussion around the plans to visit Kirkwood Hall later in the year. |
| Thursday 2nd November at 10.00am (in respect of the Committee meeting on 7th December) | Kirkwood Hall Visit - Discussion on the proposed visit to Kirkwood Hall on 21st November<br>Abi and Mike attending to discuss the remit and content around the Dementia update. |
| Thursday 8th February at 10.00am (in respect of the Committee meeting on 28th March 2024) | |

*Mid Cycle Briefings are attended by the Chair, Vice Chair and Group Spokespersons only.
Please note that the work programme is under continuous review and items may be rescheduled several times during the year.

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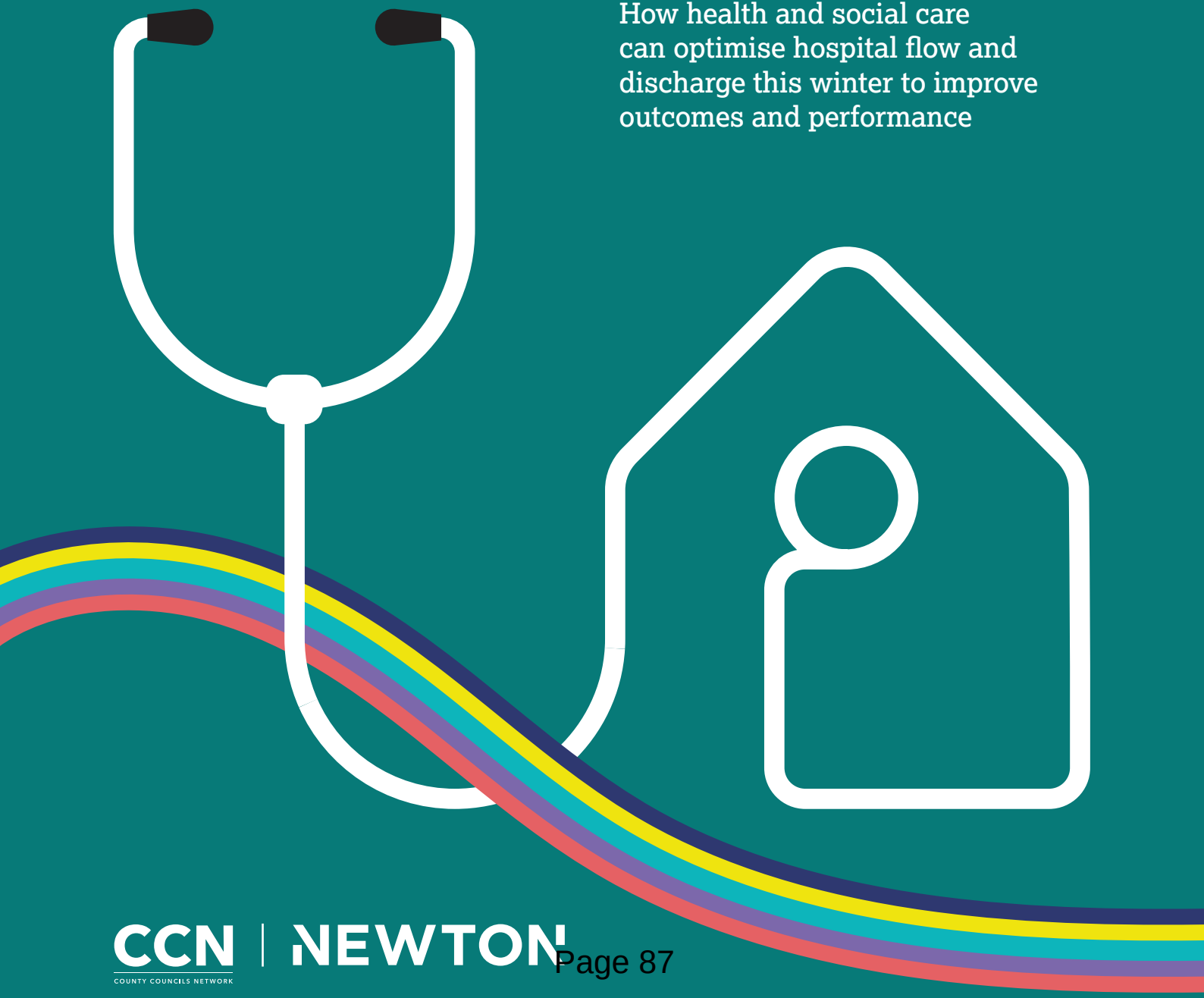
# Finding a way home

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



CCN | NEWTON

COUNTY COUNCILS NETWORK

# Contents

# Partners

## 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.

Find out more by visiting **countycouncilsnetwork.org.uk**

## Newton

Newton is an improvement, innovation, and leadership partner to local government, reimagining public services to improve outcomes and financial sustainability.

They partner with local authorities to redesign efficient and effective people services – safeguarding outcomes for people and families while putting local authorities on a financially sustainable footing.

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.

They're passionate about delivering value, putting 100% of their fees at risk against achieving measurable results.

Find out more by visiting **newtoneurope.com**

**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.

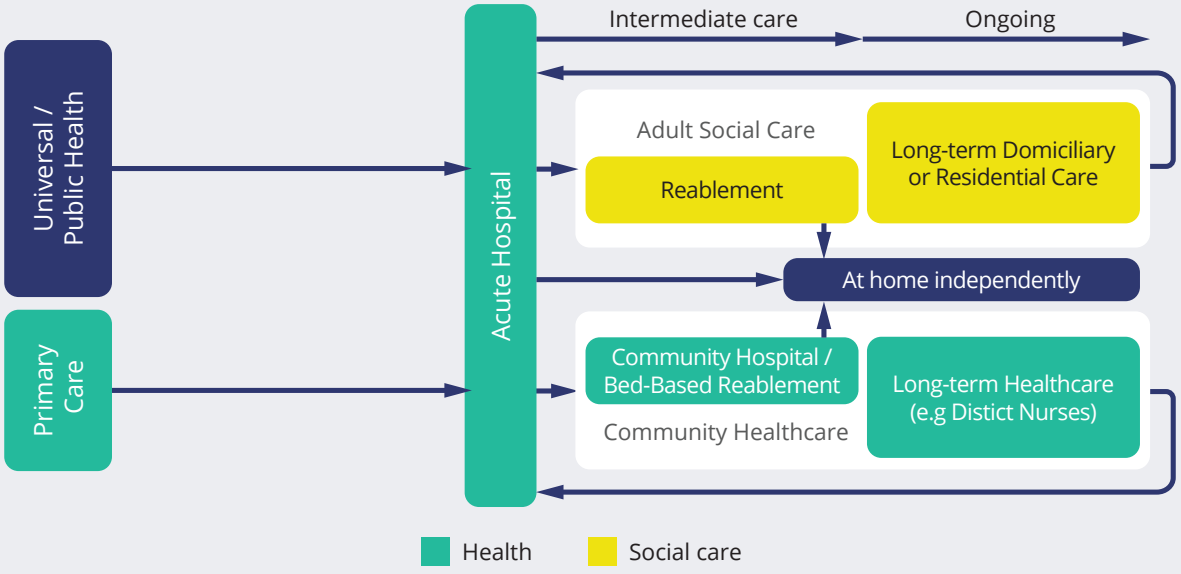



**Figure 1. A generic and simplified health and social care 'pathway' to demonstrate possible journeys through the system.**

# 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.**

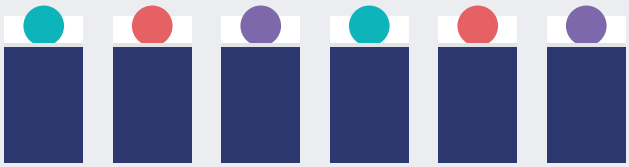
This is achieved primarily by building trust, confidence, and awareness of alternative community resources.

# 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.

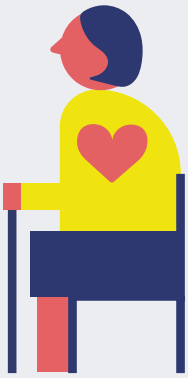
**There could be 1.1m fewer bed days lost to delayed 'complex' discharges – primarily as a result of improving capacity in intermediate care and reducing delays in the discharge process.**

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.**

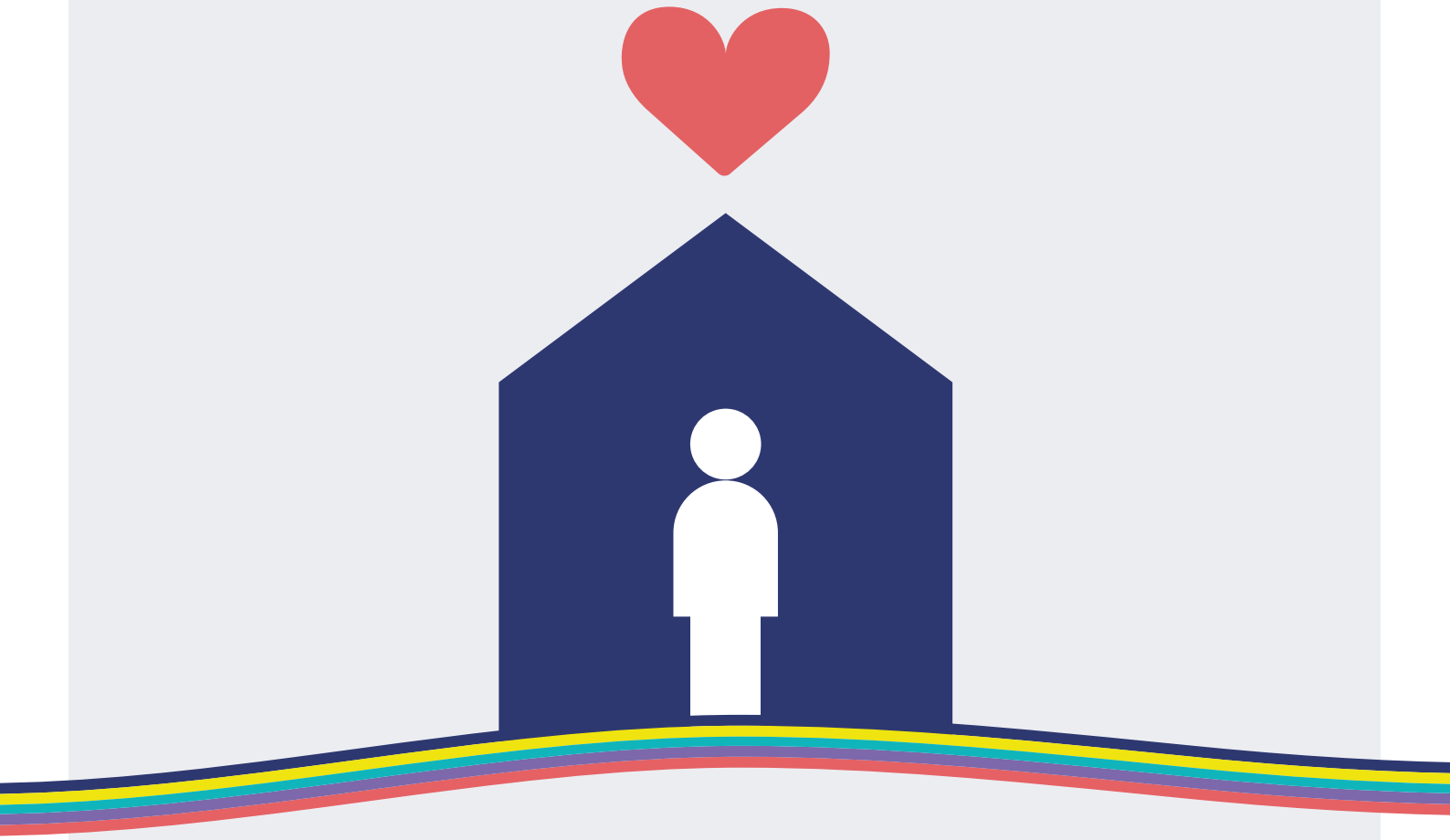
This is primarily as a result of lack of capacity of the right intermediate care, and risk averse decision-making.

**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.

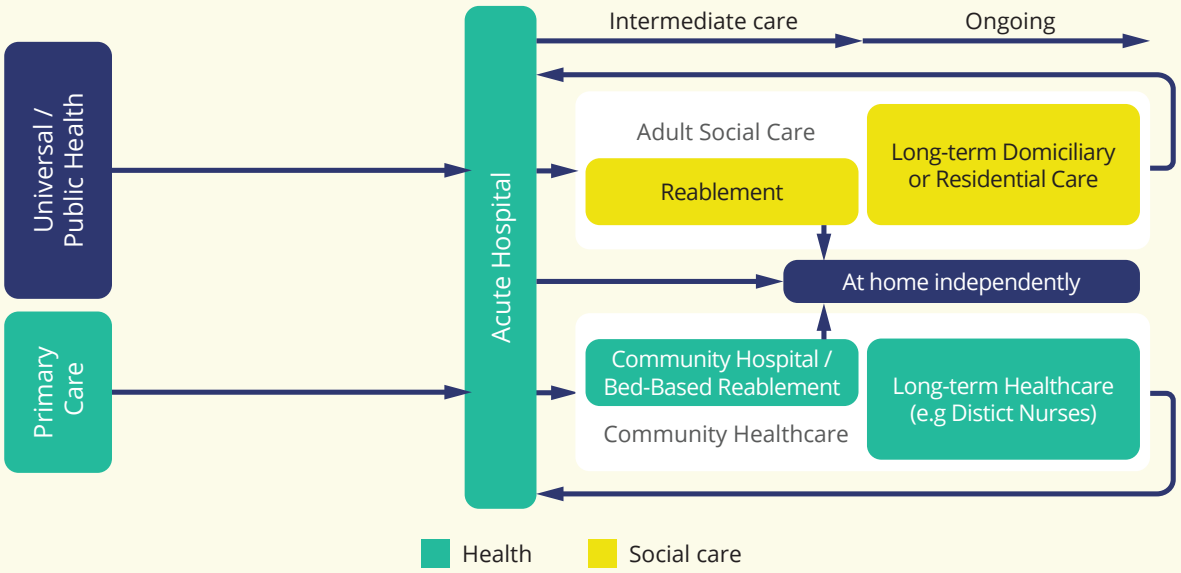



**Figure 2. A generic health and social care 'pathway' to demonstrate possible journeys through the system.**

# 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.

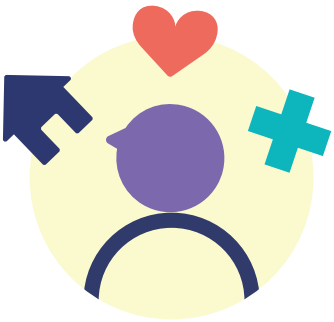
It follows a significant piece of research conducted in 2021, by CCN and Newton, entitled 'The Future of Adult Social Care'.[5] This described how the delivery of adult social care could be optimised, and the role of local authorities in this. The core belief underpinning this research was that the best 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).

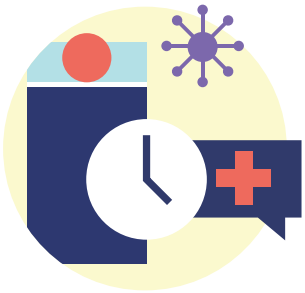
It has also focussed on the point at which an individual is discharged from hospital – how the support provided might maximise their independence, minimise delays, and reduce pressure on the NHS and social care.

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.

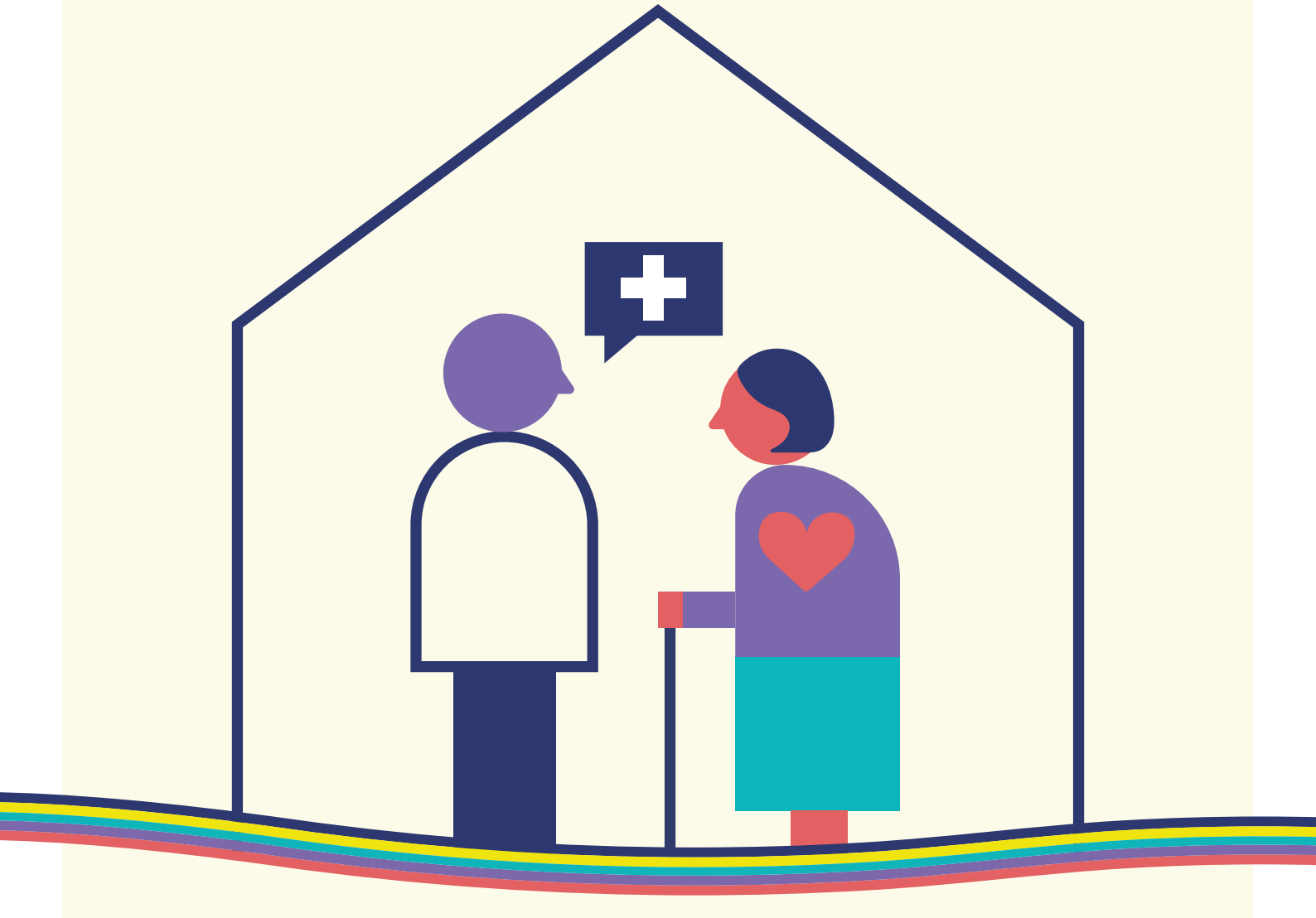


**Explore the driving forces** behind these challenges and assess the impact of existing interventions.

**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

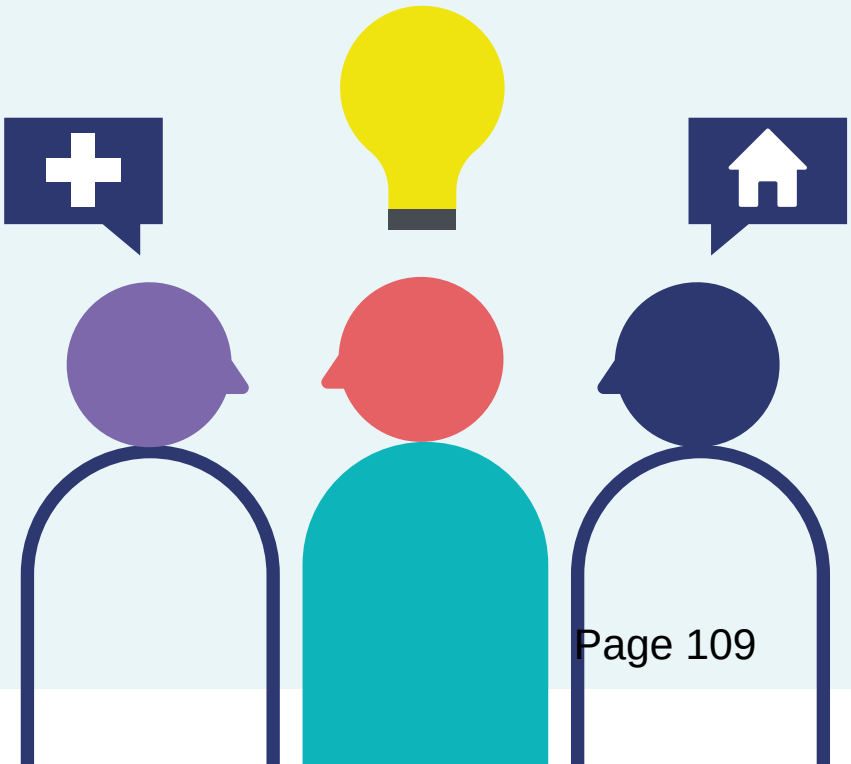
This work programme was overseen by a cross-sector advisory group.

**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]

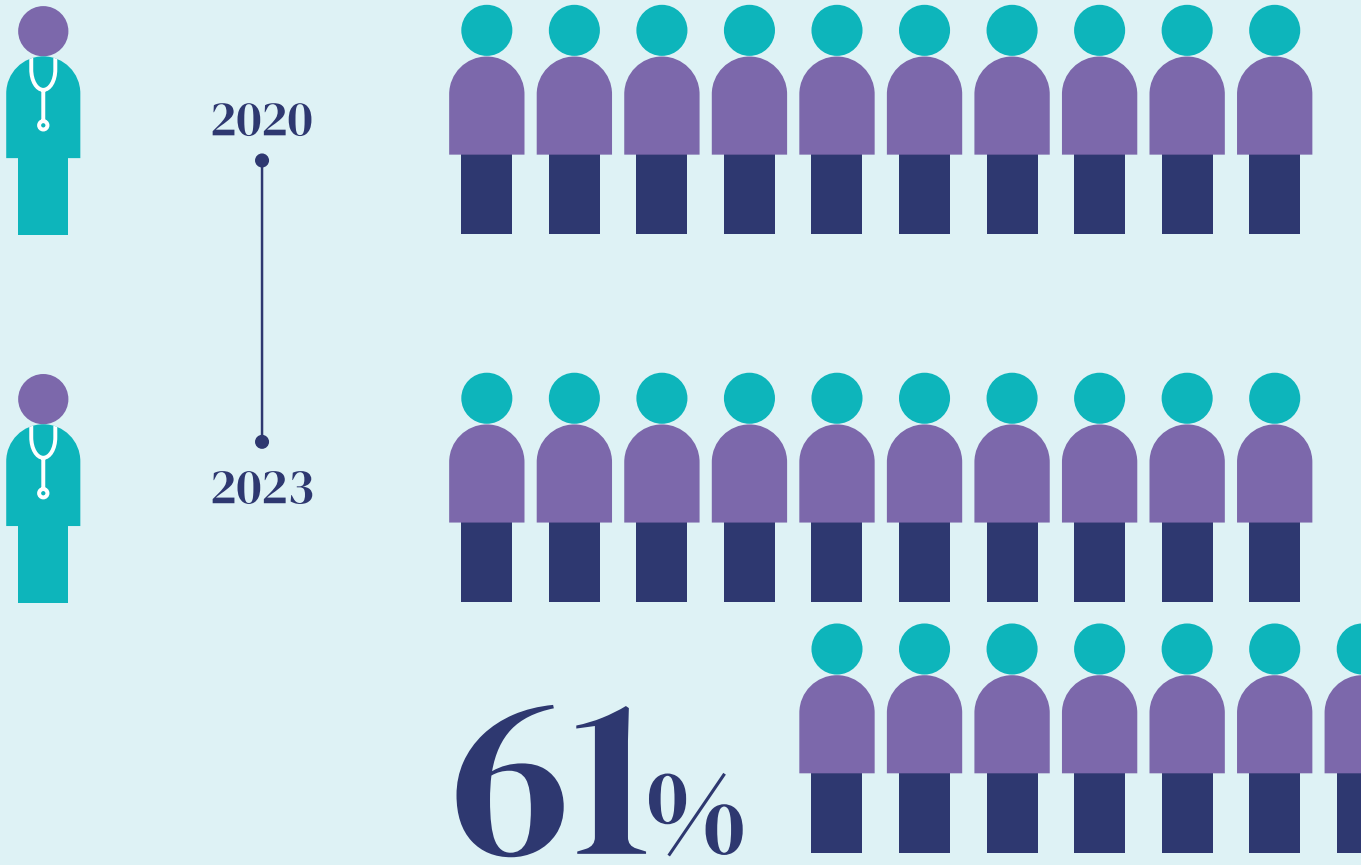
## Integrated care systems

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

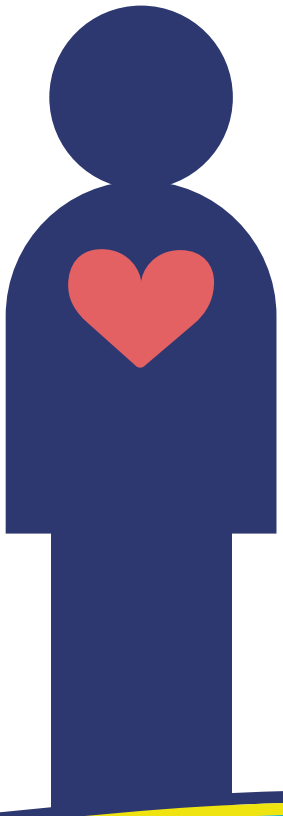
# What is a person-centred approach?

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.

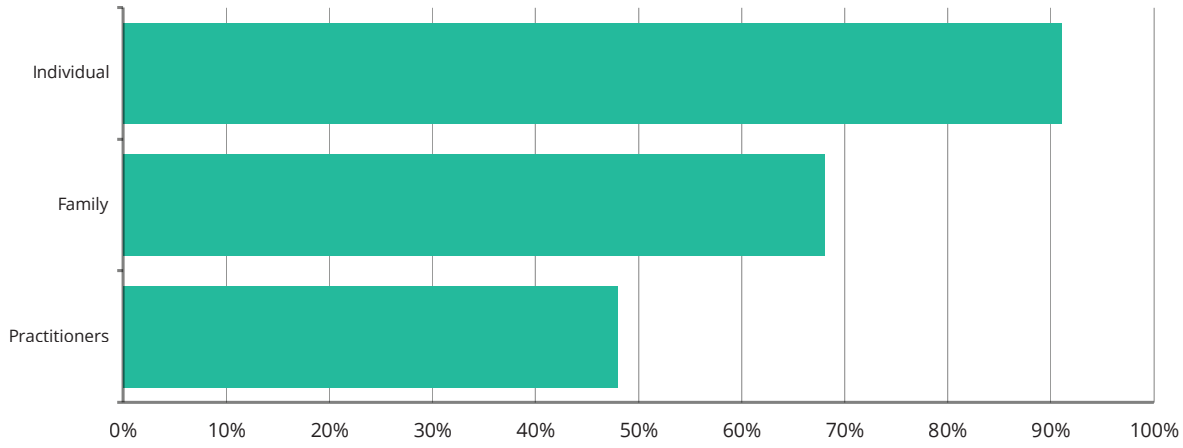



**Figure 3. Proportion of individuals who wanted to go home after a hospital stay in comparison to their family and practitioners.**

## 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.

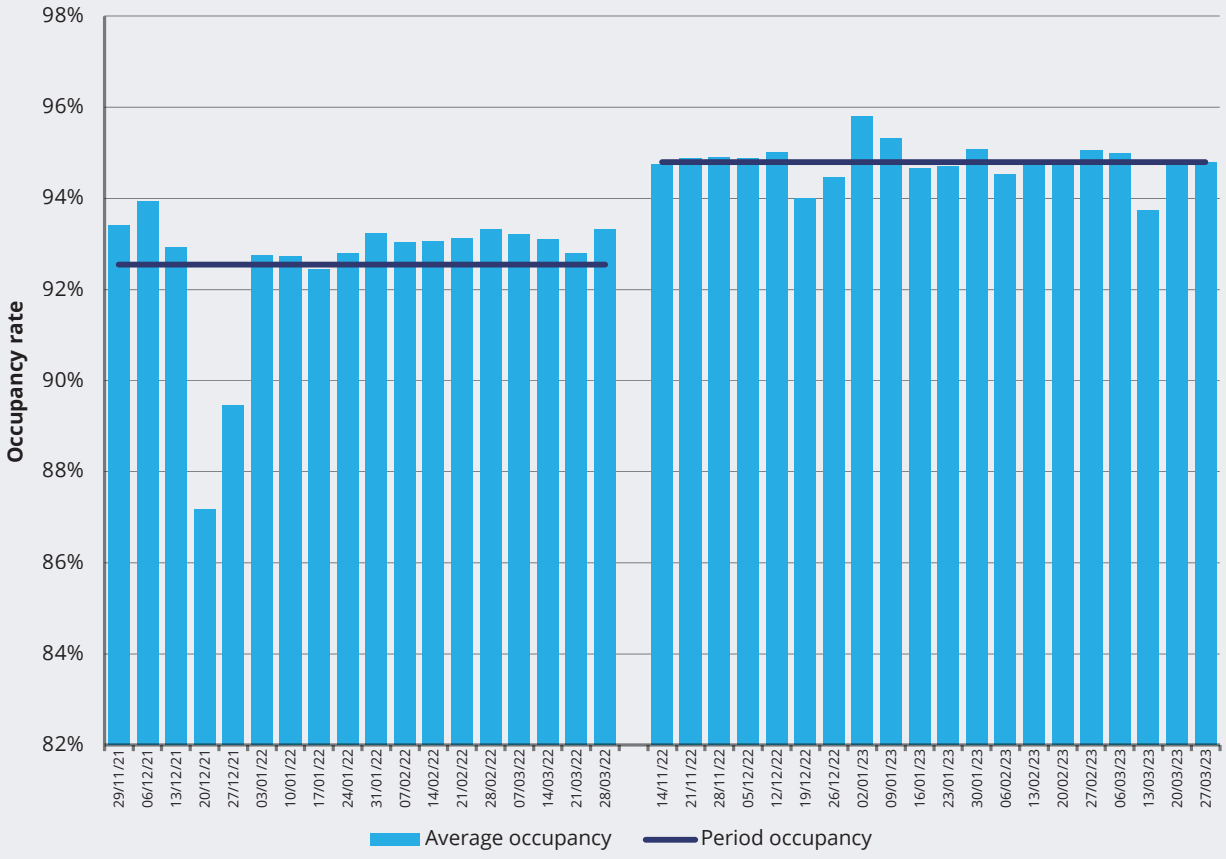



**Figure 4. Weekly occupancy rate for general and acute, and adult critical care beds.**

## 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.

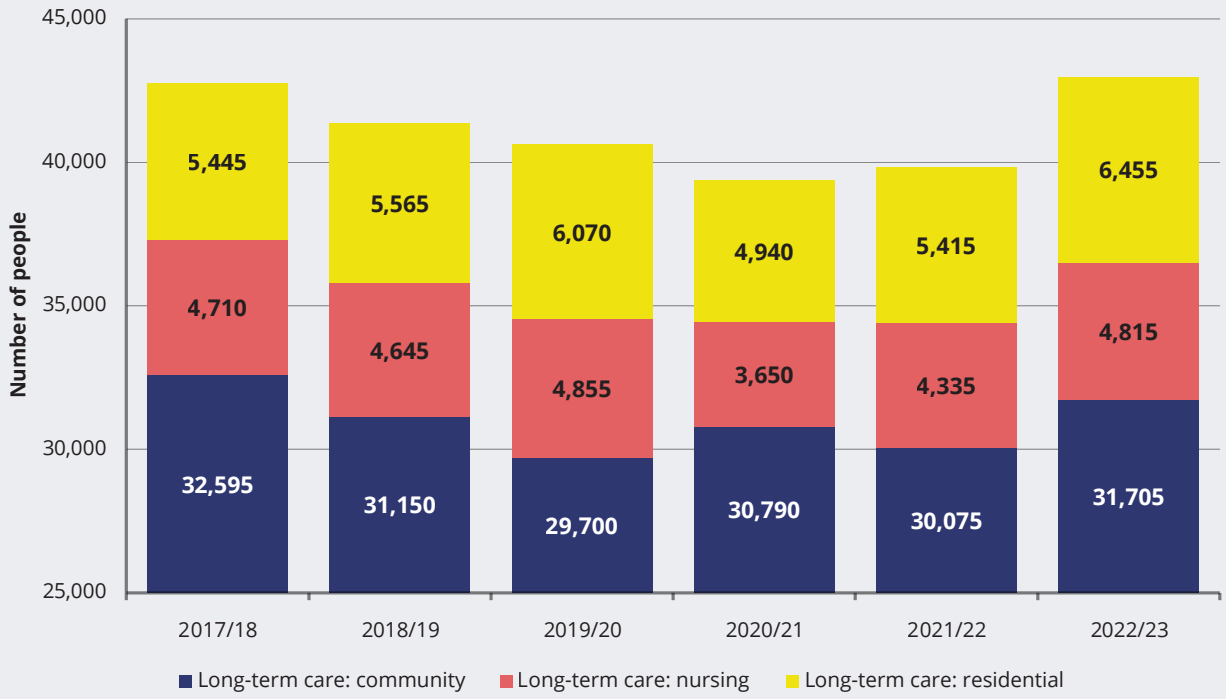



**Figure 5. Number of 'new' people being discharged from acute hospitals to long-term care.**

# 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.

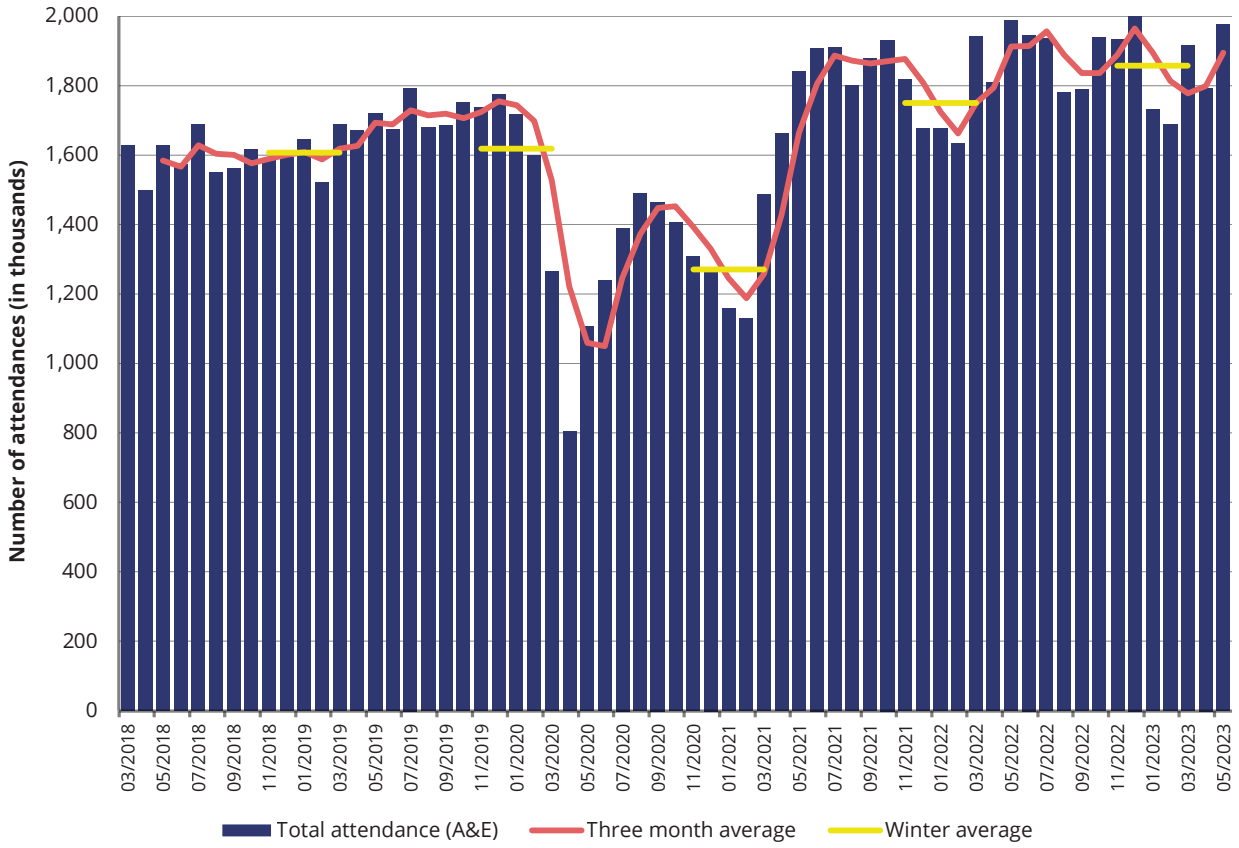



**Figure 6. Attendance rates at all English trusts with a type 1 A&E department (between March 2018 and May 2023).**

## 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.

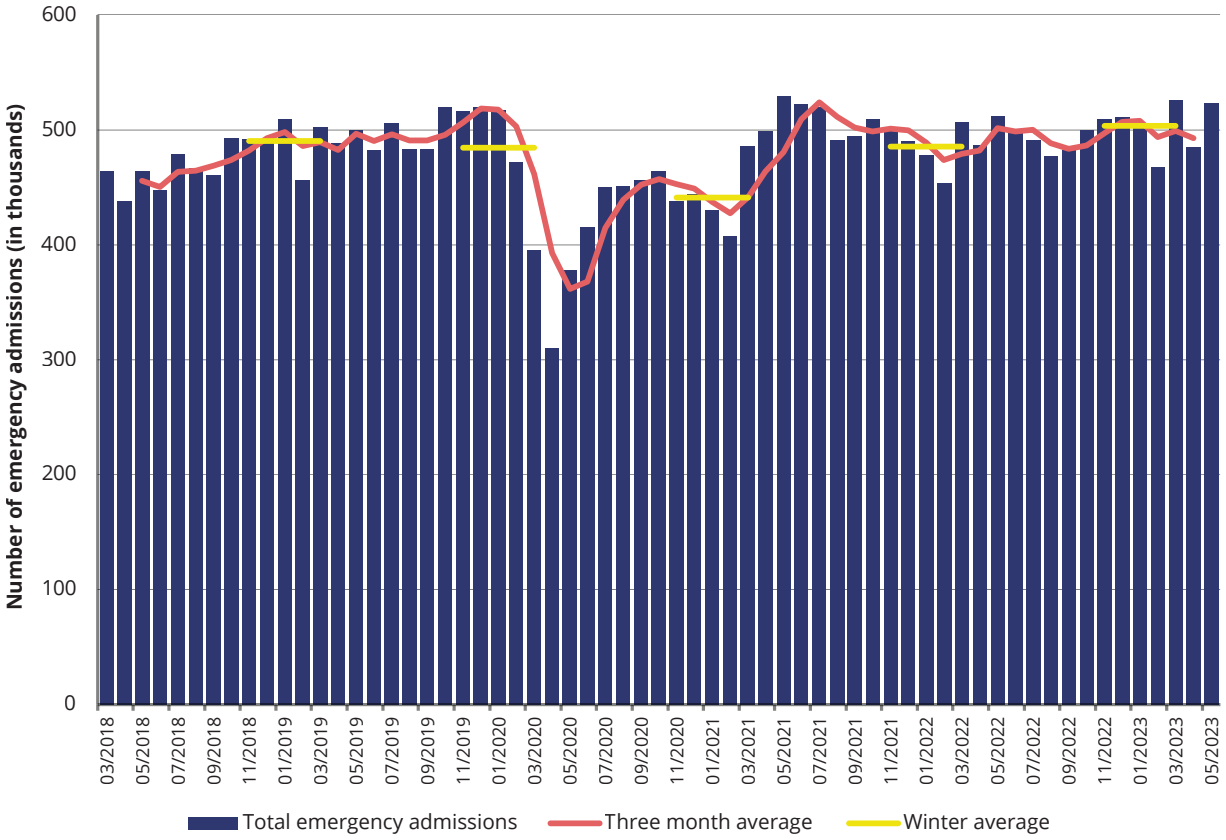



**Figure 7. Acute emergency admissions to hospital trusts with type 1 A&E departments (March 2018 to May 2023).**

### 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.

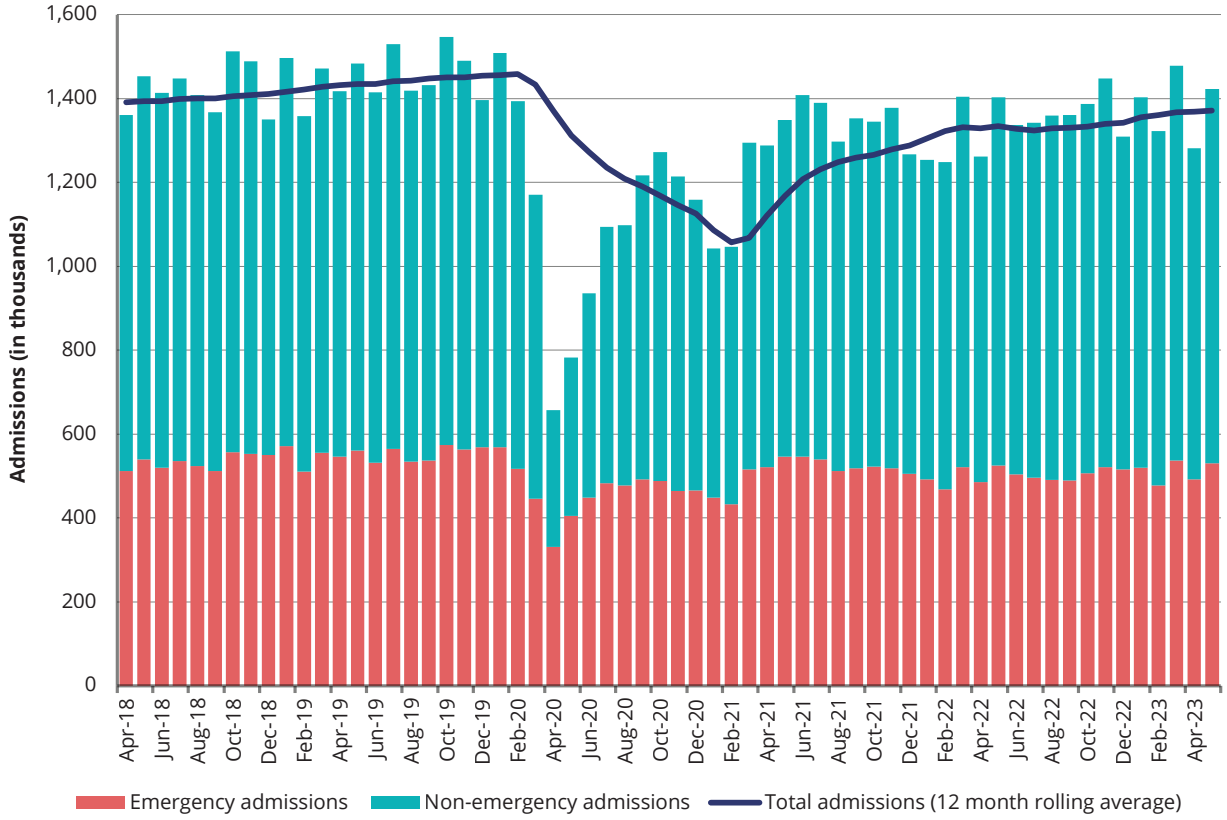



**Figure 8. Total admissions from April 2018 to May 2023 across all English trusts.**

## 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.

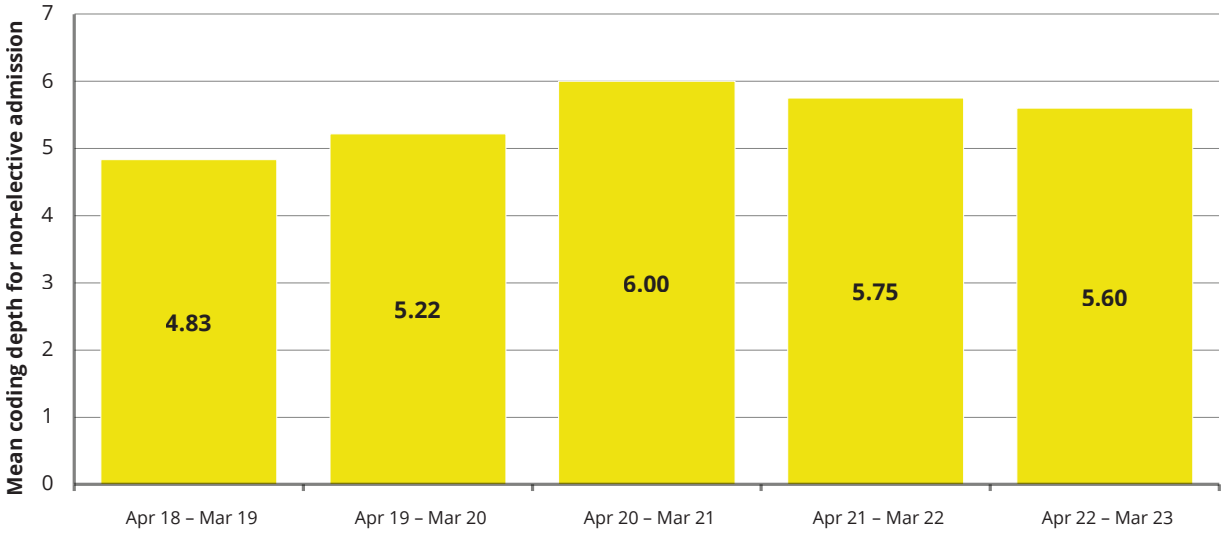



**Figure 9. Average number of co-morbidities for non-elective admissions for all trusts with type 1 A&E departments.**

# 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.

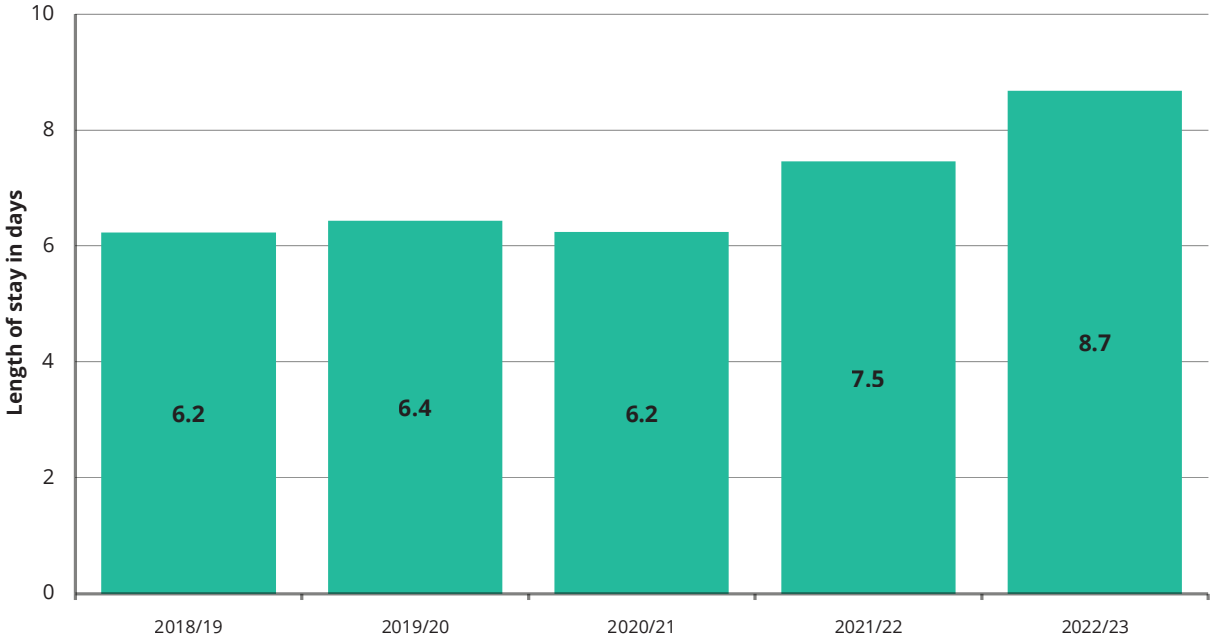



**Figure 10. Average length of stay in hospital across nine trusts for individuals aged 65 or above, following a non-elective admission.**

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).

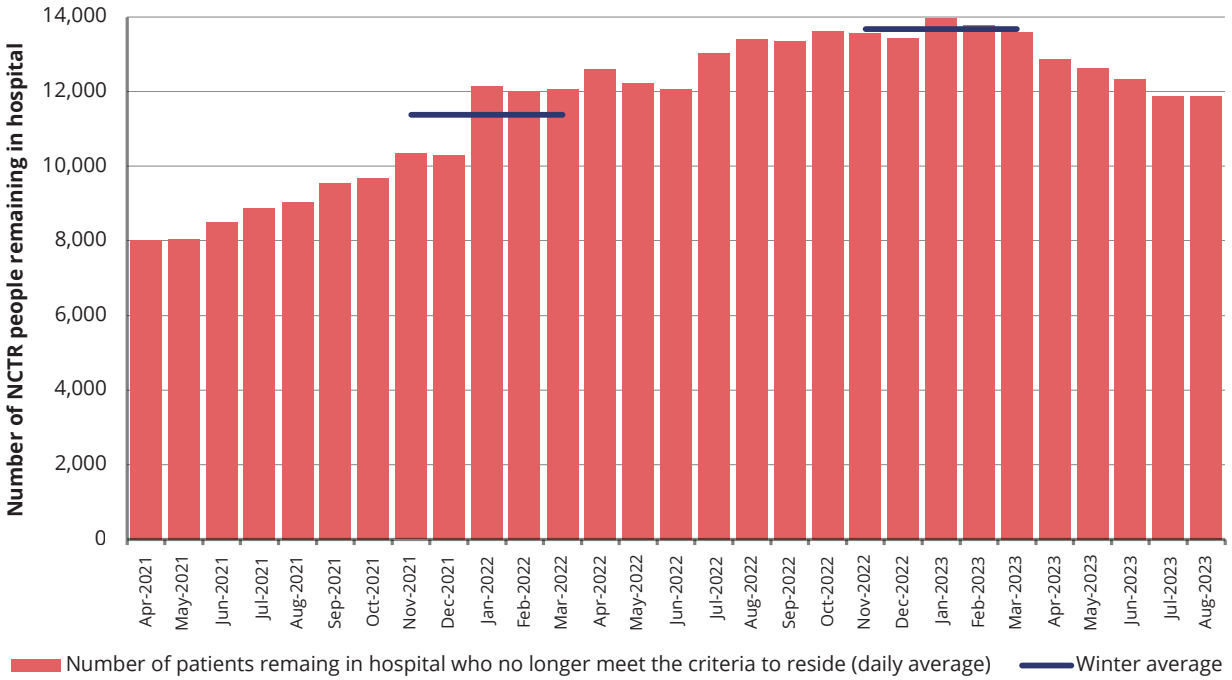



**Figure 11. Number of people medically fit remaining in hospital (i.e., with no criteria to reside) for all trusts with type 1 A&E departments. April 2021 to August 2023.**

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]

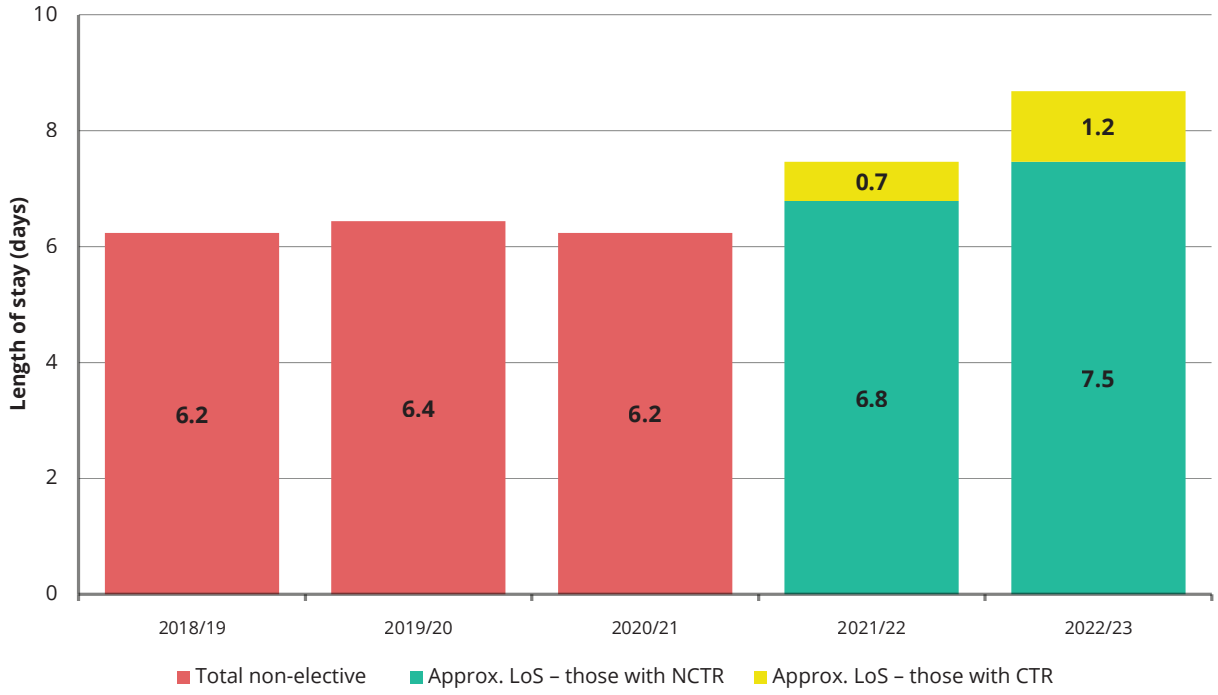



**Figure 12. Average length of stay (LoS) across eight trusts for individuals aged 65 or above following a non-elective admission, for those with both criteria to reside (i.e., not medically fit to be discharged) and no criteria to reside (i.e., medically fit).**

# 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.

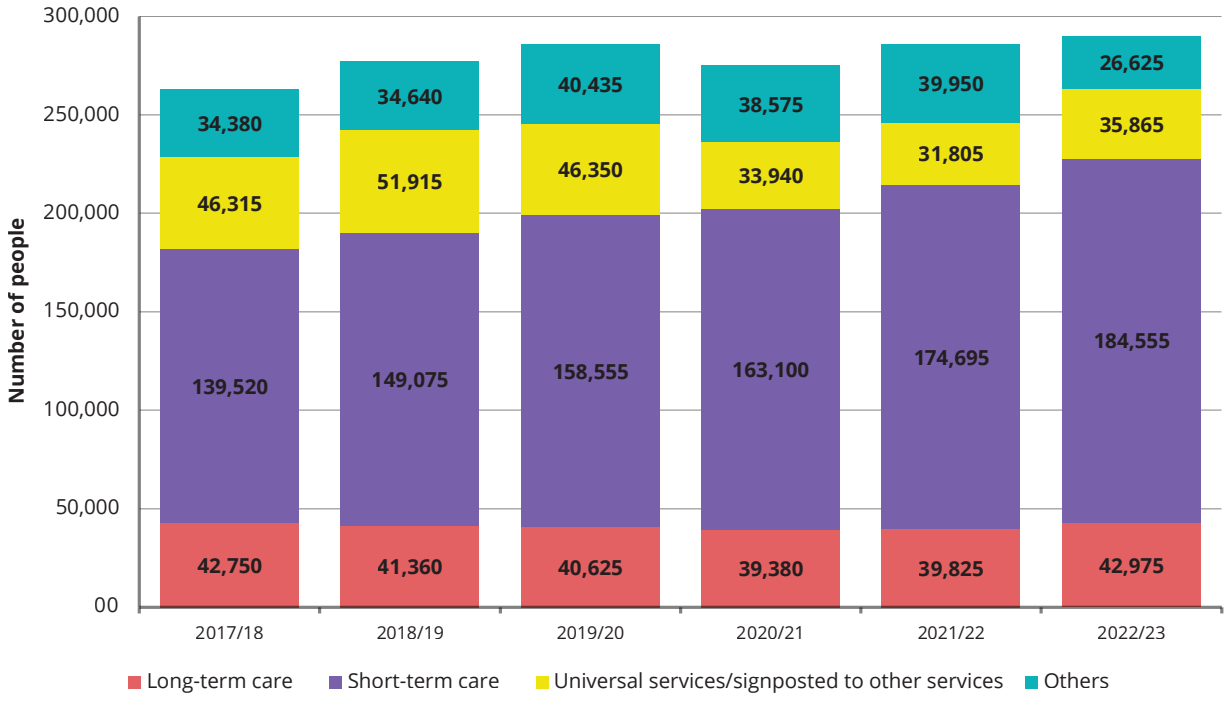



**Figure 13. Type of care provided to older people from the point of hospital discharge.**

# 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.

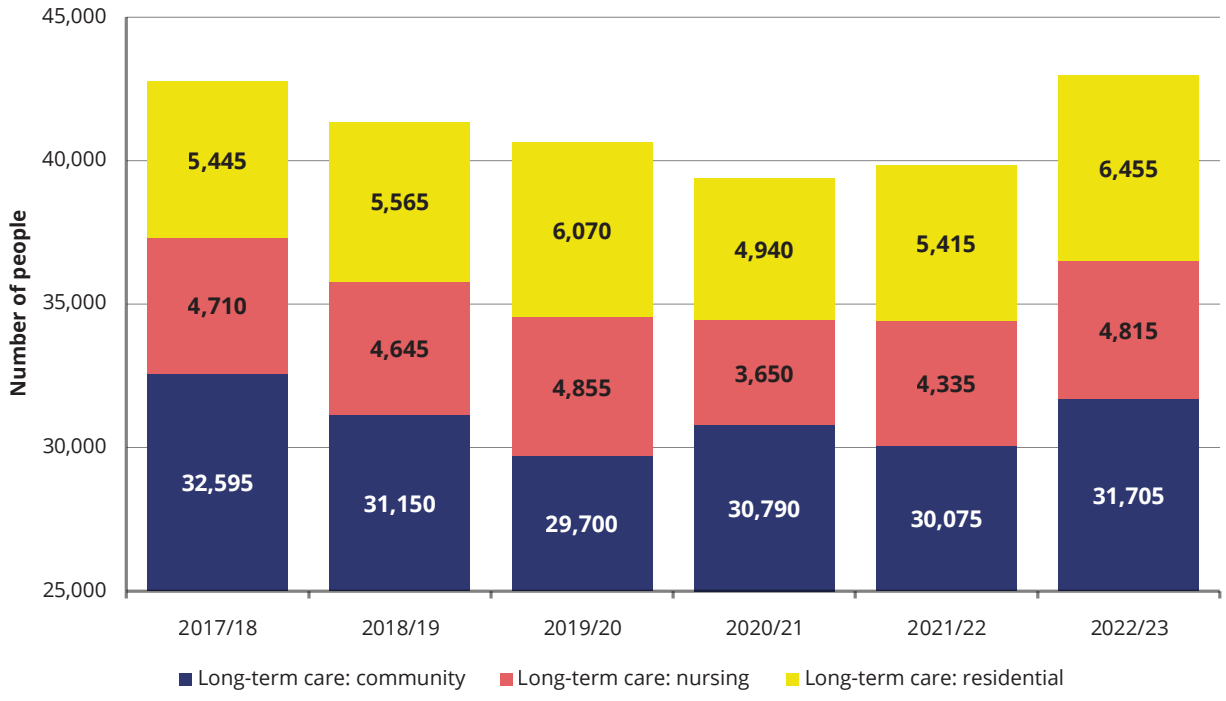



**Figure 14. Number of 'new' people being discharged from acute hospitals to long-term care.**

# 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.

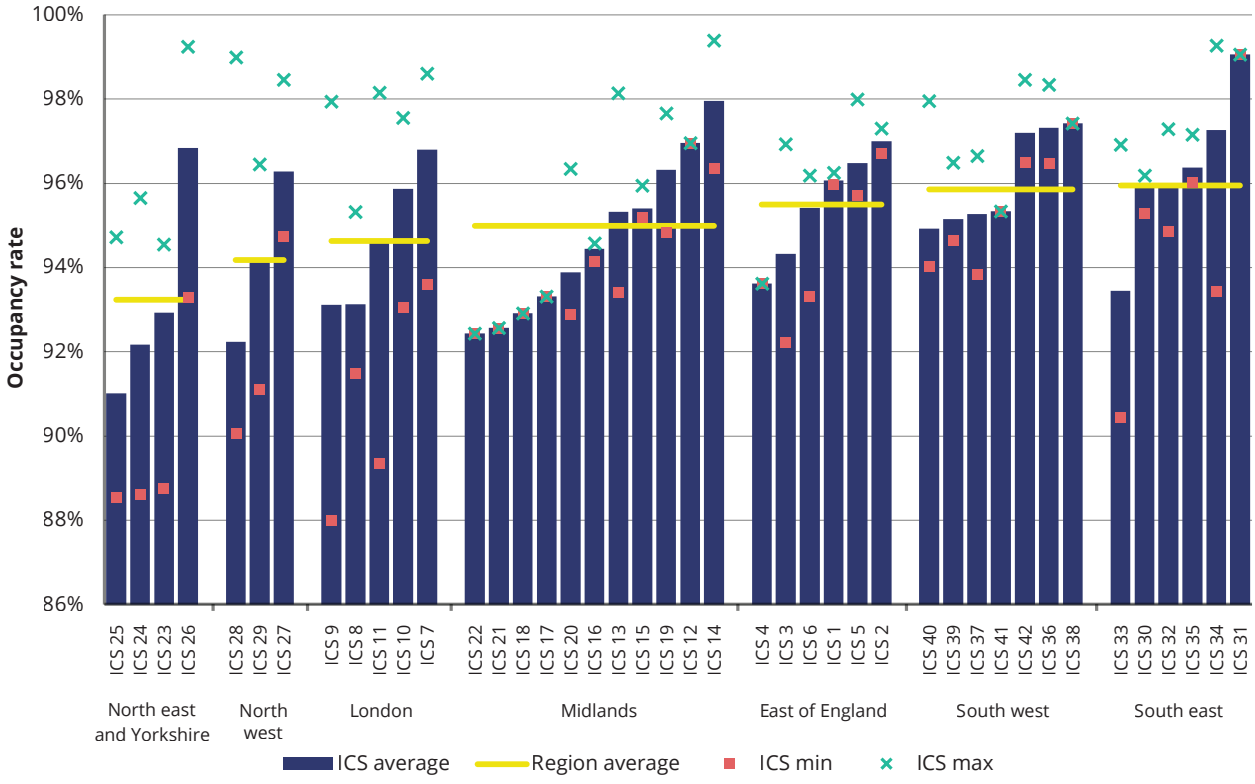



**Figure 15. Winter 2022/23 occupancy rates in both adult general and acute, and critical care beds, split by ICS.**

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.

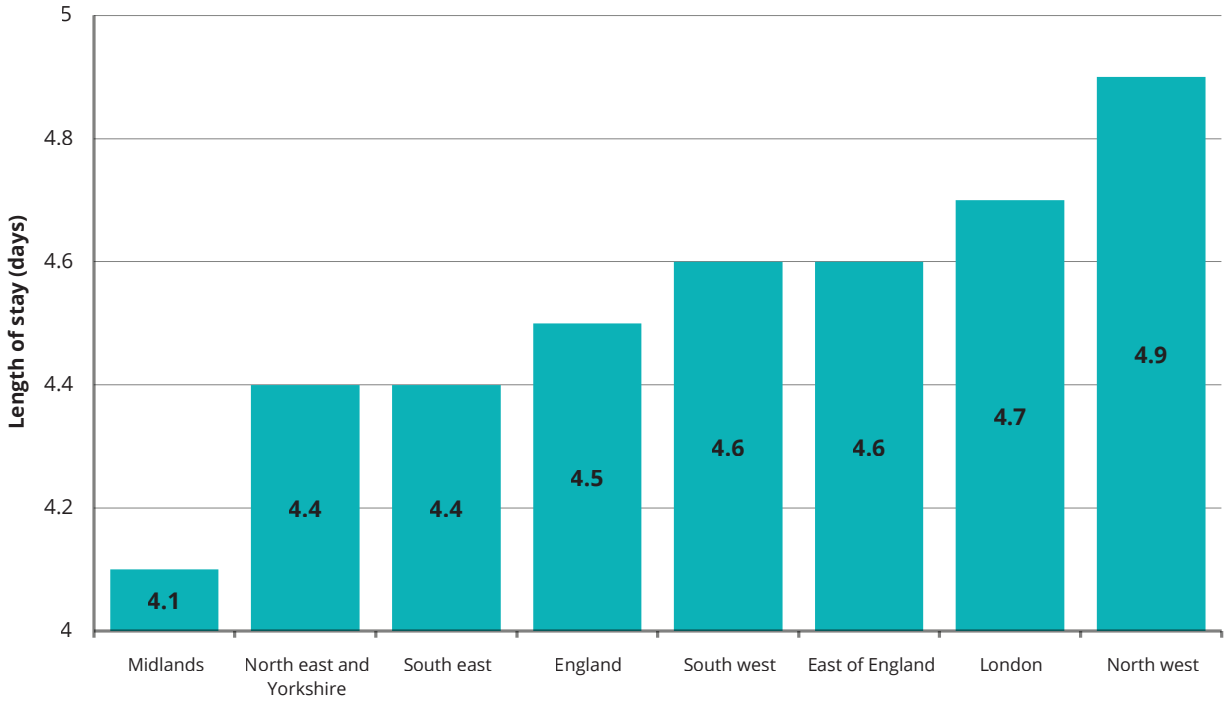



**Figure 16. Average length of stay (for emergency and elective admissions combined) for all trusts with type 1 A&E departments by region, in year 2022/23.**

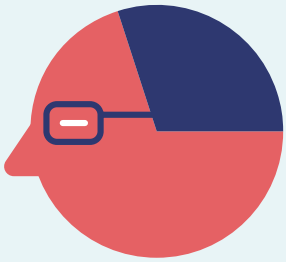
07

# 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%**

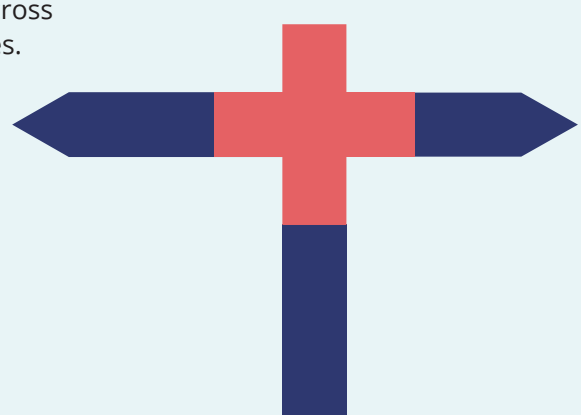
of the total length of stay of an older adult on a non-elective pathway is made up of avoidable delays.

**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.

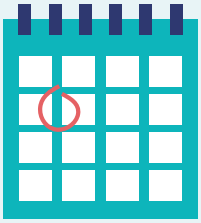
### Complex discharges

**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.



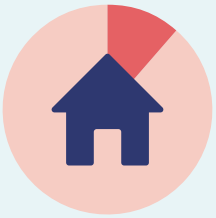
## Intermediate care

– 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.

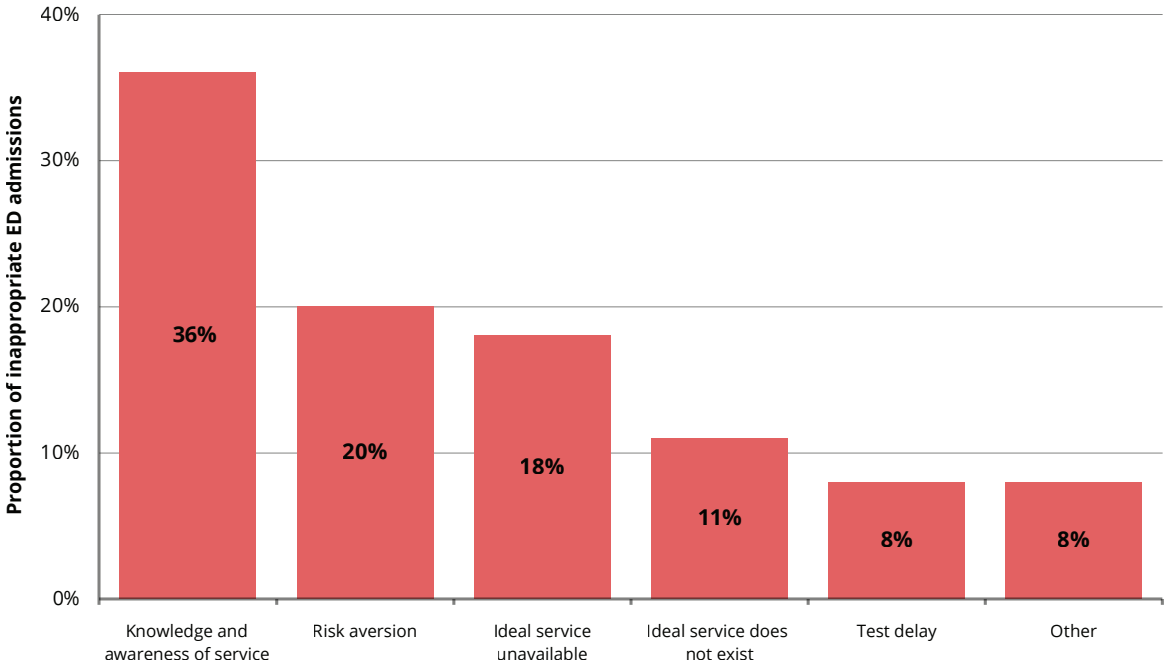



**Figure 17. Reasons for inappropriate hospital admissions across seven local health and social care systems where an older adult was admitted to an acute hospital.**

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.

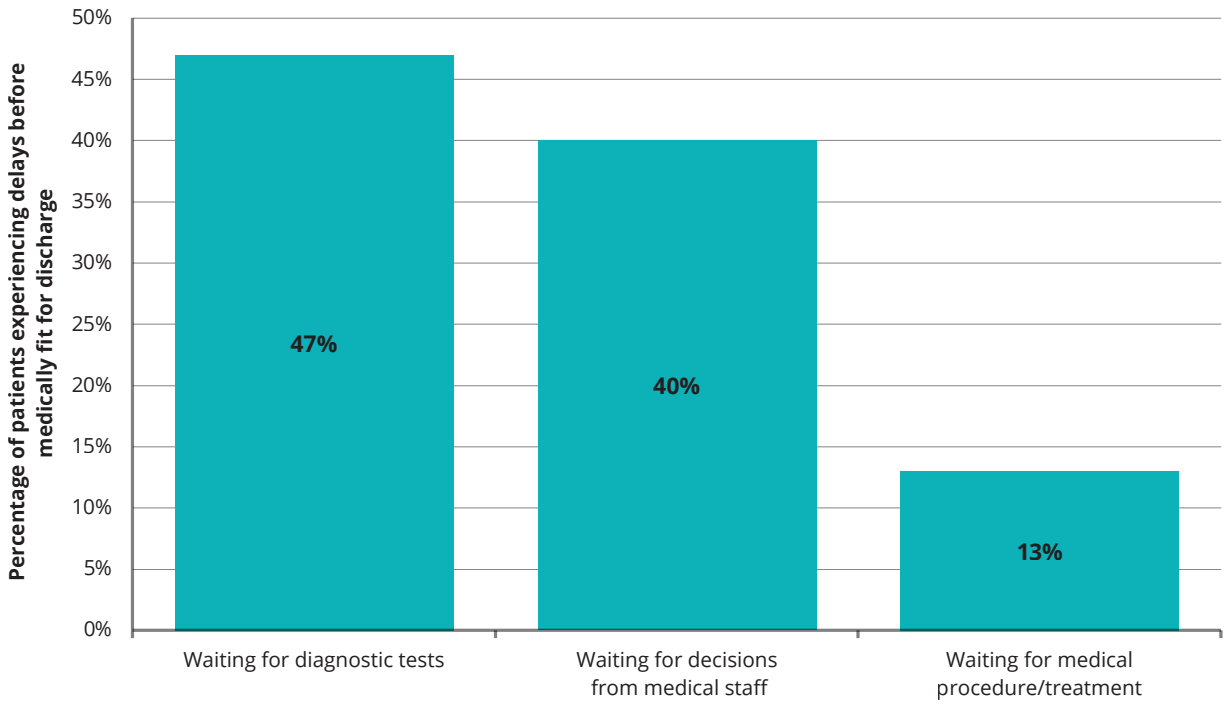



**Figure 18. Reasons for delays in hospital treatment, and percentage of people impacted.**

## 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.

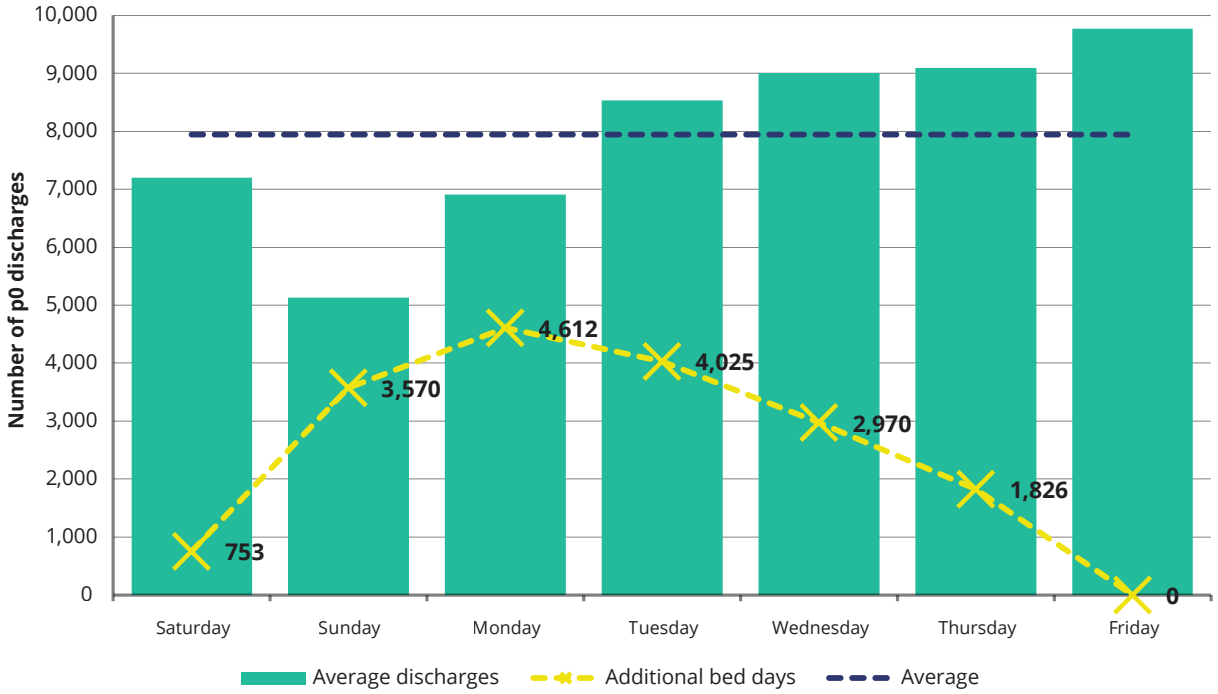



**Figure 19. Average Pathway '0' discharges per day in winter 2022/23 and associated bed days impacted.**

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.

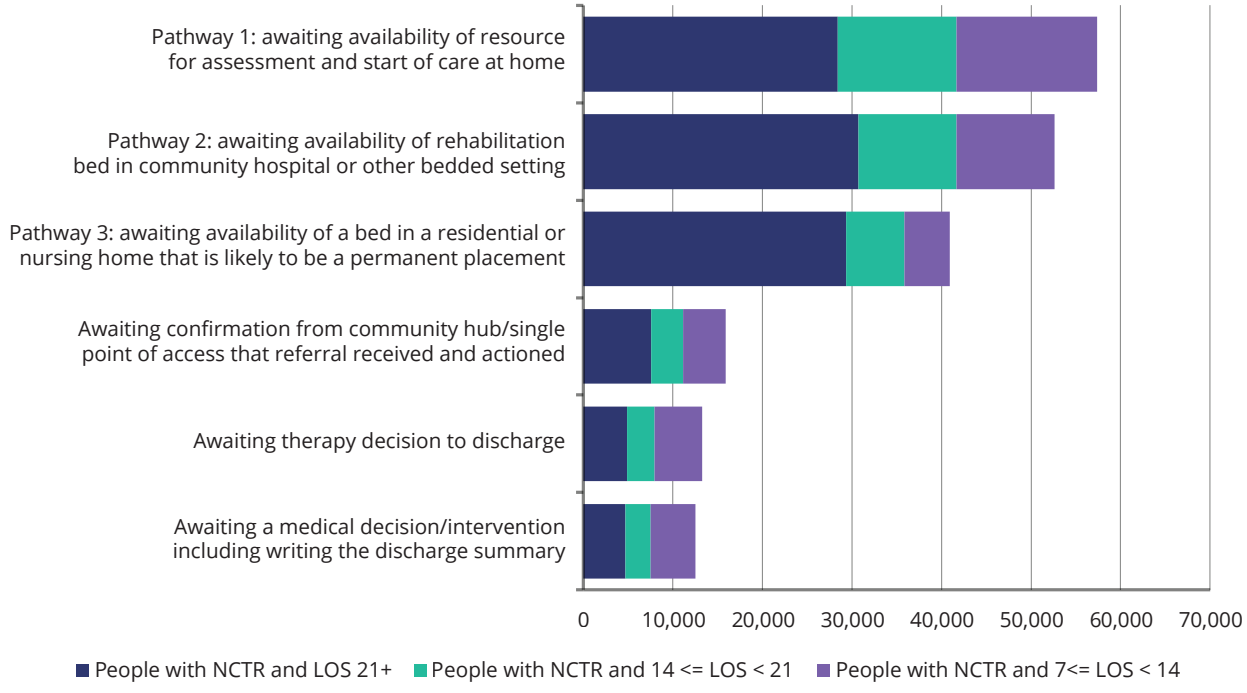



**Figure 20. Key reasons why people medically fit (i.e., with no criteria to reside) with different lengths of stay remain in hospital (winter 22/23).**

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

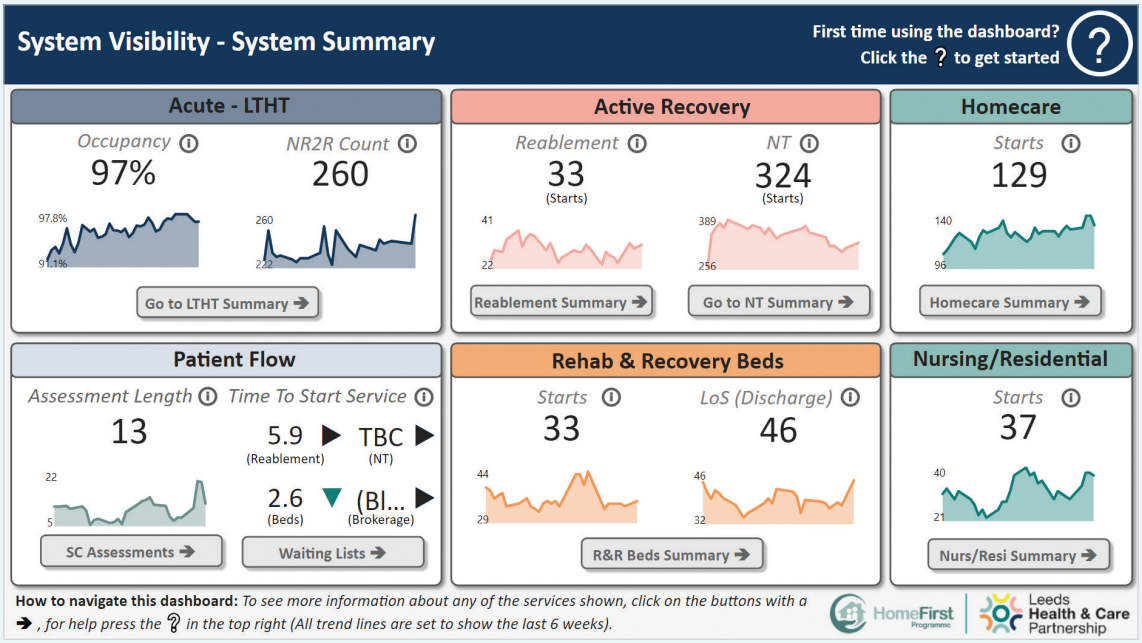
Crucially, the tool enables people to see in real-time the impact of any changes that are made to address issues. This not only helps to build trust in those changes but can also allow further adjustments to be made until the desired impact is achieved.

## 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]

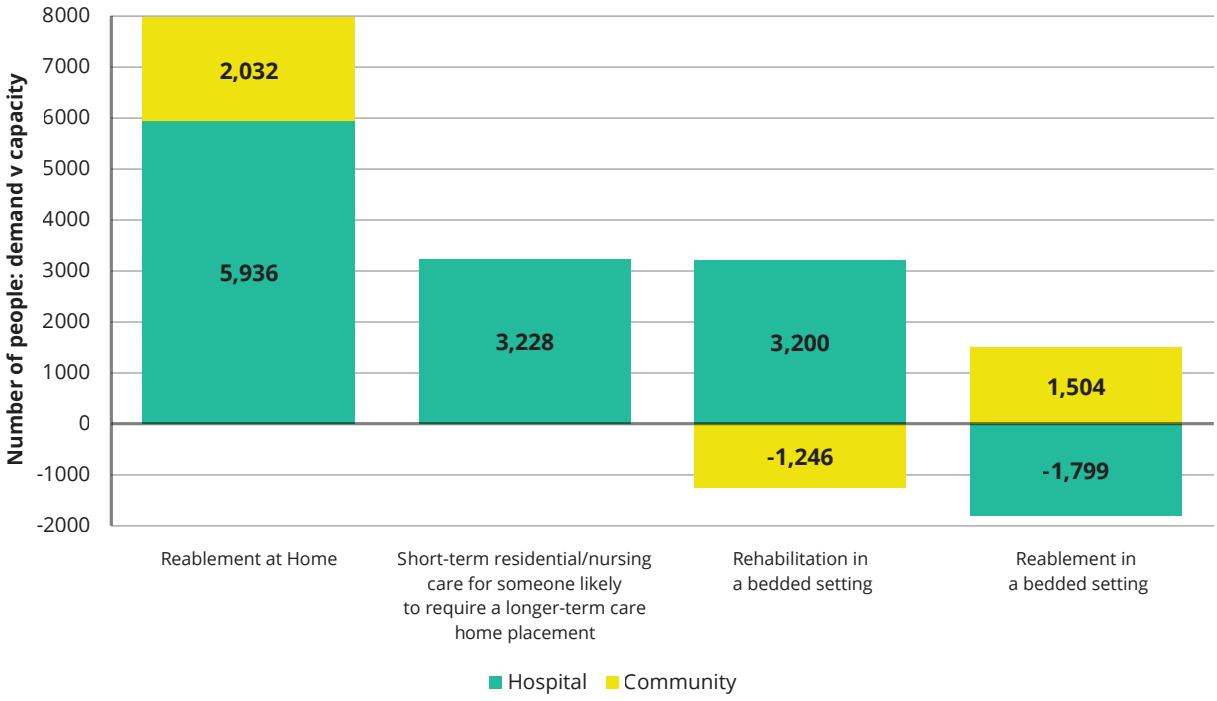



**Figure 22. Analysis of social care capacity for hospital discharges in 2022/23.**

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.

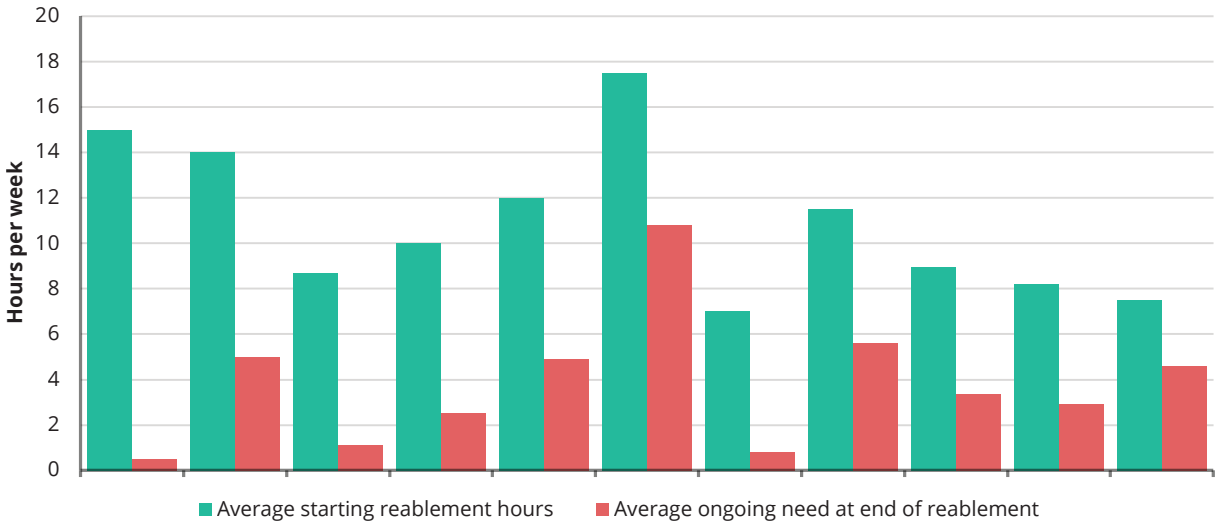



**Figure 23. Comparison of effectiveness of 11 different reablement services, comparing start need to end need.**

## 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.

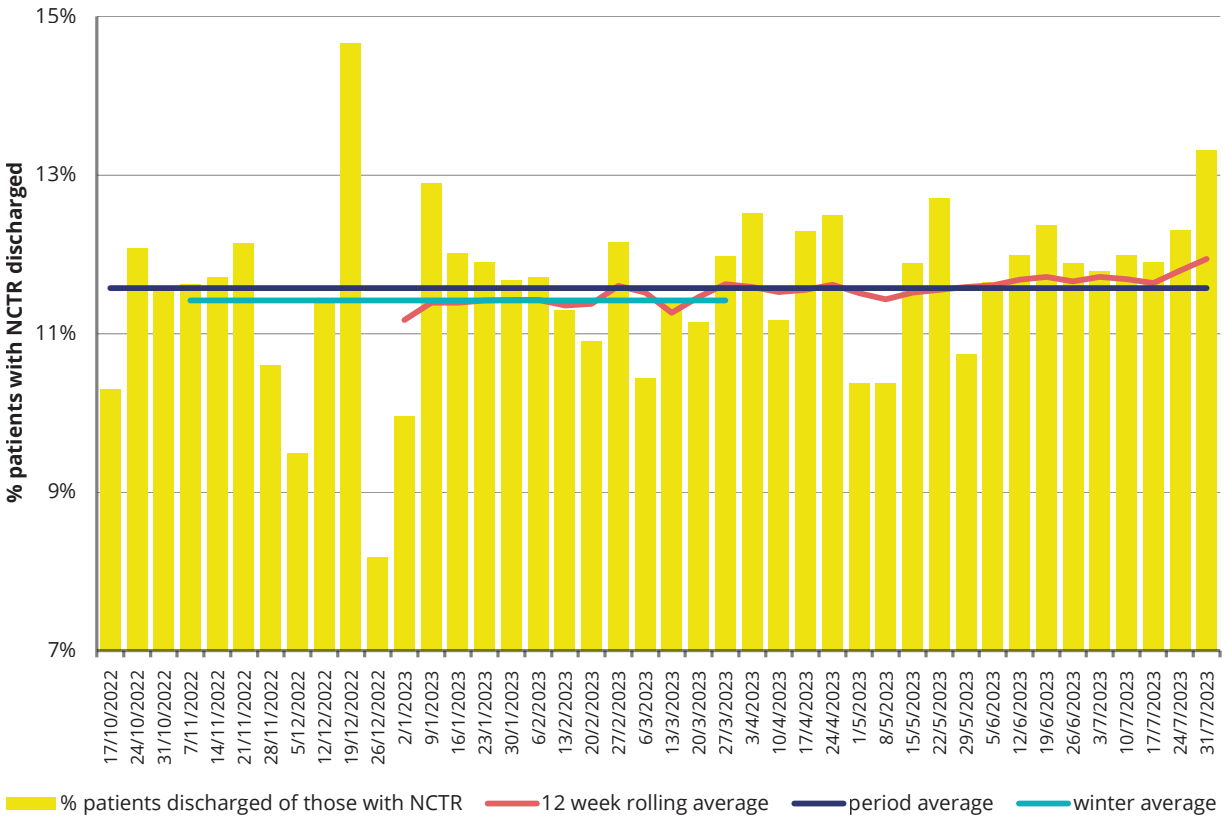



**Figure 24. The proportion of people who are medically fit (i.e., who have NCTR) who are discharged on time.**

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

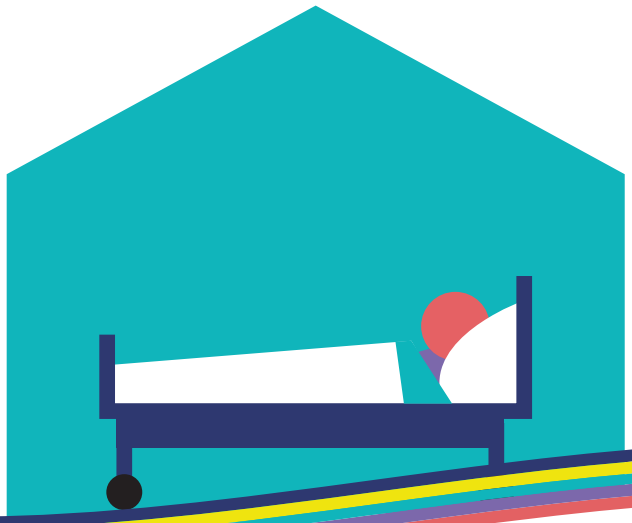
Where hospital flow and discharge are optimised, decision-making around long-term outcomes has an appropriate approach to risk management and prioritises long-term independence as the core principle. In doing so, this focus on long-term independence also supports minimising discharge delays, with fewer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

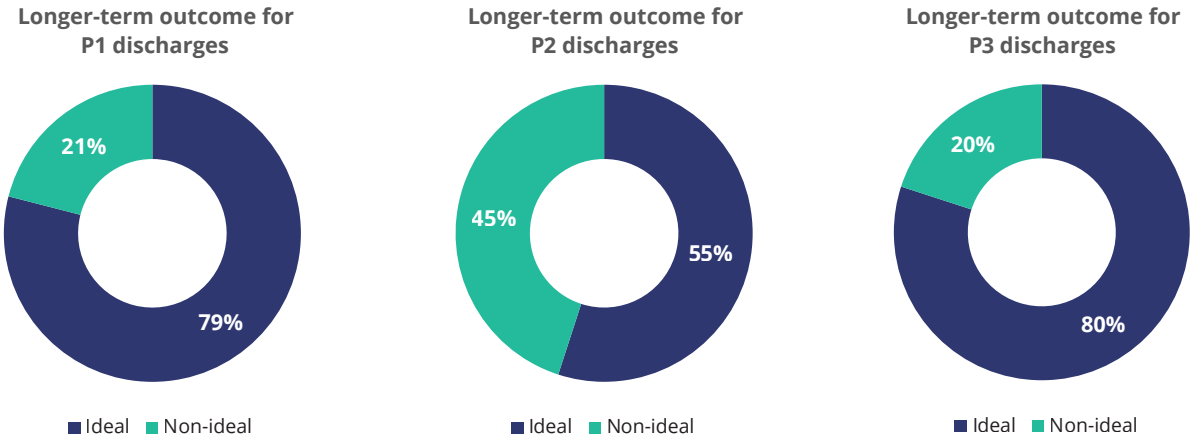
This replaced a local service that had been previously run through the NHS and which had not achieved outcomes required. The new reablement service agreed to pay providers £1,200 per episode of reablement whatever time the recovery took for the older person. This averages out at around 48 hours delivered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

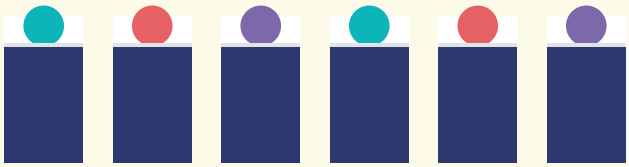
This is achieved primarily by building trust, confidence, and awareness of alternative community resources.

# 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.

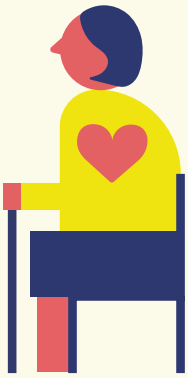
**There could be 1.1m fewer bed days lost to delayed 'complex' discharges – primarily as a result of improving capacity in intermediate care and reducing delays in the discharge process.**

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.

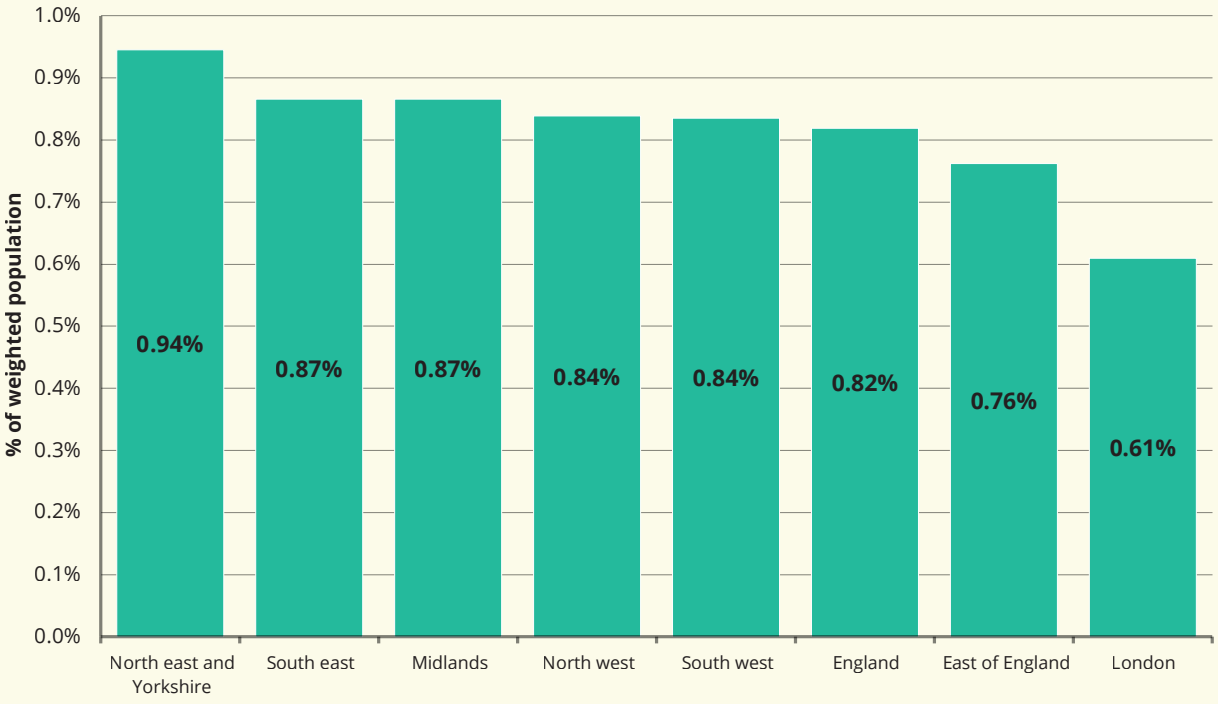



**Figure 26. Emergency admissions per weighted population in winter 2022/23.**

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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