Patient demographics
PHIN data reveals who is using private healthcare

One eye on the future
CHEC CEO Imran Rahman talks about the company's growing role in the NHS

Delayed discharges
Randeep's Dr Michelle Tempest takes the temperature of care coordination across ICSs

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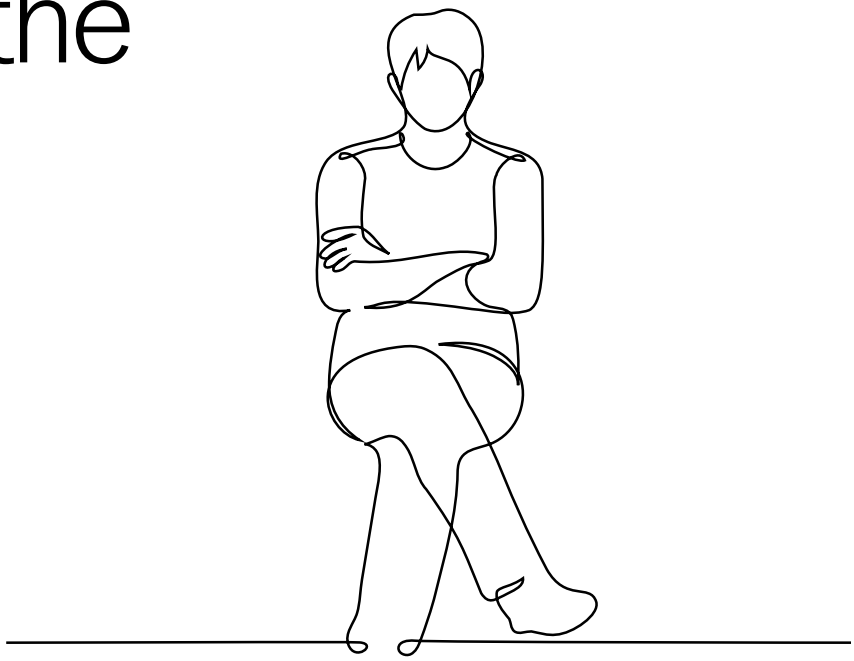
In focus

Firm foundations?

Self-pay has bolstered private healthcare providers since the pandemic but can it be sustained?

Delayed Transfers of Care have plagued the NHS for decades and despite the obvious benefits, there is little sign they will be eliminated any time soon. **Dr Michelle Tempest**, partner at Candesic, takes the temperature of care coordination across Integrated Care Systems and looks for hope in collaboration between leaders, investors and operators to join up care pathways

Hospital discharges taking on the delays



As next year's General Election fever looms, politicians of all parties will be tempted by the siren sound of headline grabbing NHS revolutionary change. Spin doctors have been employed to inspire and prepare for election battle. For example, Prime Minister Rishi Sunak's team have started by inviting social media influencers such as Dr Azmain Chowdhury and Dr Francesca Jackson-Spence to behind-the-scenes footage at Number 10 Downing Street.

However, radical healthcare announcements which can be 'seen from space' may not inspire voter confidence. They can be unsettling and unnecessary. The recipe for saving the NHS will require both bravery and new ideas to change the NHS from a sickness service into proactive healthcare prevention. But is radical policy change needed? The 42 Integrated Care Systems (ICSs) are still quite new. ICSs only legally formed after the passing of the Health and Care Act of 2022, with four broad aims:

1. **Improve outcomes for population health and care**
2. **Tackle inequalities in outcomes, experience and access**
3. **Enhance productivity and value for money**
4. **Help the NHS support broader social and economic development**

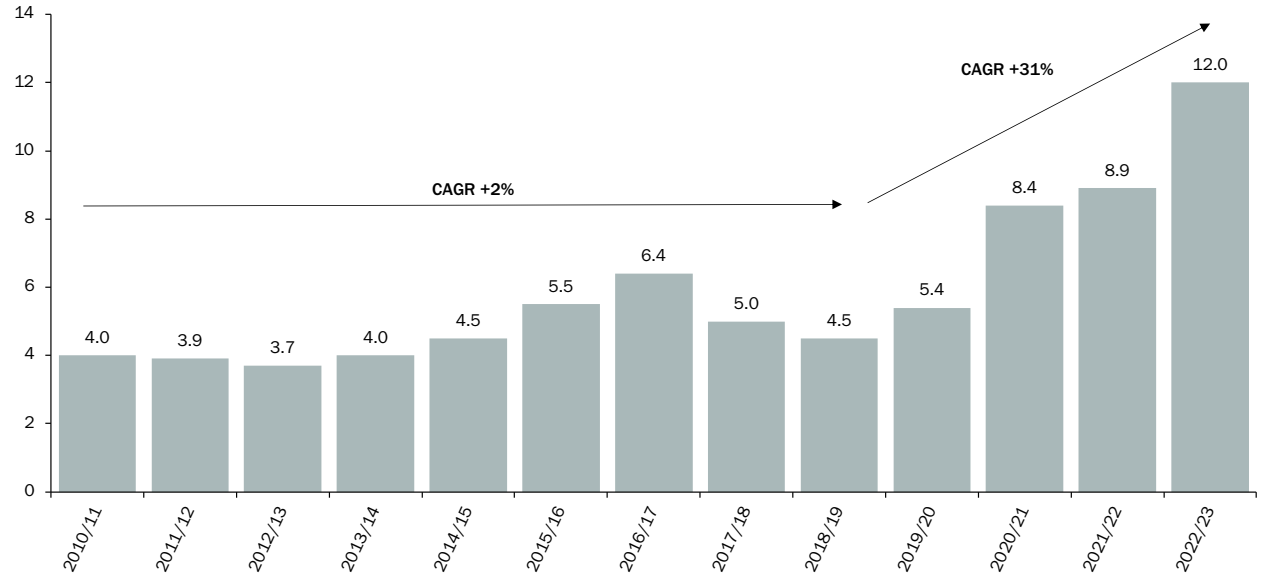
The ICS formation holds the promise of a fundamental shift to focus on linking integrated joined up care delivery across both health and social care systems. Arguably, the people at the helm of the 42 ICSs across England could greatly impact their local populations, which vary in size from around 500,000 to 3 million people. Local initiatives are yet to embed, but ICSs start their journey with some chronic challenges, acutely exacerbated by the pandemic.

As a brief reminder, let's start with some well-known fast fire facts:

- The NHS celebrates its 75th birthday this July and its infrastructure is aging
- Hospital waiting lists have spiralled, in England over seven million people are in a long and sometimes pain ridden queue for specialist care or surgery
- A record 2.5 million people are out of work because they are off sick
- NHS staff are leaving the profession in droves and at a faster rate than any other time in history
- Around 300,000 adults are waiting for social care assessments
- Britain lags its rich-world peers in terms of life expectancy, which

FIGURE ONE
DELAY IN TRANSFERS OF CARE OUT OF HOSPITAL HAS BEEN GROWING OVER 30% YEAR-ON-YEAR SINCE THE PANDEMIC

DELAY IN TRANSFER OF CARE (2010/11–2022/23), 000s OF DAYS



NOTES 2022/23 DATA CORRECT AS OF APRIL 2022; DELAY IN TRANSFER OF CARE - NUMBER OF DAYS DURING THE REPORTED PERIOD, ACUTE AND NON-ACUTE, FOR NHS ORGANISATIONS IN ENGLAND BY THE TYPE OF CARE THAT THE PATIENT WAS RECEIVING WHEN A PATIENT IS READY TO BE DISCHARGED BUT STILL OCCUPIES A BED
SOURCE NHS DIGITAL; CANDESIC RESEARCH AND ANALYSIS

has remained pretty static over the last decade, and sadly has some of the worst survival rates for diseases such as cancer

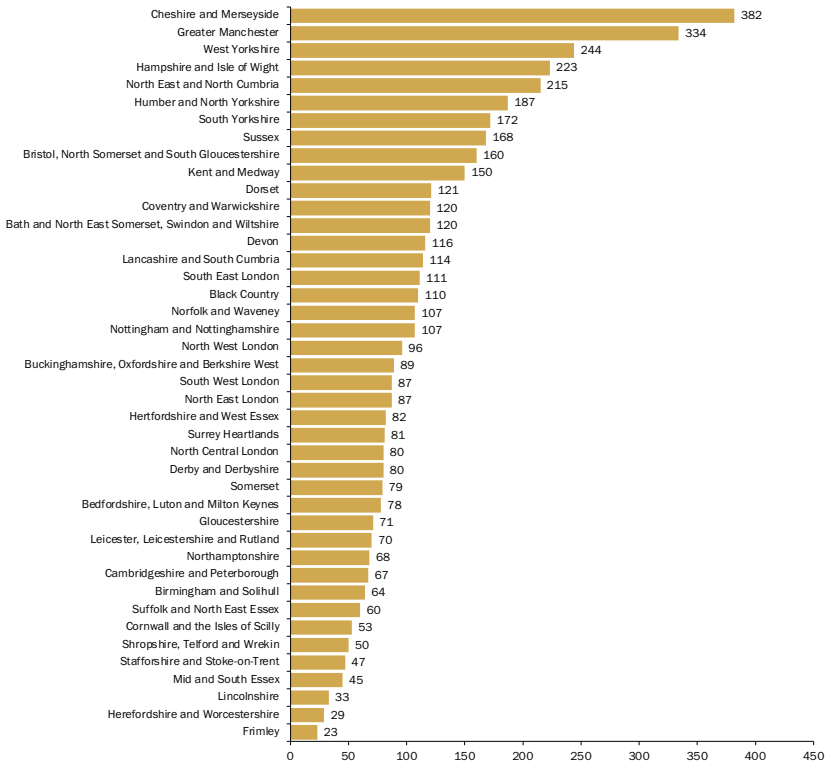
- Health absorbs the biggest chunk of government spending, 38p in every pound spent on public services goes to the NHS. Although no OECD country invests less on a per-person basis

- Demand is escalating as people live longer with more chronic conditions and over the next 25 years the number of Britons aged 85 and older will double

This article focuses on the time patients are waiting to leave acute hospitals. Since the start of the pandemic delayed discharges have increased 30% year on year, see Figure One. Other increased waiting times in 2023 include: waiting for ambulances, waiting for GP appointments, waiting for elective care, waiting for talking therapy appointments, waiting to be seen in A&E, the list goes on. Nobody wants these waits. Long waits are not good for health outcomes as they put people at risk of hospital acquired infections, a loss in mobility and a decline in cognitive function. From operational

FIGURE TWO
CHESHIRE AND MERSEYSIDE ICS RECORD THE HIGHEST ABSOLUTE NUMBER OF DELAYED CHARGES HITTING 382,000 BED DAYS IN 2022

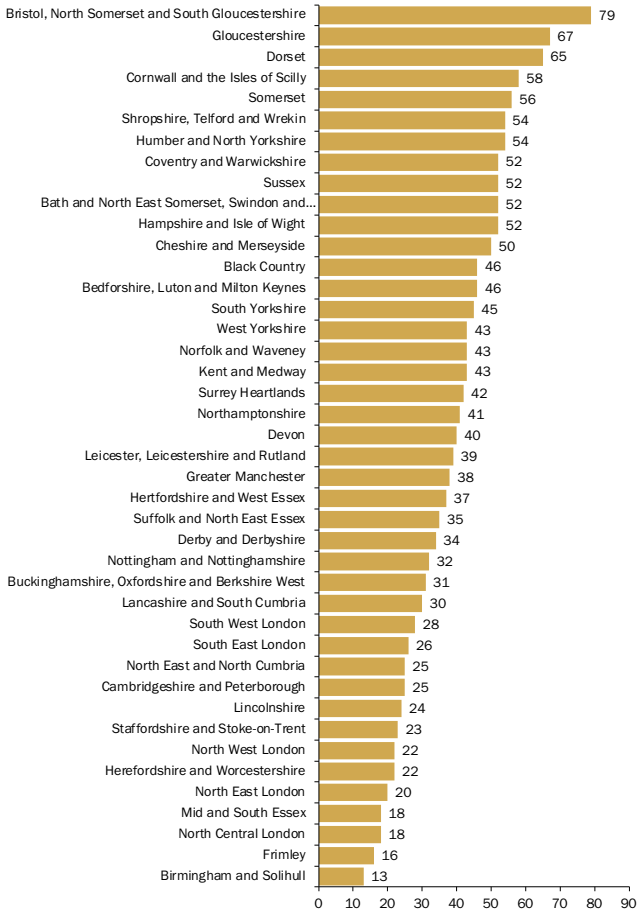
NUMBER OF DELAYED BED DAYS BY ICS (FY2022^{E})
000s OF DELAYED BED DAYS



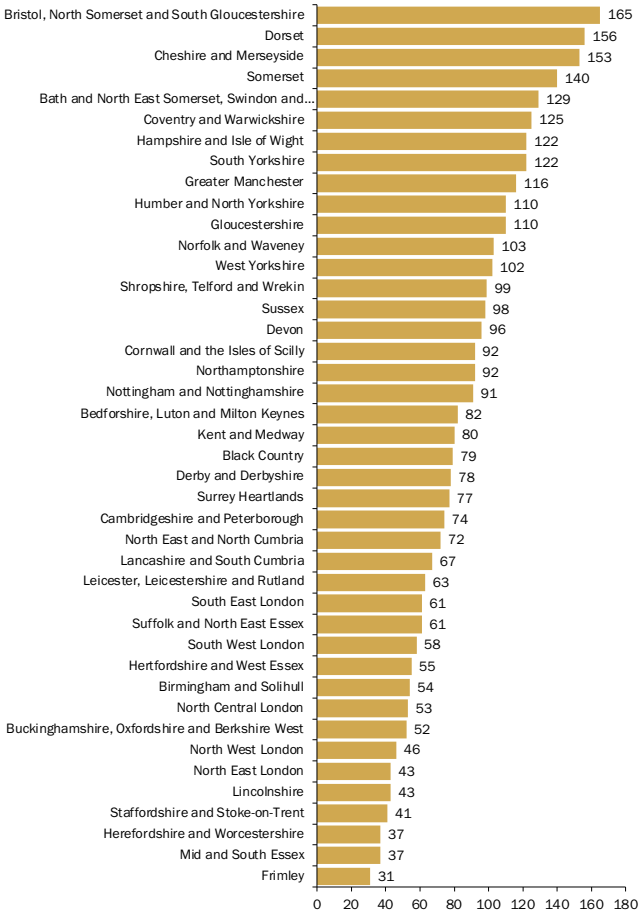
NOTES E DATA FROM MARCH 2022 IS MISSING, THEREFORE FULL YEAR DATA HAS BEEN ESTIMATED
SOURCE NHS DISCHARGE DELAYS (ACUTE) DATASET; CANDESIC RESEARCH AND ANALYSIS

FIGURE THREE
BRISTOL, NORTH SOMERSET AND GLOUCESTERSHIRE ICS HAVE THE HIGHEST DTOC PER AVAILABLE BED AND PER 1,000 POPULATION

DELAYED BED DAYS PER ACUTE PHYSICAL HOSPITAL BED, PER ICS (FY2022[E])
ANNUAL DELAYED BED DAYS PER ACUTE PHYSICAL HOSPITAL BED



DELAYED BED DAYS PER 1,000 POPULATION PER ICS (FY2022[E])
ANNUAL DELAYED BED DAYS PER 1,000 POPULATION (ADULTS AND CHILDREN)



NOTES E DATA FROM MARCH 2022 IS MISSING, THEREFORE FULL YEAR DATA HAS BEEN ESTIMATED
SOURCE NHS DISCHARGE DELAYS (ACUTE) DATASET; CANDESIC RESEARCH AND ANALYSIS

project work experience, long waits are highly symptomatic of an overstretched system. When the system is overcooked, everything starts slowing down. This could be the case for most NHS Trusts as demand pressures put them at an average occupancy level of 92%. Evidence shows that hospitals work most safely and effectively at bed occupancy levels no higher than 85%.

Delayed discharge from hospitals

Delayed discharges from acute hospitals, also called delayed transfers of care (DTOC), are a simple sense check of coordination between and across care settings. This albeit noisy metric is a good enough measure of system flow, because it is a record of how long someone waits in an acute hospital bed after they have been discharged as fit to return home by the treating doctor and clinical team. Figure Two illustrates wide variation across different ICSs for 2022 DTOC data. Cheshire and Merseyside ICS record the highest absolute number of delayed discharges hitting 382,000 bed days in 2022. Figure Three shows Bristol, North Somerset and Gloucestershire ICS have the highest DTOC per available bed and also top DTOC per 1,000 population. Delayed discharges have many pain points, but the top three include:

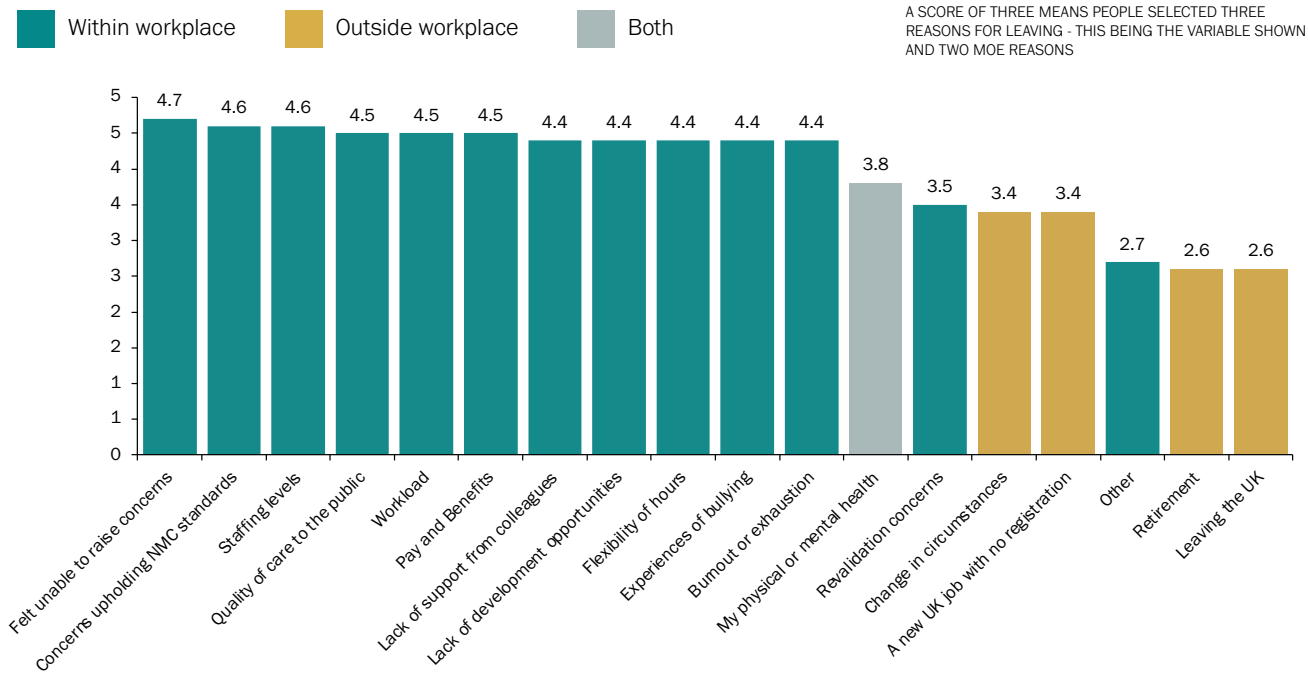
- Delay in obtaining post-acute care – this can be due to a delay in assessment and a delay in obtaining social care, most frequently a home care package or a residential or nursing home placement
- Delay in coordinating care – also known as discharge to assess. Even after a care package has been found there can be delay in coordinating different and disparate care systems. Many moons ago this was done by the 'family doctor', aka the GP, but care navigators remain a pivotal role and are somewhat missing from the system flow

FIGURE FOUR
NURSING AND MIDWIFERY COUNCIL SURVEY HIGHLIGHTS PEOPLE ARE LEAVING THE JOB DUE TO CONCERNS AROUND SAFETY AND STAFF SHORTAGESC

WHY DID YOU LEAVE THE NMC REGISTER?
ALL RESPONDENTS - NUMBER OF 'REASONS' CHOSEN (OUT OF FIVE)

VALUES ARE THE NUMBER OF REASONS SELECTED FOR LEAVING WHEN CHOOSING A FACTOR (SCORE COULD RANGE FROM ONE TO FIVE)

A SCORE OF THREE MEANS PEOPLE SELECTED THREE REASONS FOR LEAVING - THIS BEING THE VARIABLE SHOWN AND TWO MOE REASONS



SOURCE NURSING AND MIDWIFERY COUNCIL (NMC); CANDESIC RESEARCH AND ANALYSIS

- Delay in discharge administration – frequently caused by waits for administration of paperwork, delays in access to medication and medical devices and waits for limited transport

Interestingly, although also intuitively, having adequate hospital staff is vital. After running the analysis there was a correlation between lower staff numbers in hospitals and an increase in delayed discharges.

Staff shortages in the community further exacerbate delayed discharges.

Joining up the systems

Rather than complain and simply report on the problem. What are some solutions to help? What are some action points? The good news is that there are solutions when looking at staff, technology and leadership.

Staffing

It's a sad state of affairs to see nurses and doctors take strike action. It's not usual for caring professionals. But as demand increases, staff take the brunt and remain hurting after the brutal Covid years masked-up in PPE. They are sounding the alarm. So, what can be done? Staff need to be valued. There are so many things to discuss on how to improve recruitment, retention and training. It's perhaps the lowest hanging fruit to pick. For the sake of brevity, here are two actions:

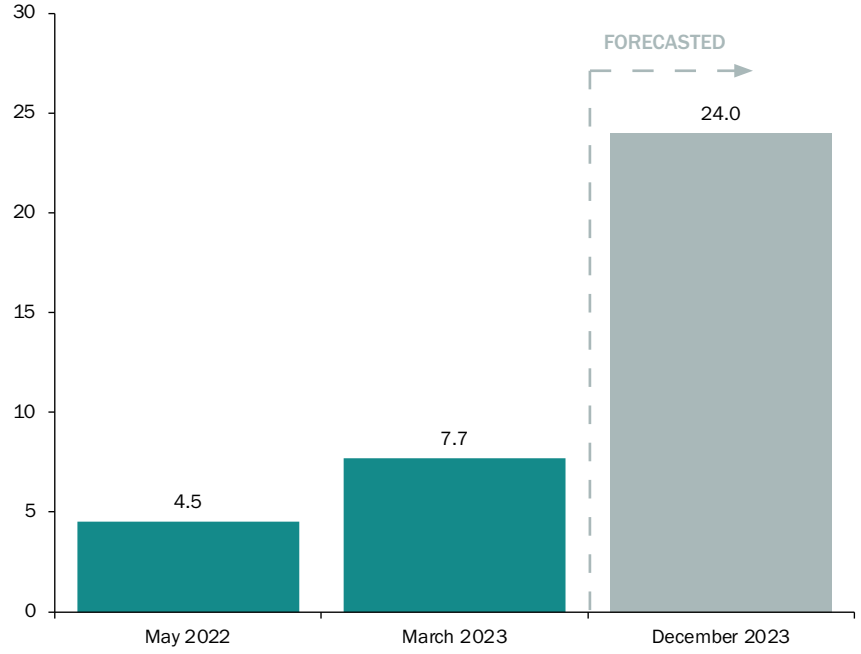
DELAYED DISCHARGES FROM ACUTE HOSPITALS ARE A SIMPLE SENSE CHECK OF COORDINATION BETWEEN AND ACROSS CARE SETTINGS

Honour safe staffing levels

Years of academic data has gone into working out how to operate hospitals with defined staff requirement per patients. The evidence is robust. Personally, I would like to see safe staffing levels open to the public, as it may help refocus when locum levels are too high and even red flag when staff levels drop below minimum standards. Staff all around the UK want to work within a clinical environment with safe staffing levels. It goes hand in hand with professional standards. Credit to them. In the recent 2023 report by the Nursing and Midwifery Council (see Figure Five)

FIGURE FIVE
THERE ARE CURRENTLY c.7,700 VIRTUAL BEDS IN ENGLAND, WHICH IS FORECASTED TO REACH c.24,000 BY THE END OF 2023

VIRTUAL WARD BEDS IN ENGLAND
000s OF VIRTUAL WARD BEDS



SOURCE NHS; CANDESIC RESEARCH AND ANALYSIS

the three most common reasons for leaving the NMC register included: 'felt unable to raise concern', 'concern upholding NMC standards' and 'staffing levels'.

Reduce laborious workloads

The digital foundations across hospital, community care providers and primary care have been built, with most having Electronic Health Record systems. However, the evolution needs to be more than a tick in the digital box with slow implementation. There needs to be laser focus on how technology can save human time and reduce the admin burden on humans.

Many front-line workers call IT systems 'death by a thousand clicks', as they waste hours of their day logging on and off systems and manually plugging in admin data, often repeatedly, into COWs – Computers On Wheels. As an advocate of digital and AI, the future is exciting – but the pace of change needs to keep up with staff needs. Tech has to be part of the solution as there are just not enough human carers in the world for the disease burden and aging population. Digital disruption needs to refocus. OECD research in 2023 found around three-quarters of doctors and nurses reported performing tasks for which they were overqualified. In the Royal College of Nursing estimates around 18% of nurses' time is spent on 'non-essential' paperwork, while the British Medical Association says more than 13.5 million hours of doctors' time is being lost each year in England due to inadequate technology - the equivalent of almost 8,000 doctors.

Technology

There are many solutions to help reduce delayed discharges by using technology. For example, some start-ups have off-the-shelf platforms which use excel to match a discharged patient and their care needs, with available residential, nursing and home care beds in the community. This may sound simple, but some ICSs are already seeing improvement by having a digital dashboard system to link NHS acute care data with community care availability. Another solution to help people move out of hospitals is by increasing capacity of virtual wards. Natalie Douglas, a long-standing advocate of home care and previous CEO of Healthcare at Home (re-branded Sciensus) said: 'Combining human care-givers with medical devices, digital therapeutics and monitoring, means that even high acuity cases can be treated within their home setting. Plus, AI can help give live proactive feedback on health status – helpful for clinical teams, plus very reassuring for the individual and their family.' Figure Five highlights the growth in virtual ward contracts.

Leadership

There is a saying that 'it takes a village to raise a child' and the same could be said when working in care coordination. To link care across acute, community and home settings, leaders could take inspiration from this African proverb, which was later evidenced by Bronfenbrenner's ecological theory. Brofenbrenner moved thinking towards a system of relationships, rather than a unidimensional approach. ICS leaders could do well to embrace the full ecosystem within their village – not just the acute physical and mental health trusts but also link care and costs across the wider sector inclusive of charities, private providers and innovators of all sizes – from tech giants such as Palantir, to start-ups, both local and global.

Investor opportunity

There is so much reason for hope. Never before has there been a time with so many innovative solutions and so much eagerness to help. In summary, this is my call to all leaders and investors to concentrate on how to link the pieces of the jigsaw puzzle together.

Opportunities exist along the entire care pathway chain – from real estate through to point of care home tests. Return on investment will come from solving the pain points, whereas historically politicians tried to patch the system with a sticking plaster.

The time is now to spend on what works, even if that means ignoring the rhetoric.