28 March 2025

Layla Moran MP
Chair, Health and Social Care Committee
House of Commons

By email

Dear Layla,

Thank you for the invitation to give evidence at the fourth session on the *Adult Social Care: The Cost of Inaction* inquiry on 5 March. I appreciated the opportunity to give a national overview of the challenges faced by NHS foundation trusts and trusts. This letter provides the further detail as promised regarding data on delayed discharges and the impact of a lack of adequate social care. The available data does not indicate where social care capacity is a factor in delayed discharges, but the broader analysis and evidence I set out below illustrates the impact.

Recent delayed discharges data

The most recent NHS England data on delayed discharges is from the last winter period, running from Monday 25 November until Sunday 2 March[1].

1 On average, nearly 13,000 hospital beds per day were occupied by patients medically fit for discharge, equating to 90,500 bed days lost per week, or 1.27 million bed days lost throughout winter. These figures are broadly in line with the previous year.

2 On average this winter, 1 in 7 beds were occupied by patients medically fit for discharge.

[1] Data from NHS England's daily sitrep reports, published each Thursday over winter, https://www.england.nhs.uk/statistics/statistical-work-areas/uec-sitrep/urgent-and-emergency-care-daily-situation-reports-2024-25/.

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3 57.4% of patients who were medically fit for discharge at some point this winter remained in hospital longer than they needed to, an increase from 55.8% last winter.

4 The number of patients staying in hospital for long periods also increased over winter. The last week of winter saw an average of 19,180 patients staying in hospital for over 21 days, an 8.1% increase from the first week of winter, when there were on average 17,750 patients who had stayed for longer than 21 days. This data has not been broken down to show what is attributable to social care packages not being available.

5 Delays may be caused by pressures in social care and a lack of capacity, as well as factors within healthcare such as hospital discharge processes and waits for community care. Research by the Nuffield Trust published in August 2024 helpfully sets this out in more detail, illustrating that social care capacity is more likely to be a relevant factor in delayed discharge where patients have been in hospital for three weeks or more, given they tend to require more support.

6 Throughout January 2025, data from NHS England shows that nearly three in five (58.5%) patients who were medically ready for discharge remained in acute hospitals at the end of a day, a 23-month high[2]. In December 2024, there were nearly 2,500 patients discharged from an acute setting who had a delay of 21 days or more[3]. In community settings this is even higher, with over four in five medically dischargeable patients remaining in intermediate care at the end of the day[4] – a trend lasting over two years.

The impact of delayed discharges

I would also like to offer supplementary evidence on the impact of delayed discharges, collated below.

1 The impact of delayed discharges on patients can be significant, with long hospital stays contributing to the risk of people being exposed to healthcare acquired infections, deconditioning, and a general deterioration in their sense of independence and wellbeing. This is especially true for older people and those with frailty. Without adequate social care provision upon discharge, there is also a greater risk of the patient returning to hospital.

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[2] NHS England's Acute Discharge Situation Report, https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/acute-discharge-situation-report/

[3] NHS England Report on Discharge Ready Dates, https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/

[4] NHS England Report on Discharge Delays (Community), https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays-community-data/

2 Delayed discharges also impact the wider health and care system, contributing to pressures across the urgent and emergency care pathway. This January, a record high of 61,500 patients waited over 12 hours from a decision to admit to admission, highlighting the disruption to patient flow through the health and care system[5]. Most respondents (54%) to our June 2024 finance survey said that social care capacity and/or funding was a barrier to improving patient flow across the system. NHS Providers' 2024/25 financial challenge survey ran between May-June 2024 with responses from 114 trusts representing 55% of the provider sector.

3 Bed capacity to tackle the elective care waiting list is also limited by delayed discharges. In December, over 272,000 bed days were lost due to delayed discharges[6], while the waiting list stands at 7.46 million pathways and has grown by over two-thirds since 2019[7].

Although trust leaders across England are developing innovative ways of working with the social care sector and local system colleagues to alleviate pressure across the health and care system, more support is needed at a national level to put the sector on a sustainable footing. Investing in social care capacity would help to reduce delayed discharges, therefore freeing up hospital beds, decreasing waits of over 12 hours from decision to admit to admission and handover delays, as well as improving patient outcomes and experience.

Case studies: integration across health and care

Trusts, integrated care systems (ICSs) and social care colleagues are working together in a range of innovative ways to improve care and reduce delayed discharges. I set out below a number of case studies to illustrate the work underway.

Coventry and Warwickshire ICS: the ICS is working to improve timely access to intermediate care services upon discharge from hospital. The team has developed a Community Recovery Service, made up of domiciliary care workers and allied health professionals from **South Warwickshire University NHS Foundation Trust** to deliver intermediate care. The package of care is provided and paid for by the NHS (via the Better Care Fund) for up to six weeks. The aim is to reduce length of stay in acute hospitals and allow people to receive the care they need in the right place.

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[5] NHS England data on A&E Attendances and Emergency Admissions 2024-25, https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ae-attendances-and-emergency-admissions-2024-25/

[6] NHS England Report on Discharge Ready Date, https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/

[7] Consultant-led Referral to Treatment Waiting Times Data 2024-25, https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2024-25/

Benefits for patients include reduced time to sort packages of care, more people being assessed at home, and greater integration across health and care. This approach successfully supported over 2,500 people last year and has strengthened working relationships between health and social care. A multidisciplinary team approach has been key and includes administrative support, therapists, clinical managers and domiciliary care providers.

Hertfordshire Community NHS Trust: the 'Minus Nine' project is seeking to build on the work of the Hospital at Home service, looking at how it can provide more proactive support for individuals through targeted interventions. The project aims to identify need and intervene for patients approximately nine days before a hospital admission or crisis intervention. To do this, the trust will look to identify the highest risk patients across the system and aim to provide wrap-around care at an earlier stage. Rollout for the project is planned for winter 2024/25.

Derbyshire Integrated Neighbourhood Team: the team brings together services that provide preventative care (including anticipating health problems) with reactive or urgent care. It addresses a wide range of issues for people with frailty, including any immediate or long-term physical and mental health problems or social care problems, and connecting people with third sector organisations for wider issues such as debt management, housing problems, isolation and loneliness or difficulty shopping. Results include fewer category three ambulance responses and reduction in hospital stays. Derbyshire Integrated Neighbourhood Team has worked with the local council to move approximately 130 homecare support staff from the council to the trust. The partnership is underpinned by a Section 75 agreement[8], and pooling of resources. This has helped boost the system's capacity and resilience and supported integrated care delivery for service users.

South London and Maudsley NHS Foundation Trust: bringing together health and social care budgets to support mental health patients with complex needs has enabled investment in a community accommodation facility in partnership with a specialist third sector housing partner. Partnership working between local organisations including social enterprises and charities has been key to supporting the shift to more community-based care, enabling local provision to be tailored to local needs.

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[8] Section 75 of the NHS Act 2006 allows partners (NHS bodies and councils) to contribute to a common fund which can be used to commission health or social care related services. This power allows a local authority to commission health services and NHS commissioners to commission social care. It enables joint commissioning and commissioning of integrated services. https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/better-care-fund/better-care-fund-support-offer/

Hampshire and Isle of Wight Healthcare NHS Foundation Trust: the trust has identified housing and community inclusion as key areas that impact the mental health and wellbeing of its patients. It has set up several new approaches to take preventative action in these areas, including providing supported accommodation pathways to improve flow out of inpatient settings, embedding early intervention within local authority housing teams, and employing Citizens Advice case workers on hospital wards.

North Staffordshire Combined Healthcare NHS Foundation Trust: the trust has established a crisis care centre, which brings together a range of teams offering services to people of all ages throughout the year, including an accessible service for anyone who feels they are in distress or need advice or reassurance. The trust has also been working 'upstream' on the mental health crisis pathway by reaching out into the community and linking people through to the right service.

Walsall Together Place-Based Partnership: the partnership has a particularly strong focus on the importance of housing as a wider determinant of health. One of the key partners in the place-based partnership includes the Walsall Housing Group which enables the partnership to improve access for some of the most vulnerable people in the borough.

I hope this is helpful and NHS Providers looks forward to continuing to work with the Committee on these key issues. If you would like to discuss any of the above further, please contact publicaffairs@nhsproviders.org.

Yours sincerely

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