Capacity & Demand Planning

Reflections from working in a number of systems, supporting the understanding of capacity & demand

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Date 2023

Helping places develop their Capacity and Demand Plans

The work has been commissioned by the **Local Government Association** (LGA) on behalf of the **Better Care Fund** (BCF) working with the **Department of Health and Social Care** (DHSC)

Places are either recommended for the help by the BCF or DHSC or they request help for themselves direct from the LGA – access via: **BCFsupport@local.gov.uk**

Contractors were commissioned through the LGA procurement process

The concept of using Capacity and Demand Planning to help places meet the needs of older people either in admission avoidance or in hospital discharge was outlined by Professor John Bolton in his paper: “Commissioning out of hospital care services to reduce delays” published by IPC in March 2020. This paper also built on earlier work on “Care Pathways”.

JRFB Limited did the pilot work (pre-Covid) and have developed the approach in the post covid era. LGA published paper *“Developing a capacity and demand model for out of hospital care”* – September 2021

What does our approach look like (1/2)

Understand the week by week/ month by month demand on each of the care pathways (as defined in the DHSC Guidance) with a focus on Intermediate Care Services (P1 and P2)

Critique why the use of each pathway is as it is for each system – unique

Examine the services that have been commissioned for the purpose of supporting older people recovery and rehabilitation post discharge – Intermediate Care Places

Examine the services that are being used to support hospital discharge but were not set up for that purpose e.g., short-term residential care

What does our approach look like (2/2)

Discuss what practices are required to change the patterns of demand – can more people be supported on P0 or P1?

Discuss what changes in commissioning needs to take place and what services need to be developed to meet local need consistently

PRODUCE CAPACITY AND DEMAND PLAN FOR SHORT AND MEDIUM TERM – constantly review the data and the plans (use as a live tool) but plan to develop over a few years

BCF/LGA partnership running webinars and offering support

The basic data for older people – different for each acute hospital

	Percentage of older people being discharged on each pathway	Number in a week	
Pathway 0	**59%**	**320**	Could be higher
Pathway 1	**26%**	**142**	Could be higher
Pathway 2	**8%**	**42**	Could be lower
Pathway 3	**6%**	**34**	Should be lower
Total	**100**	**538**	

	Jun-23 discharges		Jul-23 discharges		Aug-23 discharges	
	Number	%	Number	%	Number	%
Total discharges: NEL Discharges	*4498*		*4429*		*4660*	
Pathway 0	4185	93.0	4125	93.1	4345	93.2
Pathway 1	190	4.2	176	4.0	171	3.7
Pathway 2	73	1.6	71	1.6	85	1.8
Pathway 3	50	1.1	57	1.3	59	1.3

	Jun-23 discharges		Jul-23 discharges		Aug-23 discharges	
	Number	%	Number	%	Number	%
Total discharges: Excluding Obst & all Paeds Specs	*3220*		*3191*		*3411*	
Pathway 0	2907	90	2887	90	3096	91
Pathway 1	190	6	176	6	171	5
Pathway 2	73	2	71	2	85	2
Pathway 3	50	2	57	2	59	2

	Jun-23 discharges		Jul-23 discharges		Aug-23 discharges	
	Number	%	Number	%	Number	%
Total discharges: Further limiting to just PF Wards	*2457*		*2445*		*2717*	
Pathway 0	2144	87	2141	88	2402	88
Pathway 1	190	8	176	7	171	6
Pathway 2	73	3	71	3	85	3
Pathway 3	50	2	57	2	59	2

Don’t make this too complicated
- This is not “rocket science”

Better Care Fund
Support Programme

Demand

The numbers of older people requiring post hospital support (for recovery and rehabilitation) vary significantly from place to place – for most places a range of between 20% and 30% of older people leaving hospital require help from Intermediate Care Services (P2 or P3) but places do have as low as 10% or as high as 40% - places with 30% or over struggle

There are many factors that impact on demand:

- The participation of older in activity during their hospital stay and the impact of deconditioning on those people (Spanish study)
- The risk averse practices within hospitals from the multi-disciplinary team
- More bed days are lost from P0 than from P1, 2, & 3 combined
- The ready availability of the right type and quality of commissioned services to meet known need (40% of older people leave on the “wrong care pathway”)
- The processes and decision making within the acute hospital
- The adoption of Discharge to recover and then assess - D2A or D2RA
- The investment in P0 – community, carers and voluntary support

Capacity

Most places have commissioned insufficient capacity to meet the known demands of older people for recovery and rehabilitation post an episode in an acute hospital

This has meant that large numbers of older people are either unnecessarily delayed in the acute hospital or when they eventually leave, they are placed on the wrong care pathway

This means that unnecessary demand for longer term social care is created by the poor discharge system – particularly higher placements in residential and nursing care
The biggest significant areas where there is a short fall in services are:

- Insufficient commissioning of specific dementia care services in both community and in bedded care
- Too much commissioning of inappropriate bedded care of little value for the older person
- Insufficient focussed support and capacity in the care at home services – rapid response/urgent care (nursing) and reablement

Not enough Intermediate Care: Older People on “wrong” care pathway

- Reduce the numbers of older people going to care homes on Pathways 2 & 3 – at least half of these could have gone home in many systems. P3 should be in P2 services (D2A)
- Improve the recovery-based offer for those older people on Pathway 2 – don’t spot purchase residential care beds for this purpose – 66% should make a recovery to return home
- Improve the efficiency and effectiveness of those who require Pathway 1 – and increase capacity on Pathway 1 66% should have no further support needs
- Work with voluntary sector to make an offer to help older people return home with minimum support on Pathway 0 – taking pressure off Pathway 1
- Improve community and bedded offer for older people with demntias

Step-Up or Step Down

Focus on rehabilitation / recovery/ reablement

Community Hospitals can play both roles but historically not really fulfilled much of an admission avoidance role

Strong with a focus on frailty – helping people cope at home

Good with older people with multiple co-morbidities – complex needs

Not helpful for older people with dementias- partly because of requiring more specialist staff

If Intermediate Care facilities are going to be used for step up as well as step down that needs to be added to the required capacity in the system and properly funded

Evidence for admission avoidance shows investment in community health services makes the biggest impact

Bedded Facilities (1/2)

- Greater functional independence at 6 months for those who had been in a bed -based rehabilitation unit than those who had not which proved to demonstrate the cost effectiveness of this help - Exeter University Research – Measuring and Optimising the efficiency of community hospital in-patient care for older people. Other International Studies show similar impact.

- Health and Care systems report, that if an older person is placed in a residential care home without any focus on rehabilitation, there is an 70%-80% chance they will remain in that place for the rest of their lives – if the bedded facility (Community Hospital or Care Home) has a focus on rehabilitation and recovery there is a 65%- 85% chance that they will return to their own home.

- Exeter study found 2/3rds can return home. 15% at risk of readmission, 10-15% admitted to longer term care with average length of stay in Community Hospital at 26 days with high bed occupancy (86%-100%)

Bedded Facilities (2/2)

- Several places have recently commissioned new bedded rehab services in both Community Hospitals (e.g., Leicestershire, Leicester City and Rutland) or in Former Care Homes (Northamptonshire) with a very positive impact on the outcomes for older people
- Some places (North Yorkshire) use some extra care housing beds to help older people rehabilitate
- Evidence suggests the outcomes achieved will, in part, depend on the in-take of people admitted e.g., Northants take people with confusion/delirium

Bedded vs Home

Philosophy of Home First – best place to recover

Cost of bedded care about 2X as much as care at home per day (National Audit of Intermediate Care)

However, some people require a more protected and supported environment in which to recover – good use for someone who is considered may require long term residential care because of physical frailty (rather than dementia)

The cost of NOT helping an older person to recover is very high for both NHS and Social Care

No one should be assessed in an acute bed for their longer-term care needs – need opportunity and time for recovery

LLR had no admissions on P3 for a period as all those eligible went on P2.

If bedded placements make up over 30% of those who are on care pathway – hard to sustain

Key Measures for Intermediate Care

Patient Flow

- How long does a patient remain in each stage of the process from a hospital bed, awaiting discharge (awaiting admission to a care home), in a P2 service and in a P1 service.
- Understanding the above information also helps to calculate how much resource is required for each of the Intermediate Care services

Outcomes

- What proportion of older people in a P2 service return home?
- What proportion of older people in a P1 service require no on-going support?
- The suggested performance for both services is 66%

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Read papers:
Developing a capacity and demand model for out of hospital care –
Developing a capacity and demand model for out-of-hospital care (local.gov.uk)

https://ipc.brookes.ac.uk/publications.html
Commissioning Out of Hospital Care to reduce delays
New Developments in Social Care
Reducing Delays in hospital transfers in the care of older people: key messages in planning and commissioning

NHS Webinars
https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/better-care-fund/the-better-care-exchange/

https://future.nhs.uk/bettercareexchange/view?objectId=172463621
https://future.nhs.uk/bettercareexchange/view?objectId=172462021

Better Care Fund Support Programme