Joining up health and social care

Improving value for money across the interface

December 2011
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Summary

1 Both the NHS and councils need to make significant savings over the next three years. Integrated working across health and social care could offer potential, both for efficiency savings and improving outcomes for people.

2 There has been a strong focus on improving joint working across the NHS and social care for many years, but progress still remains patchy.

3 This briefing sets out:
   ■ the potential areas for local action;
   ■ the questions local commissioners might ask themselves and the evidence that may help with the answers;
   ■ potential indicators for identifying areas for improvement and for tracking progress; and
   ■ what the national data suggests in these key areas.

4 It is important to take a whole-system view of efficiencies, in which investment and benefit are transparent and fairly balanced between partners. The proposed new health and wellbeing boards will have a strategic role to play in providing leadership and in building the local picture.

5 Partnerships need to be clear about the outcomes they are trying to achieve and how they will know what progress they are making towards achieving them.

6 Partnerships should use existing data sets to identify areas for joint action and to track progress. These include:
   ■ emergency admissions to hospital for people aged 65 and over;
   ■ emergency bed days for people aged 65 and over;
   ■ admissions to residential or nursing care;
   ■ admissions to residential or nursing care direct from hospital; and
   ■ the numbers of people dying at home.

7 We estimate that primary care trusts (PCTs) could save about £132 million a year if all the areas with high emergency admissions, after taking account of their population’s characteristics, reduced activity to match the current national average. This is money that could be invested to help people live independently in the community.
8 Partnerships should understand and use their local data, benchmark themselves against others and know what makes a difference. We describe an initiative in the North West in which councils and health organisations are working together to do this.
Both the NHS and councils need to make significant savings over the next three years. The NHS needs to make up to £20 billion of efficiency savings by 2015 under the Department of Health's Quality, Innovation, Productivity and Prevention (QIPP) initiative. Councils with social services responsibilities are expecting their spending to reduce by 6.5 per cent across all services. Adult social care is being protected, with planned 2011/12 spend 2.5 per cent less than 2010/11 (Ref. 1). These financial pressures will have an impact at the same time as the NHS faces reorganisation and demand for health and social care services rises. The shifts towards personalisation and localism profoundly change the environment in which care is delivered.

Integrated working across health and social care could offer potential both for efficiency savings and improving outcomes for people. The first briefing in this series showed that many councils saw partnership working as an important way of achieving efficiencies (Ref. 2). This briefing is aimed at commissioners of health and social care, and the emerging health and wellbeing boards and clinical commissioning groups proposed in the Health and Social Care Bill (Ref. 3). It is a practical guide to inform decisions about how best to use the funds allocated to the NHS and councils to support joint working. This briefing will also help commissioners and the new health and wellbeing boards to monitor progress and it may also assist health scrutiny committees in reviewing performance.

The briefing sets out:
- potential areas for local action;
- the questions which local commissioners might ask themselves and the evidence that may help with the answers;
- potential indicators for identifying areas for improvement and for tracking progress; and
- what the national data suggests in these key areas.

This briefing focuses on older people with one or more long-term conditions. These people are often regular users of high-cost health and social care services. The Nuffield Trust has mapped the patterns of service use of a group of older people over time (Ref. 4). Figure 1

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i Health and wellbeing boards and clinical commissioning groups are both proposed in the Health and Social Care Bill 2011. In some areas shadow health and wellbeing boards and clinical commissioning groups are already working.
shows the contacts that one older person had with care services over a three-year period. Understanding the ways in which older people with long-term conditions use services can highlight gaps in service as well as duplication and opportunities for greater coordination. The aim is not only to be more efficient, but also to offer older people better care, more choice and a better experience.

Figure 1: **Understanding the way in which people use services is important**

![Individual health and social care event timeline over a three-year period](image)

*Source: Nuffield Trust*

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Audit Commission | Joining up health and social care
Introduction
Improving joint working

13 Improving joint working across the boundary between health and social care has the potential to make significant savings and has been a priority for many years (Ref. 5). Integration remains central to current policy and the government has allocated extra social care funds to councils via the NHS to help achieve it (Ref. 6). Despite these efforts, progress remains uneven (Ref. 7). Local history, leadership and relationships have important roles in building a shared sense of direction and in cementing joint working. Structural solutions are unlikely, by themselves, to lead to improvements (Ref. 8 and 9). Many NHS and social care partnerships can describe better working relationships. But our research, and that of other organisations, highlights only a few examples where it is possible to demonstrate that partnership working has achieved efficiencies and positive impacts on people’s lives (Ref. 10).

14 Joint working applies to structural arrangements and to less formal cooperation. It includes:

- jointly provided services, such as community-based intermediate care teams that include both nursing and social care staff;
- jointly commissioned services, such as support from voluntary and community organisations; and
- aligned services, where partners agree to work on shared priorities.

15 Joint working should start with the needs of the person. This will, in turn, help to tackle system difficulties. For example, inadequate NHS continence care has a huge impact on peoples’ lives. It can also mean that higher numbers of older people are admitted to residential or nursing care. Poor-quality hospital care can also reduce confidence and increase dependency. At the same time, a shortage of reablement services might mean that people are less able to live independently. It might also affect the NHS, for example by increasing hospital admissions.

16 The NHS and social care interface represents just one part of a wider approach to helping people remain independent. Its success depends on a stronger focus on prevention, personalising care and involving communities.

17 As financial constraints bite harder, there is a danger that both the NHS and councils will focus solely within their own organisations when seeking to make efficiency savings. But cuts to one part of the
Joining up health and social care can lead to unintended consequences elsewhere, such as new pressures or rising demand. Equally, the benefits of investment in, for example, prevention by one partner can create efficiencies for the other. It is therefore important for partnerships to take a rounded, whole-system view of value for money, in which investment and benefit is transparent and fairly balanced between partners. Health and wellbeing boards will have an important strategic role to play in providing leadership and in building the local picture. The Joint Strategic Needs Assessment (JSNA) will help to define local priorities.

Case study 1 gives an example of the NHS and councils building a whole-system approach to investment when designing care services for the future.

Case study 1

**Joint commissioning in Essex**

NHS and social care commissioners in Essex have worked with Tricordant Ltd to develop a joint approach to commissioning services for older people. The vision for the project was to create the best sustainable health and social care service possible for older people in Essex, with the triple aims of improved user experience, improved user outcomes and reduced total cost of care.

Tricordant produced a catalogue of best practice, summarising the top 20 health and social care interventions proven to help achieve the triple aims of the review. This acted as the foundation for the new care pathway, and also helped to model the likely financial impacts. A matrix of investment and benefit was developed (Figure 2). Each bubble represents one of the 20 identified best-practice interventions, for which there is strong evidence. For example, bubble six represents falls prevention.

For each intervention the matrix shows whether the investment is likely to come from the NHS, from social care, or from both. It also shows where any savings are likely to be made.
The project has resulted in the council and PCT identifying approximately £30 million of efficiency savings through a range of developments, including:

- reducing admission to institutional settings, whether acute hospitals or residential care homes;
- consistent use of assistive technology across Essex;
- consistent implementation of a virtual ward, which is a preventative scheme using a predictive risk tool and multidisciplinary case management in the community; and
- consistent implementation of integrated intermediate care, reablement and crisis response services across Essex.

Source: Audit Commission

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**Figure 2: The investment and benefits matrix**

**Investment and Benefits Matrix**

<table>
<thead>
<tr>
<th>Beneficiary</th>
<th>NHS</th>
<th>Both</th>
<th>Social care</th>
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Source: Tricordant Ltd

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**Agreeing priorities**

The Association of Directors of Adult Social Services (ADASS) has set out the elements of a whole-system approach to care in a time of budget pressures (Ref. 11). The goals are to help people remain independent for as long as possible and to support them to recover after an illness or crisis. There are six overall themes.
**Prevention**
Living an active life as a citizen for as long as possible.

**Recovery**
Achieving as full a recovery as possible and receiving help in times of crisis.

**Continued support**
Getting a personal budget and choosing how to spend this from a range of services that offer value for money.

**Efficient process**
Designing processes to minimise waste, and eliminating anything that does not add value to what people need.

**Partnership**
Working together to achieve these outcomes across health and social care, councils or government, and the independent sector.

**Contribution**
Making a fair contribution to this support: financially; through informal care and support; or from carers or the person concerned playing their part in achieving the desired outcomes.

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20 As a first step, partnerships need to ask themselves a few high level questions about what outcomes they are trying to achieve, and the progress they are making towards achieving them. These questions might include the following.

- What outcomes are we trying to achieve together?
- What can we only do together?
- Where are resources spent across health and social care?
- To what extent does spend reflect our joint priorities?
- How could efficiencies be made and shared?
- What metrics or indicators are we using to track progress?
- What local data is available to help us understand the local interface, and how good is the quality?
- How do we compare with other, similar areas?
- If trends are in the wrong direction, what factors are driving this?
- What do we each need to do separately to get back on track?

21 A well-functioning local care system will focus on keeping people well. If people do become ill or experience a crisis, services will concentrate on recovery. Intuitively, the most significant savings and
The greatest improvement in the quality of care and peoples’ lives will be achieved by jointly providing better prevention and care in community settings. This will avoid unnecessary (and expensive) admissions to hospital or residential or nursing home care. For health and social care partnerships, this means focusing on:

- reducing unplanned hospital admissions;
- reducing admissions to residential and nursing home care from the community;
- improving hospital discharge arrangements, particularly to residential and nursing home care; and
- enabling people to die at home rather than in hospital if that is what they prefer.

22 The following section provides a table of questions that partnerships can ask to help them better understand the underlying reasons for performance difficulties in these key areas. While not comprehensive, the table summarises some of the current best available evidence on the services and interventions most likely to make a difference.

23 Key points for each area are: identifying how any additional services will be funded; the savings likely to be released; and how they will be shared. For example, overall hospital admissions are only likely to be reduced and savings made if the number of beds is reduced. Social services might incur increased costs in achieving this, but savings would be made by the hospital trust.
Identifying areas to improve value for money

The questions to ask and the action to take for each key area, supported by relevant evidence of successful outcomes.

### 1. High or rising emergency admissions

#### Questions to consider

1.1 How well are you managing long-term conditions and supporting people to help themselves?
1.2 How proactively are you identifying people at risk and intervening early to help them remain independent?
1.3 How well are you developing people to manage their own health and wellbeing?
1.4 How quickly can you respond to a crisis to prevent an admission?
1.5 Are there any patterns in admissions (for example, time of day, day of week, where living when admitted)?
1.6 To what extent are patterns influenced by GP activity?
1.7 Have you distinguished between short-stay (less than 24 hours) and longer-stay admissions? They are likely to have different causes and resolutions.
1.8 Are there any specific conditions that merit attention, or is frailty the main problem?

#### Interventions that might help

- Identification of patients most likely to need admission to hospital (risk identification)
- Early intervention
- Case management
- Joint community-based teams
- Virtual wards in the community
- Intermediate care
- Crisis response
- Telecare and telehealth
- Diversion from A&E
1. High or rising emergency admissions

Evidence of efficiencies and outcomes

- The Department of Health’s Long-term Conditions QIPP workstream is based on three key drivers that will improve the clinical outcomes and experience for patients with long-term conditions. This workstream is seeking to reduce unscheduled hospital admissions by 20 per cent, reduce length of stay by 25 per cent and maximise the number of people controlling their own health through the use of supported self care. The key interventions are: risk profiling; integrated neighbourhood care teams; and self-care/shared decision-making. [www.networks.nhs.uk/nhs-networks/commissioning-for-long-term-conditions/about-us](http://www.networks.nhs.uk/nhs-networks/commissioning-for-long-term-conditions/about-us)

- Care Services Efficiency Delivery (CSED) overview of forecasting tools, including Projecting Older People Population Information (POPPI) and Projecting Adult Needs and Service Information (PANSI). [www.csed.dh.gov.uk/dfAndCapacityPlanning](http://www.csed.dh.gov.uk/dfAndCapacityPlanning)

- The NHS Atlas of Variation, which includes the standardised rate of emergency admissions in people over 75 per 1000 population by PCT. [www.rightcare.nhs.uk/atlas/](http://www.rightcare.nhs.uk/atlas/)


- Partnerships for Older People Projects (POPP) evaluation – proactive case coordination led to a 60 per cent reduction in A&E visits. [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/King’s Fund analysis of clinical and service integration and the route to improved outcomes. [www.kingsfund.org.uk/publications/clinical_and_service](http://www.kingsfund.org.uk/publications/clinical_and_service)

- CSED crisis response outcomes – for example £4.3 million net savings were achieved in health and social care in Bristol in one year. [www.csed.dh.gov.uk/CrisisResponse/SuccessfulServices](http://www.csed.dh.gov.uk/CrisisResponse/SuccessfulServices)


- CSED’s summary of economic benefits of telecare. [www.thinklocalactpersonal.org.uk/Browse/EIP/Telecare](http://www.thinklocalactpersonal.org.uk/Browse/EIP/Telecare)

- The Care Quality Commission’s State of Care report provides information on readmission rates for older people and contains examples of the joint approaches that have worked best. [www.cqc.org.uk/stateofcare2010-11.cfm](http://www.cqc.org.uk/stateofcare2010-11.cfm)
2. High or rising admissions to residential or nursing care

Questions to consider

2.1 What are the local factors that affect older peoples’ pathways into residential/nursing care?
2.2 To what extent are services in place that tackle the main reasons for care home admissions?
2.3 Can you identify whether and what support might have prevented admission in a sample of recent cases?

Interventions that might help

- Housing advice and provision for older people
- Carer support
- Initiatives to tackle social isolation
- NHS continence care, stroke care, mental health services

Evidence of efficiencies and outcomes

- The Audit Commission report *Under Pressure* includes case study examples of action to tackle the four Wanless factors. [www.audit-commission.gov.uk/nationalstudies/localgov/underpressure](http://www.audit-commission.gov.uk/nationalstudies/localgov/underpressure)
- CSED’s paper *Configuring Joint Preventative Services* includes a review of the evidence of some of the Institute of Public Care (IPC) top seven conditions on care home admissions, plus questions for commissioners. [www.csed.dh.gov.uk/dfAndCapacityPlanning/configFutureServices](http://www.csed.dh.gov.uk/dfAndCapacityPlanning/configFutureServices)
- The Department of Health's *Use of Resources in Adult Social Care* report includes examples of the ways in which councils have reduced local use of residential and nursing care. [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance)
- The Department of Work and Pension has identified a number of resources to support those commissioning services for older people as part of its Ageing Well programme. [www.dwp.gov.uk/policy/ageing-society/products-tools-goodpractice](http://www.dwp.gov.uk/policy/ageing-society/products-tools-goodpractice)
### Questions to consider

#### 3.1 What opportunities do older people and their families have to consider their options?

#### 3.2 What systems are in place for discharge planning and how effective are these?

#### 3.3 What is the length of stay for older people? (Distinguish between short stay – less than 24 hours – and others)

#### 3.4 Has a review been undertaken of hospital bed use to identify people who could be discharged earlier to identify the services that could help them?

#### 3.5 What are the trends in delayed transfers of care, and what are the causes of any delays?

#### 3.6 How widely available are intermediate care services, and how well are they operating?

#### 3.7 How widely available are reablement services and are they targeted at the right group?

#### 3.8 What is the readmission rate and can this be reduced?

### Interventions that might help

- Step-down services
- Reablement
- Intermediate care
- Home from hospital
- Joint discharge teams

### Evidence of efficiencies and outcomes

- Southwark POPP hospital discharge example (reviewed by IPC). [www.iriss.org.uk/resources/money-matters](http://www.iriss.org.uk/resources/money-matters)
- Social Care Institute for Excellence evidence summary on the impact of reablement services. [www.scie.org.uk/publications/briefings/briefing36](http://www.scie.org.uk/publications/briefings/briefing36)
4. Low or falling numbers of people dying at home

Questions to consider

4.1 What information and advice is available for people approaching end of life, and for their carers?
4.2 What specialist input is available in the community and in care homes?
4.3 Are home care services available 24/7?
4.4 How well are carers supported?

Interventions that might help

- Specialist community palliative care teams
- Training and support for care home staff

Evidence of efficiencies and outcomes

- The Department of Health’s End of Life Care website includes examples of good practice. [www.endoflifecareforadults.nhs.uk](http://www.endoflifecareforadults.nhs.uk)
- The *NHS Atlas of Variation*, which includes the percentage of all deaths in an area occurring in hospital by local authority. [www.rightcare.nhs.uk/atlas](http://www.rightcare.nhs.uk/atlas)
Using the data

24 The second half of this briefing looks at what partnerships can do to make best use of nationally published data, with a focus on the four areas identified in the previous section. There is considerable variation in local practice, with opportunities for improvement. It is therefore important for NHS and social care partners to pool data on local performance and outcomes to create a rounded picture. The development of national outcome frameworks for the NHS, social care and public health will, in time, make new data sets available.

25 However, the evidence on the impact of interventions on the NHS and social care interface is not always clear. Despite the wide variations in spending on social care by local authorities, it is not known what impact this has on NHS expenditure. The Nuffield Trust is undertaking some work into predicting social care costs (Ref 12). Our detailed analysis revealed that higher social care spending on community services does not immediately appear to result in lower emergency hospital admissions or lower admissions to residential care. Equally, investing generally in reablement services will not necessarily release savings across health and social care. However, it does improve the quality of life of those who receive it, as well as significantly reducing the need for social care services later (Ref. 13).

26 Evaluation of interventions is key to partners making the best decisions about local practice and priorities. If possible, the evaluation should include comparisons with the experience of a similar group of people. Recent work by the Nuffield Trust used person-based risk-adjusted evaluations to question whether some interventions do reduce hospital admissions. The Nuffield Trust makes a strong case for using this method of comparing the experiences of closely matched individuals, to give a more accurate, real-time picture of the impact of interventions on their lives (Ref. 14).

27 Benchmarking and learning from others are also important, with the growth of sector-led approaches. Case study 2 show how NHS and social care partnerships in the North West worked to benchmark their local performance and to share experience of the interventions and services that are helping them to meet local priorities.
NHS and social care integration for quality and efficiency in North West England

Twenty two NHS and social care partnerships in the North West are working together to improve efficiency and outcomes through comparing performance data and sharing local experience of what works. This sector-led project is a joint initiative between ADASS in the North West, the Advancing Quality Alliance, (AQuA) and the Transition Alliance, which has grown out of the former North West Joint Improvement Partnership (JIP) for adult social care.

The initiative sprang from a growing recognition that integrated working is key to keeping people out of hospital and residential care, and to delivering better outcomes. The focus of the project is on frail older people, where the greatest demand lies.

The partners together designed a locality scorecard using a limited set of data items covering core elements of the whole system. All partnerships in the region were offered their own data, calculated to the local authority boundary using postcodes. The indicators are set out below.

**Locality scorecard – data calculated to local government boundary**

- Non-elective admissions of people aged 65 and over per 1000 population
- Non-elective bed days for people aged 65 and over per head of 1000 population
- Non-elective readmission rates within 28 days for people aged 65 and over
- Non-elective readmission rates within 90 days for people aged 65 and over
- Number of delayed transfers of care for people aged 18 and over per 100,000 population
- Proportion of people aged 65 and over who are discharged direct to residential care
- Permanent admissions to residential/nursing care for people aged 65 and over per 100,000 population
- Proportion of local authority adult social care spend on residential/nursing care for people aged 65 and over
- Proportion of all deaths which occur at home for people aged 65 and over
The locality scorecard offers a trend analysis of each data point, presenting the near real-time activity in each local authority area. Partnerships use it to distinguish real improvement from normal variation. When used for benchmarking it also acts as a starting point for discussion about experience and good practice across localities. It is also the foundation for the service improvement element of the project. Based on the shared information, AQuA is setting up practice exchange opportunities through a series of workshops.

Some councils are already using the scorecard locally to strengthen partnership working and to influence local services. Some share the scorecards routinely with their new health and wellbeing board.

The Wirral story, for example, includes evidence of improving performance in emergency admissions and numbers of delayed transfers of care. This follows a strong local focus on discharge arrangements and further development of the reablement service. Efficiency gains are being made.

Source: Audit Commission

Reviewing the interface – the national picture

28 There are no direct measures of the progress and impact of joint working. But NHS and social care partnerships can use a few high-level indicators to show how well the NHS and social care interface works. These indicators are by no means definitive or exhaustive. Locally, many partnerships track progress by using a much wider range of information, including, crucially, the views of people who use services. The indicators we focus on in this briefing are:
- emergency admissions for people aged 65 and over;
- emergency bed days for people aged 65 and over;
- admissions to residential and nursing care;
- admissions to residential and nursing care direct from hospital; and
- the numbers of people dying at home.

29 Each indicator shows considerable variation nationally. As noted earlier, the variation does not seem to relate to patterns of spending. Similarly, apart from between emergency admissions and emergency beds, there is no clear relationship between each of the five indicators. For example, high numbers of emergency admissions do not necessarily lead to high numbers of admissions to residential and
nursing care. Health and social care partnerships that are performing well in one or more areas often struggle in others.

30 This emphasises the need to track changes to each key indicator independently and to target interventions, taking account of the evidence available as well as local data and circumstances. Case study 2 provides an example of this.

31 This section comments briefly on each of the five indicators in turn. Charts and maps summarising the national picture are in Appendix 1. ‘Expected’ values have been calculated for some indicators to improve comparability. The ‘expected’ value takes account of the age and sex profile of the population as well as the relative level of local deprivation. This allows comparisons to be made between actual performance and what could be expected given the circumstances of a specific area. ‘Expected’ values have only been used where relevant data is available and there is evidence that performance is related to demography and deprivation.

32 NHS and social care partnerships can benchmark their performance against others by using the web-based tool that accompanies this briefing: www.audit-commission.gov.uk/vfmhealthandsocialcare

Emergency admissions

33 Emergency admissions cost the NHS £11 billion in 2009/10 (Ref. 15). Emergency admissions are rising, increasing by 12.8 per cent between 2006/07 and 2009/10. The Nuffield Trust found a link between the rise in admissions and demand factors such as the ageing population. But supply issues also play their part. These include financial incentives to admit patients; faster discharge leading to greater bed availability; inadequate health and social care provision in the community; and lower thresholds for admission (Ref. 16).

34 On average in 2009/10, there were 2,571 emergency admissions of people aged 65 and over (per 10,000 population of people aged 65 and over). There is significant local variation amongst PCTs, ranging from 1,555 to 3,709 emergency admissions per 10,000 population of people aged 65 and over.

35 By looking at the ratio of actual to ‘expected’ admissions we can identify which areas have more admissions than expected for their population and which have fewer. Performance ranges from one PCT having one and a half times as many admissions as expected, to one that has just under two thirds of the admissions expected. If all those areas that have higher than expected emergency admissions of patients aged 65 and over had the expected number of admissions, we estimate that PCTs would have saved about £132 million in 2009/10.
Additional costs may be incurred to achieve this, but any net savings could be invested in alternative services.

36 Figures 4 to 6 in Appendix 1 show the national picture on emergency admissions for people over 65.

**Emergency bed days**

37 We found a similar notable variation in the number of emergency bed days for people aged 65 and over, which is unsurprising given the link between emergency admissions and bed days. However, the number of emergency bed days is also influenced by the effectiveness of discharge arrangements.

38 Figures 7 and 8 in Appendix 1 show the national picture on emergency bed days for people over 65.

**Residential and nursing home admissions**

39 The number of people in residential and nursing care funded by councils is falling slowly (Figure 3). This is likely to be a positive move as supporting people to remain independent can offer both good use of resources and better outcomes for the individual. The Department of Health's report *Use of Resources in Adult Social Care* (Ref. 17) suggests that reducing spending on residential care is likely to be the best way of releasing resources to change services for the future.
Joining up health and social care

Figure 3: The number of people in local authority supported residential and nursing care in England

Source: Adult Social Care Combined Activity Return 2009/10, The Health and Social Care Information Centre

40 Figures 9 and 10 in Appendix 1 show the national picture on people living in residential and nursing care.

People discharged from hospital to residential and nursing care

41 There is now a growing consensus that, given the right support, many older people will recover well from an illness or other crisis. Better intermediate care and reablement services should mean that fewer and fewer people need to be discharged direct to a residential or nursing home place and can take more time to decide their future (Ref. 18). However, once again, the national picture shows great variation, although some of this is likely to be due to poor data quality. PCTs will, in particular, find it useful to look at this area as the Operating Framework 2011/12 (Ref. 19) gives PCTs the responsibility for post-discharge support.

42 Figures 11 and 12 in Appendix 1 show the national picture on people discharged from hospital to residential and nursing care.
Deaths occurring at home

Two-thirds of people say that they would like to die at home, but only a minority do (Ref. 20). End of life care is an important part of the health and social care interface. The End of Life Strategy published in 2008 aimed to reduce admissions to hospital and to enable more people at the end of their life to choose where they wish to die (Ref. 21). The Department of Health allocated £286 million to PCTs in 2009/10 and 2010/11 to implement the strategy. Key aims of the strategy were to:

- improve provision of community services such as 24-hour rapid response nursing;
- provide health and social care staff with the skills to communicate with and support people at the end of their lives; and
- develop specialist palliative care outreach services.

The government supports the continued implementation of the End of Life Care Strategy (Ref. 21). The QIPP End of Life Care workstream is responsible for driving the delivery of the strategy.

Figures 13 and 14 in Appendix 1 show the national picture on people dying at home.
Conclusions

46 NHS organisations and social care services cannot work separately. Actions taken by NHS organisations can benefit social care and vice versa. The efficiency challenge provides an incentive to build a whole-system approach to value for money. On the other hand, there is a risk that organisations could retreat from joint working. This could lead to cost shunting and greater costs in the future, as well as worse outcomes for people (Ref. 22).\(^i\)

47 The national picture shows a great deal of variation. If all areas were performing well this would contribute both to improving outcomes for people and to meeting the health and social care efficiency challenge. Partners across the NHS and social care need to understand their local data in detail, to use this as the starting point to make changes and to track the impact of their joint actions.

\(^i\) Cost shunting is where one organisation makes a decision in isolation that reduces its costs, but passes increased costs onto another organisation.
1. Emergency admissions

Emergency admissions of older people vary significantly across the country. The ratio of actual to expected admissions also varies from one PCT having one and a half times as many admissions as expected, to one that has just under two-thirds of the admissions expected.

Figure 4: Emergency admissions of people aged 65 and over in 2009/10 (per 10,000 population of people aged 65 and over)

Source: Hospital Episode Statistics 2009/10, analysed by the Audit Commission 2011

Note: Excludes admissions where PCT is unknown. Mid 2009 population estimates used.
Figure 5: The ratio of actual admissions to expected emergency admissions of patients aged 65 and over in 2009/10

Source: Hospital Episode Statistics 2009/10, analysed by the Audit Commission 2011

Note: Excludes admissions where PCT is unknown; expected admissions standardised by age, gender and deprivation.
Figure 6: The ratio of actual admissions to expected emergency admissions of patients aged 65 and over in 2009/10

Source: Hospital Episode Statistics 2009/10, analysed by the Audit Commission 2011
2. Emergency bed days

After adjusting for age, gender and deprivation, the number of emergency bed days used by older people varies across the country.

Figure 7: The ratio of actual to expected emergency bed days for people aged 65 and over in 2009/10

Source: Hospital Episode Statistics 2009/10, analysed by the Audit Commission 2011

Note: Excludes admissions where PCT is unknown. Mid 2009 population estimates used. Expected admissions standardised by age, gender and deprivation.
Figure 8: The ratio of actual to expected emergency bed days for people aged 65 and over in 2009/10

Source: Hospital Episode Statistics 2009/10, analysed by the Audit Commission 2011
3. Residential and nursing home admissions

The number of older people who are admitted to residential and nursing care varies eightfold.

Figure 9: Permanent admissions of people aged 65 and over to residential and nursing care in 2009/10 (per 10,000 population of people aged over 65)

Source: Adult Social Care Combined Activity Return 2009/10, The Health and Social Care Information Centre

Note: 2009/10 data for two local authorities is missing; data includes adult placements.
Figure 10: Permanent admissions of people aged 65 and over to residential and nursing care in 2009/10 (per 10,000 population of people aged over 65)

Permanent admissions for 65+ to residential and nursing care per 10,000 population, 2009/10

- 15 to 63 (42)
- 63 to 74 (37)
- 74 to 82 (34)
- 82 to 116 (39)

Source: Adult Social Care Combined Activity Return 2009/10, The Health and Social Care Information Centre
4. People discharged from hospital to residential and nursing care

The percentage of older people who are admitted to hospital from their own home and discharged to permanent residential or nursing care varies widely.

Figure 11: **The percentage of people aged 65 and over who are admitted to hospital from their own home and discharged to residential and nursing care in 2009/10**

*Source: Hospital Episode Statistics 2009/10, The Health and Social Care Information Centre*

*Note: Excludes admissions of older people from residential or nursing care.*
Figure 12: The percentage of people aged 65 and over who are admitted to hospital from their own home and discharged to residential and nursing care in 2009/10

% of 65+ emergency admissions from home, discharged to residential care, 2009/10

- 0.14 to 0.75 (39)
- 0.75 to 1.14 (39)
- 1.14 to 1.61 (38)
- 1.61 to 4.16 (36)

Source: Hospital Episode Statistics 2009/10, The Health and Social Care Information Centre
5. People dying at home

The percentage of people aged 65 and over who died at home in 2009/10 varies across the country.

Figure 13: **The percentage of people aged over 65 who died at home in 2009/10**

Source: National End of Life Care Intelligence Network/South West Public Health Observatory

Note: Data is at single tier and district level.
Figure 14: The percentage of people aged over 65 who died at home in 2009/10

Source: National End of Life Care Intelligence Network/South West Public Health Observatory

Note: Data is at single tier and county level.
References


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We welcome your feedback. If you have any comments on this report, are intending to implement any of the recommendations, or are planning to follow up any of the case studies, please email:
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