Supporting Flow Across the System: Bed based intermediate care in Community Hospitals

NHS Benchmarking Network

Harnessing the power of data to drive meaningful change

NHS Benchmarking: Who are we and what do we do

Network Vision and Values

Our vision

To enable members to **improve patient outcomes**, **raise health standards**, and deliver **sustainable**, **quality** health and care services through **data excellence**, **benchmarking**, and the **sharing of innovation**.

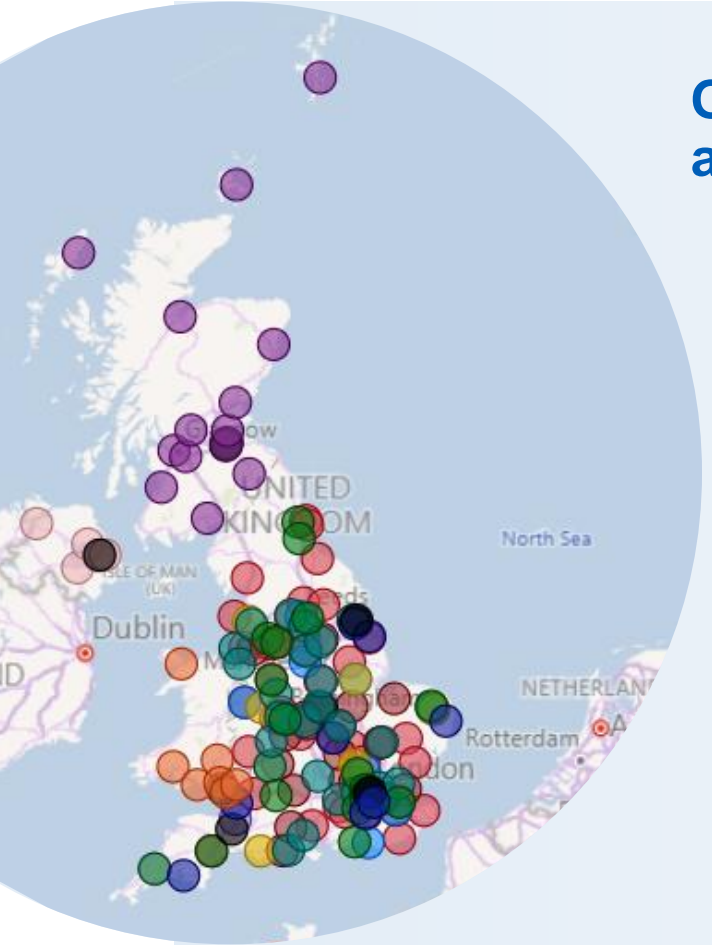
Our values

Excellence

Respect

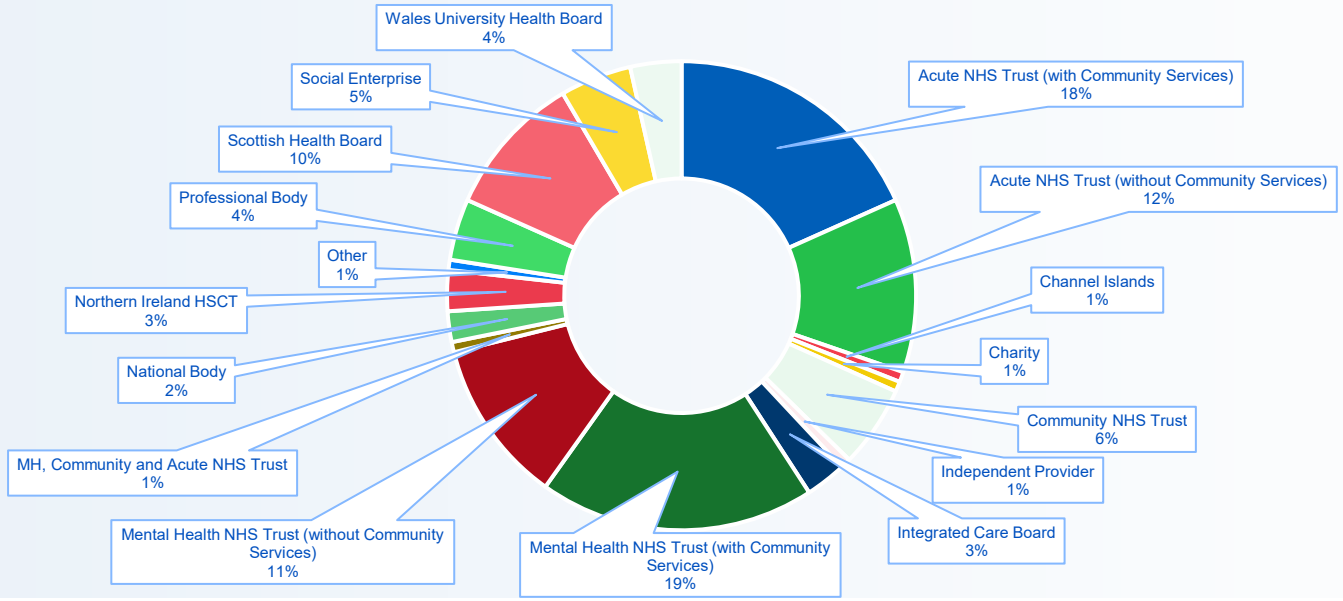
Integrity

NHS Benchmarking Network Membership



Our vibrant member community covers all sectors of the NHS, as well as National Bodies, Professional Bodies and Independent Providers.

Member Type Breakdown



NHS Benchmarking Network: What do we do?

Source Data

- Extract
- Collect
- Store

Curate Data

- Cleanse
- Pseudonymise
- Validate

Analyse Data

- Benchmark
- Describe
- Model

Visualise Data

- Dashboards
- Charts
- Reports

Collaborative Insights

- Engagement
- Improvement
- ‘So what?’

NHS Benchmarking Network: What do we do?

Membership Programme

Why the Network originally formed, offering a programme of benchmarking opportunities and insights to inform decision making within NHS and healthcare organisations.

Healthcare organisations are welcome to join.

Products and Services

We specialise in unlocking the value of data to support driving improvements across services. With over 25 years of experience, our expert team delivers bespoke analytical solutions, helping organisations translate data into meaningful insights that inform strategic and operational decision-making.

Workforce Programme

Ensuring a workforce of the right size, in the right place, with the right skills is essential to meeting current population need and underpins the ambitious transformation plans set out in key healthcare policy documents.

Currently benchmarking for the mental health workforce nationally across NHS, VCSE, LAs and offering a benchmark of workforce data in tailored solutions for NHSE WT&E.

National Clinical Audits

National Clinical Audits currently delivered by the NHS Benchmarking Network:

CVDPREVENT

National Audit of Care at the End of Life

Auditing last days of life in hospitals

Learning Disability Improvement Standards

NHS Benchmarking Network

Harnessing the power of data to drive meaningful change

NHS Benchmarking Network

30 years of trusted, meaningful insight

What datasets do we benchmark?

Indicators

- National Indicators
- Acute Indicators
- Community Indicators
- MHLDA Indicators

Cross-sector

- Emergency Care
- Managing Frailty in a Bed-based Setting
- Virtual Wards

Acute

- Pharmacy & Medicines Optimisation
- Outpatients

Mental Health

- Adult and Older People's Mental Health
- Children and Young People's Mental Health
- Learning Disability Support Services
- MH Pharmacy

Community

- District Nursing
- Children's Community Services
- Adult's Community Services
- Intermediate Care

Publicly available data
Clinical case review
Staff survey
PREM survey
Friends and Family Survey

Opinion vs Insight: What Does the Data Show?

Community Hospitals: The backbone of bed based intermediate care

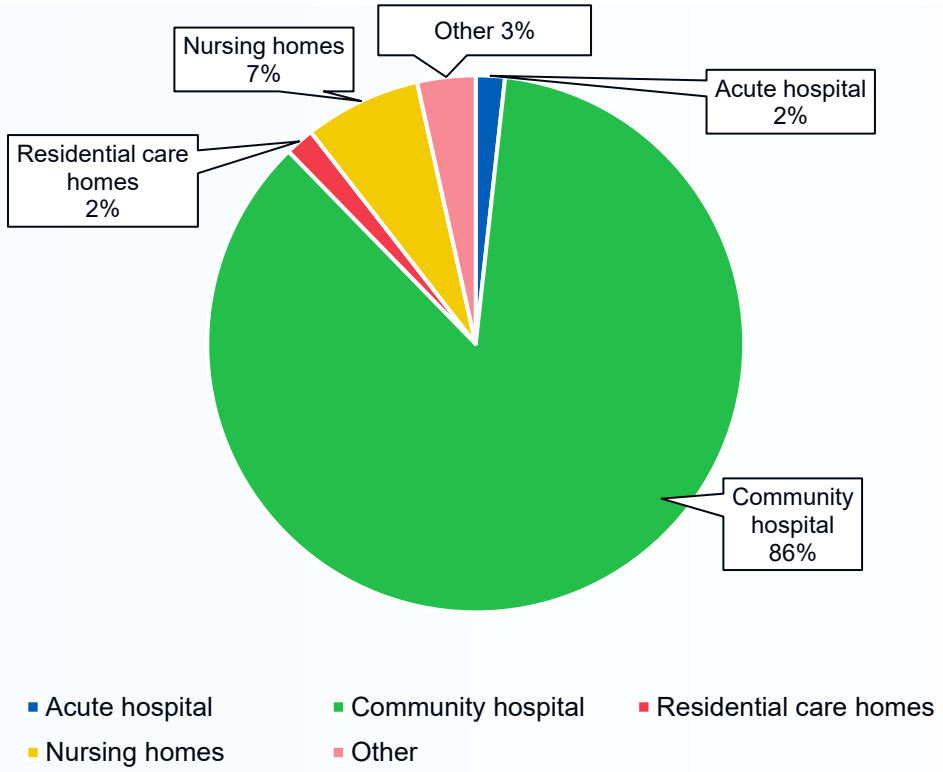
Service Delivery

86% of intermediate care services were delivered in **community hospitals**

97.9% of community hospitals accept **new patients 365 days a year**

Capacity challenges are less about availability and more about flow, staffing and discharge dependencies

Where was the service user admitted from



Capacity: how tight is the system

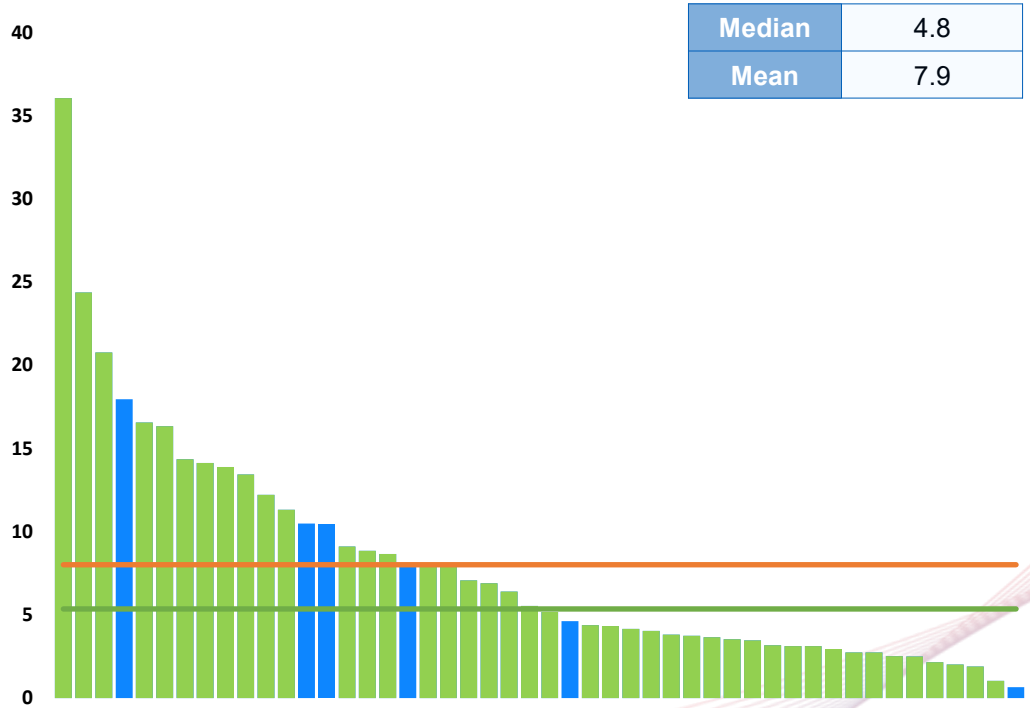
Capacity: Bed supply looks modest and variable

Intermediate care **beds** per **100,000 population**; median **4.8** bed and mean **7.9.**

There is wide variation, implying some systems have scaled capacity while many operate at relatively low bed ratios. This is an indication of different operational service models and levels of investments.

Total number of intermediate care beds provided per 100,000 population

Median	4.8
Mean	7.9



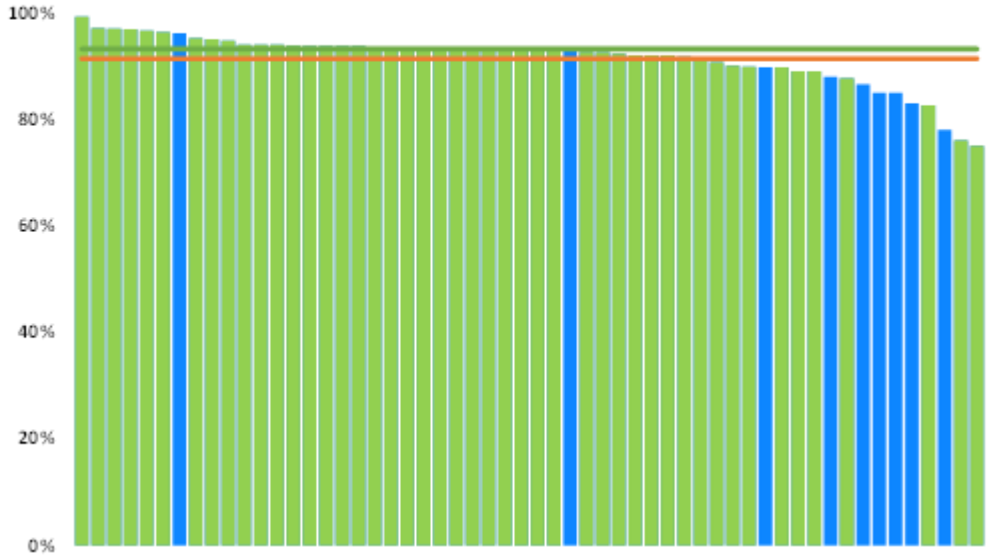
Capacity: occupancy is consistently very high

Average **bed occupancy** is **93.2%** (median)

At approximately 93% occupancy, intermediate care beds are operating close to saturation; small surges (discharge delays, staffing gaps) could quickly cause backlogs and refusal rates.

Average bed occupancy (%)

Median	93.2%
Mean	92.2%

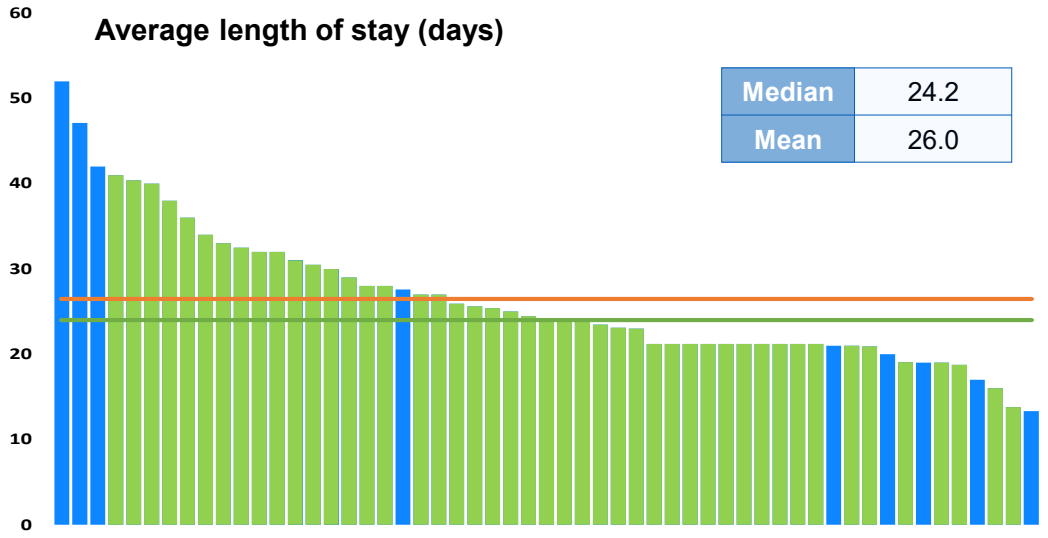


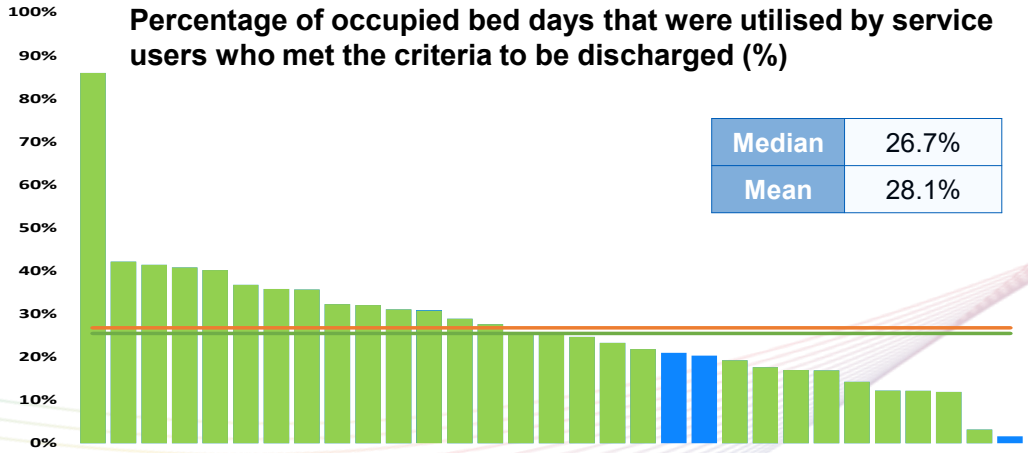
Capacity: occupancy is consistently very high

Average **length of stay** is **24** days (median).

26.7% (median) of **occupied bed days** were **used** by people who **met criteria to be discharged.**

This is ‘lost capacity’ due to downstream constraints; packages of care, equipment, step down options, transport, housing and assessment delays.





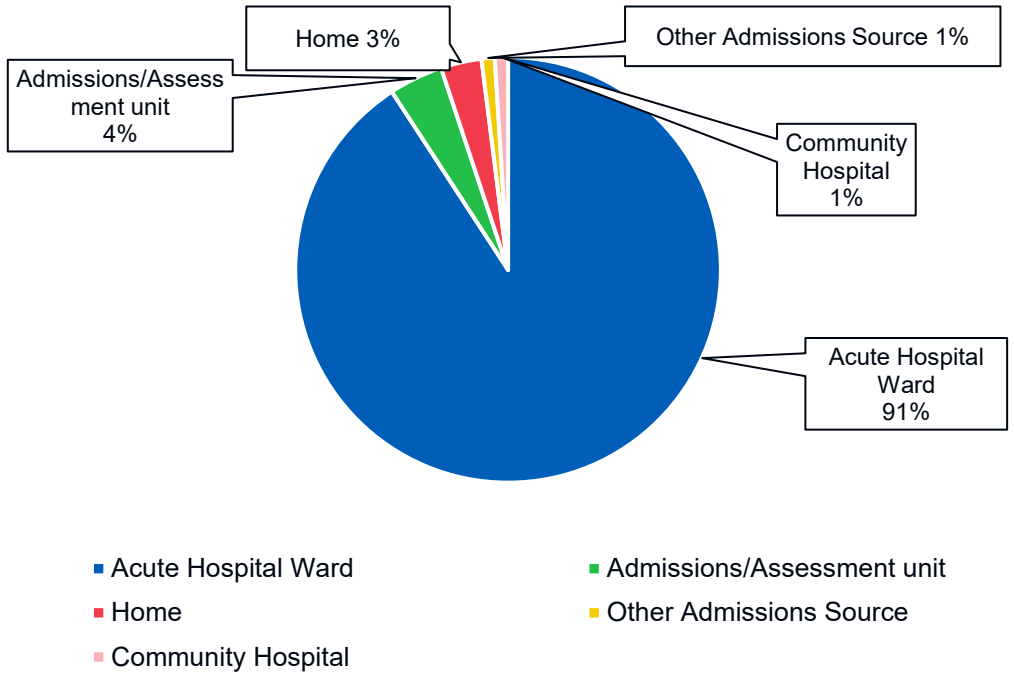
Flow and demand: the service is predominately “step down” from acute services

Flow: referrals come overwhelmingly from acute settings

In the **clinical case review 90.8%** of admissions were from an **acute hospital** wards

Bed based intermediate care in community hospitals is functioning primarily as an acute flow / discharge pathway rather than an equally balanced step-up prevention option.

Where was the service user admitted from



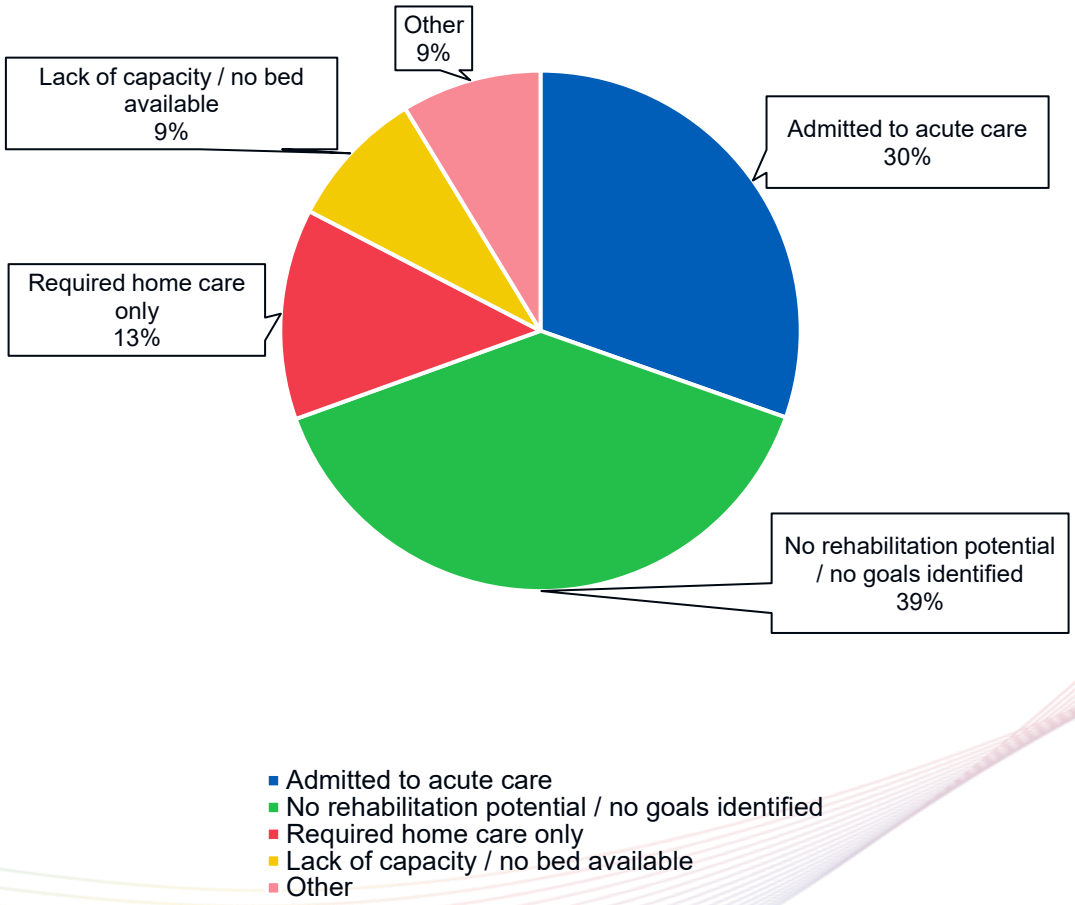
Flow: access and throughput looks ‘efficient once you get in’ – but the bottleneck is capacity

100% (median) conversion rate **referral** to **assessment** rate.

95.7% (median) conversion rate **referral** to **acceptance** rate.

In **clinical case review**, **19.8%** of referrals were **not** accepted; **8.7%** of the **non-acceptances** were due to **lack of capacity.**

Reason for non-acceptance



Integration: a mixed story

Operational integration model: mostly standalone teams, fewer embedded neighbourhood models

Service positioning:

- 59.2% standalone IC team
- 22.4% delivered as part of CICT/neighbourhood team
- 8.2% outreach from acute
- 2.0% delivered by primary care

Many services are **structurally separate** from neighbourhood /CICT delivery. That can **slow integration** with community services, social care and proactive step up routes – **unless** there are **strong interface** processes

Shared care records: progress, but not universal and not always write enabled

59.2% have **access** to shared care records.

Where access **exists**: **58.6%** have **read write** access.

A **significant minority** still lack shared records, and read-only access **limits real time joint working** (updating discharge plans, care packages, risk and therapy goals).

Frailty information sharing, the social care gap

Patient/carer **access** to frailty assessment **information**: **28.6%**

Discharge often relies on **social care packages** and **community support.**

Limited social care visibility can create **integration challenges** that **delay discharge** and **reduce** available bed **capacity**.

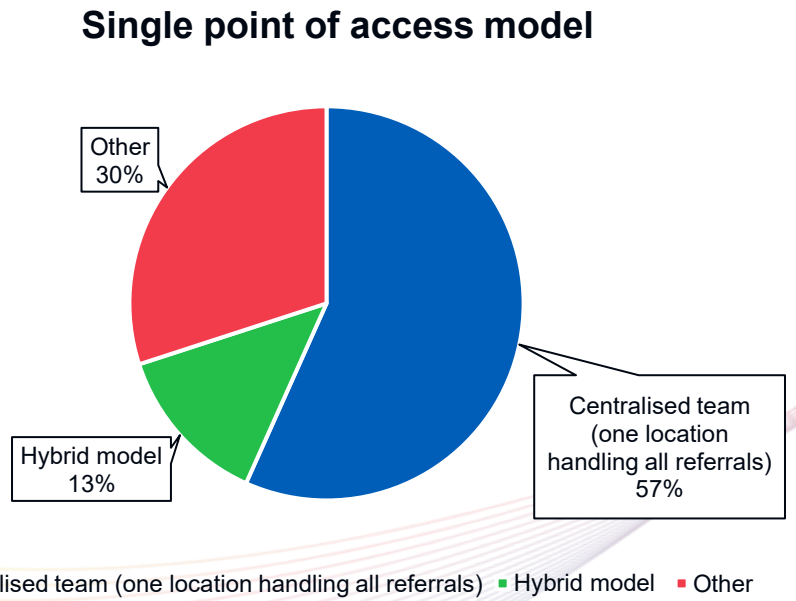
Single point of access – helpful for integration and flow

73.8% of services are **accessed** by single point of access (**SPoA**)

Service **delivery model**: **56.7%** centralised, **13.3%** hybrid, **30%** other

SPoA support **coordinated triage** and **reduces duplication.**

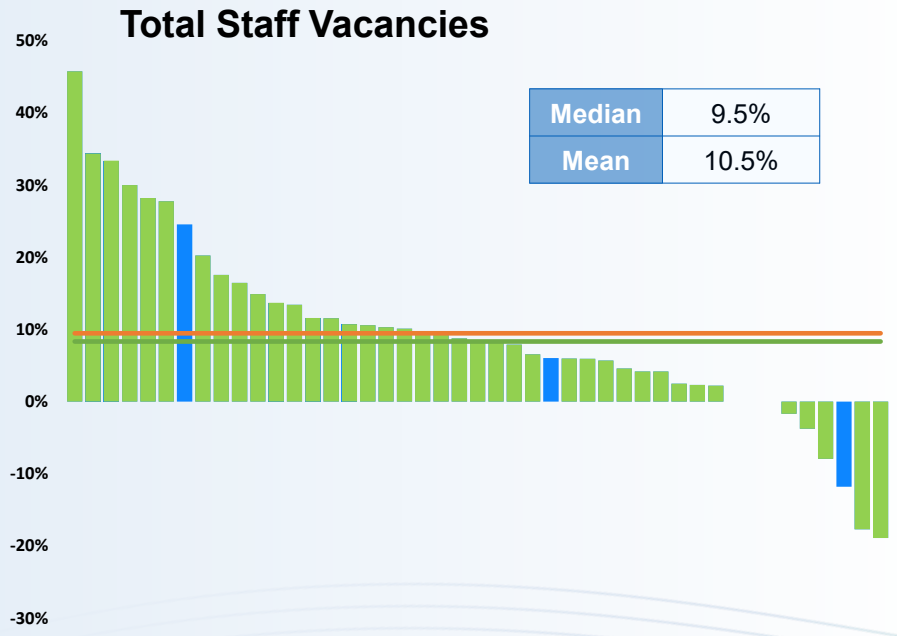
Metric	0% Yes (%) 100%	
Is your service accessed by a single point of access?		73.8%



Workforce: a direct constraint on building capacity

Staffing gaps are material – especially medical capacity

Total **vacancy** rate: median **9.15%**



Medical grade vacancy rate: median **25%**

Nursing vacancy rate: median **10.3%**

AHP vacancy rate: median **8.29%**

Transdisciplinary roles are only “halfway there”

Transdisciplinary roles in **use/development: 48.6%**

Where workforce is tight, transdisciplinary role design is a key productivity level; being under 50% suggests potentially untapped capacity to reduce delays (e.g. therapy led discharge, nursing/therapy skill mix, rehab assistants etc

Metric	0% Yes (%) 100%	
Are you using or developing transdisciplinary roles for staff?		48.6%

What does this mean specifically for building capacity in intermediate care in community hospitals

What does this mean specifically for building capacity in intermediate care in community hospitals

Reduce fit to discharge bed days

26.7% of bed days are used by people meeting discharge criteria

Improve integration with social care and shared records

Only **18.7%** share frailty diagnostic data with social care

Consider digital triage and virtual alternatives to avoid admission where possible

Adress medical cover gaps and redesign roles

Medical vacancies are **~25%** and medical involvement is **44.8%**

Questions