

*Shaping the Future NHS:
Long Term Planning for Hospitals
and Related Services*

Consultation Document on the Findings
of The National Beds Inquiry

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foreword by the secretary of state

I am pleased to publish for consultation the findings of the National Beds Inquiry. This Inquiry is unique. It is the first time that so much vital information about hospital beds and related health and social services has been brought together in this way. It will help shape work to modernise health and social care services from top to bottom – across the whole system of care.

The Beds Inquiry suggests that the trend of the last decade or more of reductions in hospital bed numbers cannot keep pace with changing needs, additional activity and the new services that we envisage for the NHS. We have to make sure that, in the future, we get the right number of the right sort of beds in the right places. As the Inquiry shows, we need to take a whole-system view of services, and under any scenario, this is likely to require an increase in the number of beds in the whole system.

Our model for a modernised healthcare system requires change at every level.

It begins with a new emphasis on empowered patients, using authoritative NHS information for self care and access to the most appropriate services. This is what NHS Direct, NHS Direct On-line and digital TV are all about.

The second level is a modernised and expanded range of primary care services. This means new walk-in centres, the new Primary Care Act Pilots, and, above all else, faster and more accessible general practice. Primary Care Groups and Trusts will provide a platform for their development.

The third level is the hospital. The hospital of the future will provide more specialist diagnosis and treatment – and will do so in new ways. I do not accept the thesis that the role of the hospital will necessarily diminish – but it will certainly change.

That in turn calls for another level – an intermediate level – fully networked into local hospital, community health and social services and primary care services. In other words, a bridge between home and hospital, specifically designed around the needs of older patients both for prevention and for a period of rehabilitation to speed their recovery.

The Beds Inquiry shows that two thirds of hospital beds are occupied by people aged 65 or over. It implies a radically different approach to the management of care in the NHS. That care has traditionally been about dealing with life's incidents – heart attacks and broken bones. Now an ageing population and increasing chronic disease means NHS care has also to be about dealing with life's experiences – getting older and becoming frailer. In other words, proactive and ongoing care not just reactive and episodic care.

So if we are to have a modern NHS we need to move away from managing single healthcare institutions and move instead towards the management of clinical conditions that span the services which patients receive.

Only in this way will health and social care in every part of the country be able to provide the care and treatment people need over the next two decades. For that to happen, we need to take action now.

Alan Milburn
Secretary of State for Health

a. introduction

1. The NHS exists to care for people. The public expects a service fit to meet their needs for the 21st century: a service that offers easy access, convenience, good quality clinical care, caring staff and a modern environment. In short, the public expects a NHS that is fit for the future.
2. The NHS cares for people in a range of settings. None is more important for public confidence than the hospital. The National Beds Inquiry was set up to ensure that the number and type of hospital beds meets patients' needs looking 10 to 20 years ahead. This document initiates a public debate on the Inquiry's findings.
3. The Inquiry grew out of concerns that the long term decline in staffed hospital beds might have gone too far. The length of hospital waiting lists and the recurrence of winter pressures on emergency beds suggested that present hospital services were not well matched to patient need. At the same time there was continuing evidence of inappropriate and avoidable use of hospital beds. To address these issues the National Beds Inquiry was asked to review assumptions about future growth in the volume of acute health services and their implications for hospital beds and other health services. To ensure that the range of "beds issues" has been covered, complementary work on mental health and children's beds has also been undertaken.
4. The Inquiry has reviewed historical trends in acute health services, examined local and international variations in services and trends, assessed the key drivers of future service requirements, reviewed different models of care, and explored a range of projections of future activity. The initial findings are summarised in this Consultation Document. More details are in the companion volume entitled Supporting Analysis. The Inquiry Team's own analysis has been supported by a programme of commissioned research, the results of which are summarised in the Supporting Analysis.
5. The Inquiry has concentrated on the future scale of long-term requirements in the hospital sector. It has not examined the related issue of acute hospital configuration.
6. The Inquiry has deliberately taken a "whole system" approach. Hospital services and beds cannot be considered in isolation from other parts of health and social care systems such as primary, community, rehabilitative and long-term care. The need for hospital services and beds is influenced by the availability of these other services. They can help prevent the need for acute interventions, can enable safe discharge to community or home-based care and can act as either substitutes for or complements to hospital services.

The Government's Agenda

7. The future requirement for hospital beds should be viewed in the context of the Government's modernisation programmes for the NHS and Social Services. These are set out in the White Papers: *The New NHS – Modern, Dependable*; *Saving Lives: Our Healthier Nation*; and *Modernising Social Services*, and the supporting policies detailed in: *Information for Health*; *Working Together*; *A First Class Service*; and *Modernising Mental Health Services*. There are also other targets to meet: reducing waiting; managing emergency pressures; and staying within budget. To help, the NHS has received an initial real terms increase in resources averaging 4.7% over three years – totalling £21 billion.
8. A coherent policy programme is not enough to deliver change. The key resources in the NHS – money, staff and facilities – must be aligned to fit the future. Effective delivery mechanisms are needed if change on the ground is to improve the day to day service received by the public. All the ingredients for change are influenced

by developments in the wider environment, for example the number of older people, the pattern of diseases, the availability of new technologies and expectations of the public and staff.

9. The key resources in the NHS – money, staff and facilities – require both short and long-term planning. This consultation paper focuses on the longer-term. The use of key resources to manage in-year pressures effectively, such as the higher number of emergency cases in the winter, the flow of non-emergency admissions, and fluctuations in the number of patients who are critically ill is the subject of other work programmes (for example: *Emergency Services Action Team (Reports 1997, 1998, 1999)*, and *Paediatric Intensive Care: A Framework for the Future, July 1997*).

10. The provision of critical care, both intensive care and high dependency care, is particularly important. The very small numbers of these beds in each hospital increases the risk that, at times of peak pressure, full occupancy could occur. To address this problem, the Department of Health is undertaking a thorough going review of critical care which will be completed by late Spring. The review will produce a framework for the future organisation and delivery of critical care to ensure the service is better able to cope with increasing pressure, particularly in winter.

11. To build the NHS for the future long term planning is essential because training doctors and nurses and building health care facilities such as new hospitals or community services takes time. And planning for all key resources should be as integrated as possible and based on a coherent view of the future.

12. Long term planning of key resources in the NHS takes place nationally, regionally and locally. At each level, effective planning should occur in a co-ordinated way, taking into account the current policy programme, changes in the wider environment and the interactions between different parts of the service. It is vital that planning between national, regional and local levels is similarly coherent.

Purpose of consultation

13. **This document has three aims:**

- i. To consider the likely future impact of current policies, and of factors in the wider environment, on the key resources needed by the NHS in the long term. The focus of this document is on staffed acute hospital beds, and the services that might support or in the longer term substitute for them better to meet patients' needs;
- ii. To share these analyses with the NHS, partner agencies and others, and to consult as to how health services, and specifically hospital beds, should be developed over the next 10–20 years both to meet the Government's vision for a modern NHS, and to respond to changes in the wider environment; and
- iii. To develop a common set of assumptions for use in the long term planning of key resources at national, regional and local level.

14. **On the first aim**, this consultation document seeks to provide information on the factors shaping health services, specifically the need for hospital beds, by:

- i. Presenting detailed information about trends and the current position of health and social services and hospital beds in England;
- ii. Highlighting local and international variations in those services and trends;
- iii. Analysing the key drivers of future service requirements;
- iv. Describing different models of care which seek to improve the balance and range of services available to patients; and

- v. Using projections of a range of activity levels to illustrate the extent of uncertainty over future requirements for services and hospital beds.

More information on all these subjects is provided in the Supporting Analysis.

15. **On the second aim**, the analysis ends with a series of questions on which the Government wishes to consult. **Responses are invited from the public, users of NHS and social services, clinical and non clinical staff, and others who are able to provide either a national or local perspective.** The consultation period will run from February 10th to May 15th. As part of this process the Inquiry Team will hold a series of regional workshops for NHS staff and other stakeholders to discuss some of the key questions. Further details on the consultation process can be found at the end of this report. The outcome of the consultation will be published.

16. **On the third aim**, the Supporting Analysis published with this document includes the initial long-term planning assumptions developed by the project team. These may be helpful to planning groups at national, regional and local level. A revised set of assumptions will be published after the consultation process taking account of comments received. These will be incorporated in guidance specifically aimed at local and regional planning groups. They will also inform national planning.

b. analysis

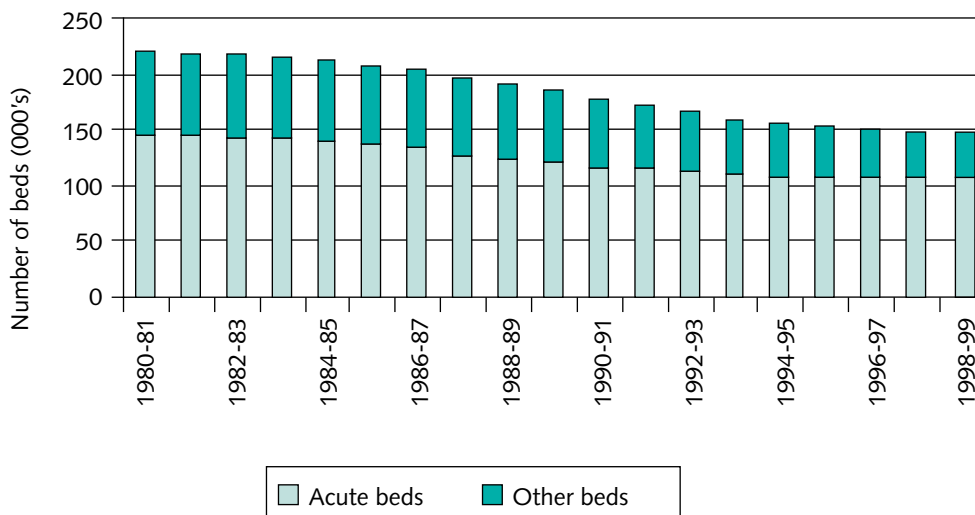
Overview of trends and current position

17. Established trends are the obvious starting point for looking at future requirements. In line with the whole system approach we have looked at trends both in hospital in-patient activity for all age groups and in the broader range of services available for older people, children and those with mental illness.

i. Acute hospital activity

18. Acute hospitals grew up in the Nineteenth Century to provide safe settings for elective and emergency treatments requiring bed rest. The number of NHS **staffed hospital beds** (for acute, general and maternity care) peaked around 1960 at about 250,000. Although hospital expenditure has risen steadily, staffed hospital beds have been falling ever since. The number of beds per head of population for acute, general and maternity care has fallen by over 2% per annum since 1980 (Chart 1). However the decline has now slowed and for acute beds may have come to a halt in absolute terms. This apparent change in trend reflects a slowing down in the reduction in bed use (as measured by bed days) across all age groups. There are currently 147,000 staffed beds in the acute, general and maternity sectors.

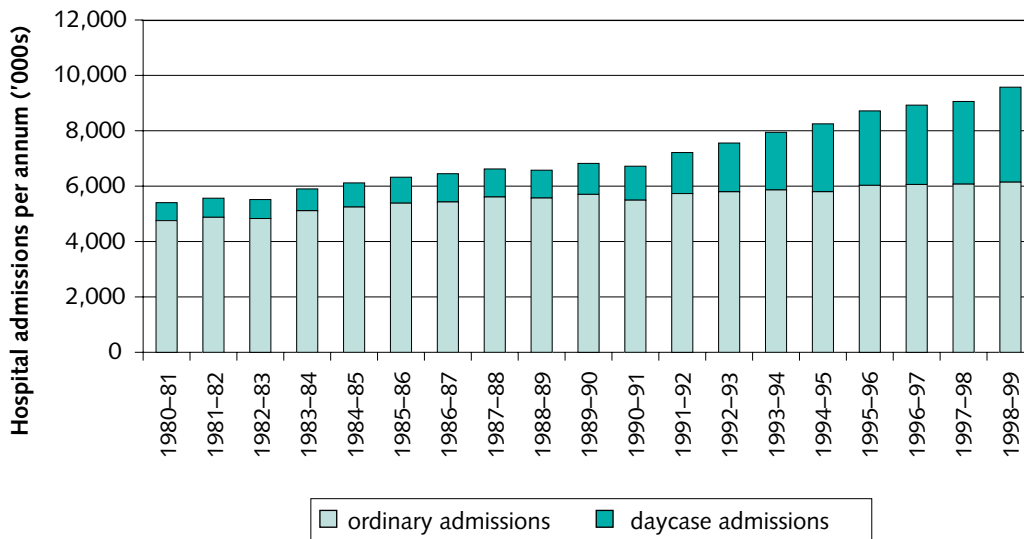
Chart 1 Staffed hospital beds: general, acute and maternity sectors



Source: Department of Health

19. The use of hospital beds has fallen because an increase in the number of hospital admissions has been more than off-set by growth in day case treatments and reductions in lengths of stay. There has been a long-term increase in acute and general admissions per head of around 3.5% p.a. The main contributor to this growth over the last decade has been the increase in the number of patients receiving care as day cases (Chart 2).

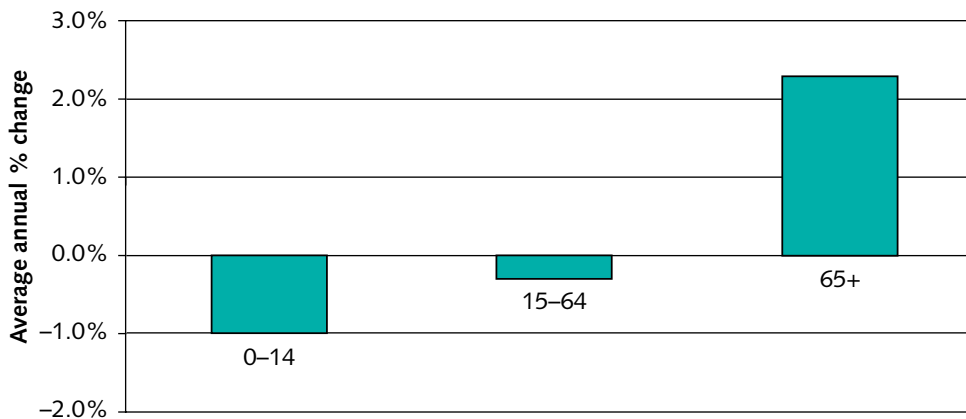
Chart 2 Hospital admissions: general and acute sectors



Source: Department of Health

20. Ordinary (overnight) admissions have grown much more slowly with most of the growth being attributable to **older people**. Admission rates are much higher for the age groups over 65. For much of the period admission rates for these age groups have also been growing more quickly (Chart 3). In 1998/9, the ordinary admission rate for the 65+ age group was 289 per thousand population. In contrast, the ordinary admission rate for the 15 to 64 age group was around one third of this, at 94 per thousand population.

Chart 3 Total ordinary admissions per head: Annual average % change (1989-1998)



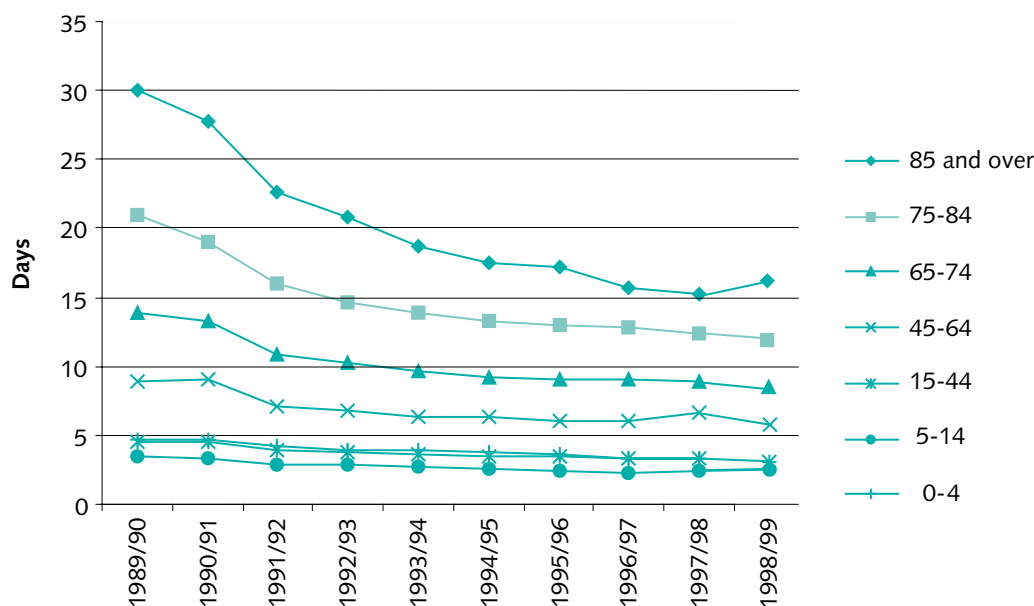
Source: Department of Health

21. **Rising emergency admissions** are the main reason why the number of ordinary (i.e. overnight) admissions has grown. Nearly 60% of the total number of ordinary admissions are now emergencies. Since 1989 the rate of increase per head has fluctuated around 2% per annum.

22. In contrast, the number of **ordinary elective admissions** has been falling for most of the last decade. Pressures for elective care have been met by a huge increase in **day case admissions** – over 12% p.a. per head since 1989. Over 60% of elective cases are now treated on a day case basis.

23. For most of the last 30 years the rise in hospital admissions has been more than off-set by a fall in the **average length of time patients spend in hospital**. The fall has been particularly marked for older patients. However, since 1994 the decline has slowed markedly (Chart 4). Indeed for all age groups the overall rate of decline has nearly halved: from 3.3% p.a. between 1980 and 1994 to 1.7% p.a. between 1994 and 1998.

Chart 4: General and Acute length of stay (by age group)



Source: Department of Health

24. **Critical care services** do not affect the *total* number of acute beds, the focus of this inquiry, but their particular importance justifies some reference. Critical care services are a relatively new development, with intensive care originating from the polio epidemics of the 1950s. Development has been rapid, with the average acute hospital now having a six bed Intensive Care Unit. High dependency care has largely developed during the last ten years. One-third of acute Trusts have no high dependency beds. There is no consistency in the organisation or extent of critical care services with wide variation in the proportion of acute hospital beds designated for critical care. The average proportion of general and specialist critical care beds is just over 2% of acute beds.

25. There are little historical data on the number of critical care beds. Bed availability and occupancy was, in the past, collected by ward type and not by individual specialties. Wards classified as intensive care under this definition may have included intensive care, high dependency and general beds depending on the ward organisation within the hospital. The published data have therefore been a poor indicator of the real numbers of critical care beds. To address this, a new census of intensive and high dependency care beds was introduced on 31 March 1999, to be undertaken twice yearly (the census dates were subsequently changed to January and July, to better record winter and summer bed levels). This census counts the number of beds occupied or available for use on one particular day, and covers separately general and specialist adult intensive and high dependency care beds. The March 1999 census recorded 2,240 critical care beds. Fast track information from the January 2000 census shows that this figure rose to 2,362 beds.

26. The above trends in admissions, length of stay and staffed hospital beds raise **two crucial questions**:

- First, has the long-term reduction in general and acute hospital beds affected the ability of the NHS to meet patients' needs? and
- Second, whether the recent trends in emergency and elective admissions and lengths of hospital stay will continue? For example, how can emergency admission rates particularly for older people best be contained? What further scope is there for the growth of day case treatment for elective care? And can the average length of hospital stay continue to fall without risk to quality of care?

27. On the first question, the downward trend in beds mainly reflects the reduction in average length of stay and the growing importance of day case treatments. But it is also partly attributable to a rise in the average level of bed occupancy. The rise in occupancy – to an average rate of around 83% – is worth noting. Since 1980 it has allowed roughly an extra 1% a year in the decline in available beds. Hospitals are filling empty beds more quickly than ever before.

28. Has the increase in average bed occupancy levels gone too far? There is a range of relevant evidence. The pressures on emergency care in recent winters indicate that in some areas with existing management arrangements the NHS struggled to accommodate the demand for care. There will always be peaks and troughs in demand and the health service needs to be able to respond to these. For hospitals this is partly a matter of running beds at a sensible average occupancy level – high enough to avoid inefficiency and low enough to avoid unresponsiveness. The Government’s Emergency Services Action Team (ESAT) report in 1997 included analyses showing that in acute hospitals average bed occupancy rates over 85% are associated with rapidly growing problems in handling emergency admissions. Subsequent analysis by the University of York has confirmed this conclusion. Managing peaks and troughs is also a matter of ensuring that resources are used appropriately and are deployed flexibly to match demand variations over the year. In its reports ESAT has identified scope for improvements in the management of emergency care services.

29. The Inquiry itself has found evidence of significant inappropriate or avoidable use of acute hospital beds. The position varies greatly between hospitals but an externally commissioned literature review concluded that “For older people around 20% of bed days were probably inappropriate if alternative facilities were in place.”

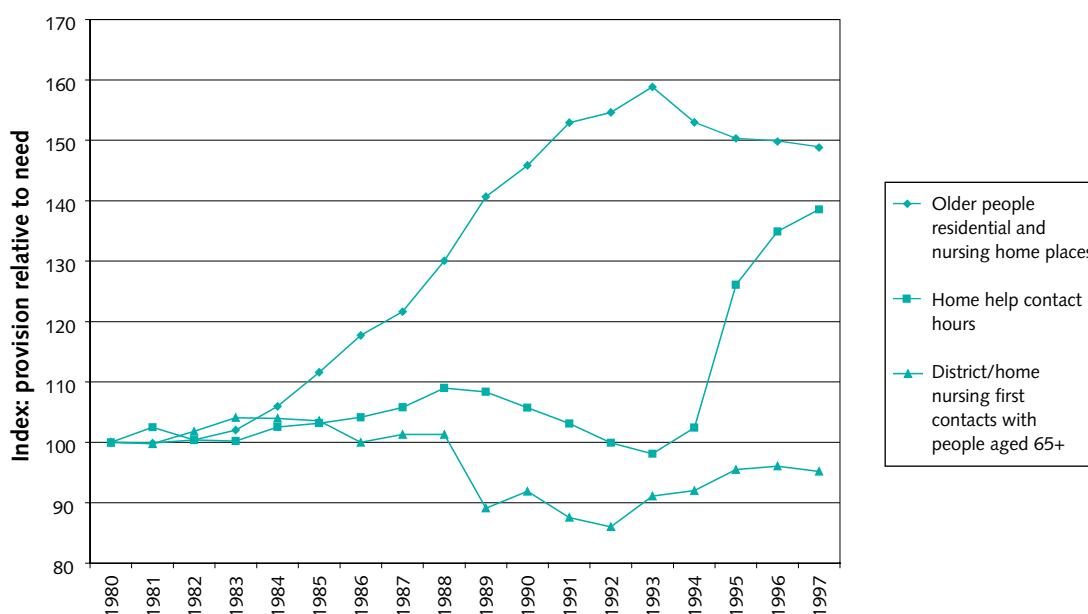
30. To draw conclusions about longer term future trends therefore requires consideration of alternative ways of organising health services and analysis of the main external drivers of future service requirements. Findings on these areas are provided in paragraphs 45–59.

ii. Trends in services for older people

31. Services for older people warrant a special focus. Year on year there has been a continuous growth in the proportion of older people requiring overnight stays in hospital. (In contrast the proportion of children and adults under 65 requiring overnight hospital stays has been falling for 30 years.) These trends, together with the growing numbers of older people and their generally poorer health, help explain why people aged 65 and over occupy two-thirds of general and acute hospital beds and account for over half the recent growth in emergency admissions.

32. Trends in the use of hospital by older people have been markedly influenced by both the supply of beds and trends in the availability of other services for this age group. Most obviously the growth of residential and nursing home places in the 1980s (Chart 5, top line) allowed hospitals substantially to reduce their contribution to continuing in-patient care. But there was no similar expansion in community nursing services (Chart 5, bottom line). They have in general not kept pace with demographic pressures. Although they have expanded relative to need over the last five years, they have not made up the ground lost in the preceding five years. Nor has there been acknowledgement until recently of the impact on carers of early hospital discharge.

Chart 5: Community health and social services provision for older people



Source: Department of Health

33. In recent years local authority home care services for older people (Chart 5, middle line) have more than kept pace with demography. But because of an increasing concentration of services on those in most need in line with policy at the time, there has still been a decline in the proportion of older people receiving home care services. There has also not been any shift to reflect changing practice in relation to acute health care such as earlier discharge.

34. Since 1991/2 around 50% of the extra emergency admissions per person aged 75 and over have been for “symptoms, signs and ill-defined conditions”. The growth in this diagnosis might reflect better recognition of the complex problems of older people but it might also be a consequence of increased pressure on carers and GPs caring for the very old and the relative decline in community health services.

Local and international variations

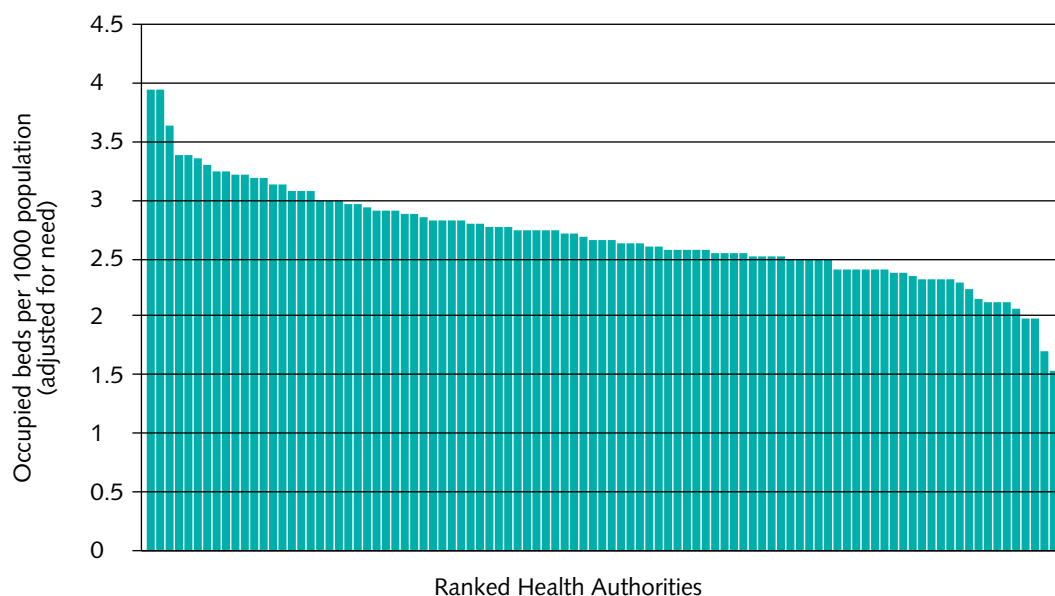
35. To throw light on the key questions about future hospital bed requirements we have examined variations in bed use both within England and internationally.

i. Local Variations

36. In England after adjusting for need there remain wide variations between Health Authorities in average length of stay and in day case rates. This suggests that there is scope both for the average length of stay to fall further and for day case rates to rise.

37. The large variations in hospital admissions and bed use per head (e.g. four fold for emergency admissions among the over 75s) that remain after adjusting for need also suggest there is scope for hospital admissions to either rise or fall (Chart 6). However, higher bed availability and use are **not** associated with a better response to emergency bed pressures. Indeed authorities using more beds for older people are prone to both longer waits for emergency admissions and above average rates of delayed discharges.

Chart 6: General and acute Bed Use by Health Authority: Occupied Beds per 1000 population (adjusted for need)



Source: Department of Health

38. In contrast, lower bed availability and lower day case rates are associated with longer waits for elective admissions, suggesting that the supply of beds can be run down too far. Increased availability of nursing home and residential care and of district nurses is associated with reduced in-patient bed use. A high day case rate has a similar effect. Comparing clusters of Health Authorities suggests that those with good provision of social and community health services and below average in-patient bed use achieve outcomes as good as those with above average in-patient bed use. However, Health Authorities with the lowest average bed use had significantly higher waiting times.

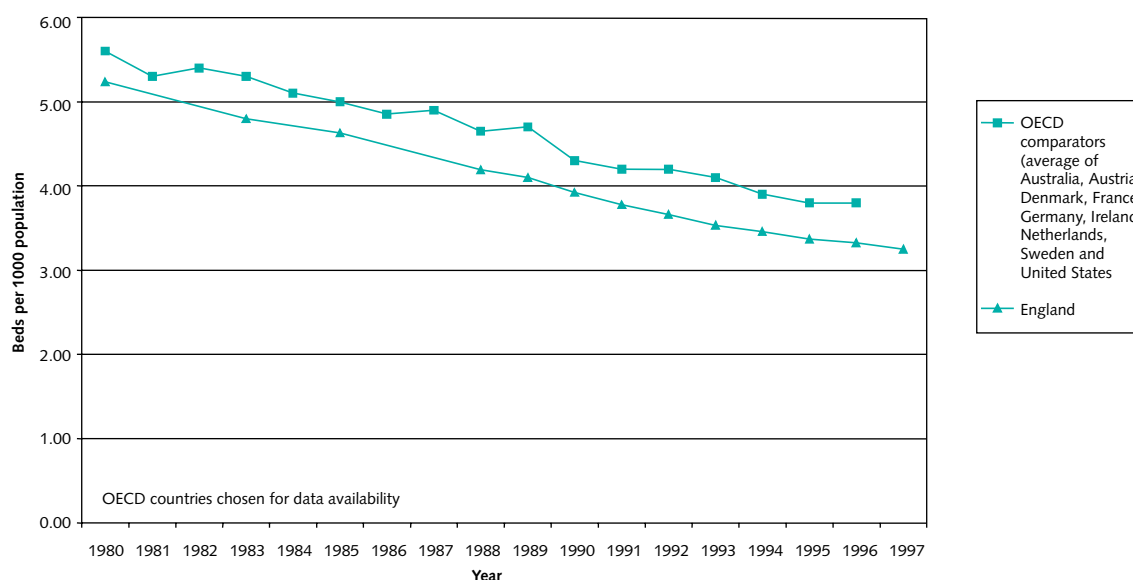
39. Discussions have been held involving samples of paired authorities, apparently similar in general characteristics but with significantly different patterns of service use. These have confirmed that availability of community health services and social care are key to differences in acute bed use, while in some cases variations in primary care service delivery are also material. It was suggested in all cases that the position will have changed following recent winter pressures initiatives. Generally speaking authorities apparently performing less well found that there were pointers to improvement from the paired authority, though no authority studied believed that it had the position absolutely right.

40. The large variations in critical care beds need further study. On average, 1% of acute beds are designated for general (not specialist) critical care, but the upper quartile of trusts have twice the percentage of the lower quartile.

ii. International Comparisons

41. The wide domestic variation in bed availability is mirrored internationally, with England towards the bottom end of the distribution on account of its below average overnight admission rates, near average lengths of stay and high occupancy rates. **But everywhere the numbers of staffed acute hospital beds are falling (Chart 7), driven mainly by reductions in lengths of stay but in some cases (including recently Scotland) also by reductions in overnight admissions.**

Chart 7 Trends in acute hospital beds in England and in OECD countries 1980–1996/7



Source: OECD/Department of Health

42. A number of health care systems in the USA operate on hospital bed day rates (per 1,000 population) that are roughly half the current England average and below the rate of even the lowest Health Authority. Their admission rates and average lengths of stay are both one third lower than in England. Also in contrast to England, in a minority of countries, notably the Netherlands, Canada and the USA, hospital admission rates for older people have been flat or falling for many years. In these countries increasing pressures for emergency care are dealt with in the community or in ambulatory or out-patient facilities.

43. Health systems with low hospital bed utilisation appear to be characterised by a large range of ambulatory and intermediate care facilities and/or strict controls on hospital services and expenditures.

44. Other countries use bed “norms” and projections to guide or control hospital development, with varying success. A newer use of norms is to encourage the development of alternatives to hospital care (e.g. Australia and Ontario).

Key drivers of future service requirements

45. The most important feature about the future is its uncertainty. The Royal Commission on Long Term Care noted that the population aged over 85 was expected to increase over the next 20 years by about 22% but the increase could be as large as 50%. Yet demography is perhaps the most predictable of the drivers of future service requirements. **All future service developments must therefore plan for uncertainty.**
46. A key driver of service requirements and the need for hospital beds is likely to be **technological advance and related changes in clinical practice**. Leaving aside the current scope to increase day surgery, in the short to medium term medical technology appears unlikely to reduce the need for planned overnight hospital admissions. Extensions of NHS Direct, IT development and telemedicine may have a more immediate impact by allowing centralised expertise to be brought closer to patients' homes. In the longer term a number of important new developments can be identified but their net impact is unclear.
47. A second major driver could be a **clarification of the evidence base on the cost-effectiveness of new models of care**. A review conducted for the National Beds Inquiry by the University of York concluded that there was more scope to treat various groups of hospital patients in alternative settings. But deficiencies in the methodologies and the range of models evaluated made it difficult to draw conclusions about the scale of such a shift that might be cost-effective. However, for specific types of patients certain alternatives to hospital do appear to offer equivalent health outcomes at similar or lower cost, and may be preferred by patients and their carers.
48. The **behaviour of increasingly well informed consumers and carers** will also be important. We can probably expect greater demands on services as a whole. There is also a range of evidence that, other things being equal, patients prefer care at home or in homely settings to in-patient care.
49. Despite the attention they receive, **demographic pressures and changes in morbidity** are not seen as major drivers of bed requirements over the next 10 to 20 years. However the uncertainties have already been referred to. Looking beyond 2020 demographic pressures will become more significant as ageing accelerates. This highlights the need to keep drivers of future service requirements under regular review in years to come.
50. The overall impact on the hospital of these future drivers is highly uncertain, but most experts believe that a wide range of services will continue to be transferred out of traditional hospital wards into new settings. Knowledge is likely to be centralised in the hospital but services will be spun out to the periphery. Telemedicine is expected to enhance this process. Some see the major acute hospital of the future as a resource centre for high technology, high cost, high risk interventions. It would operate as a hub from which expertise and advice is available to wider health networks, including a range of local facilities dealing with less risky and/or severe conditions (for example ambulatory care centres, minor injury units and rehabilitation units).
51. **What is certain, however, is that we have a large degree of freedom over the future development of health care.** The future development of the acute hospital sector and of services outside hospitals is not pre-ordained. **Government policies will be a key driver, fully as important as external pressures.**

c. developing future services

52. Given the evidence on recent trends, national and international service variations and future service drivers, how should hospital and related health services develop over the next 10–20 years? In an exploratory attempt to answer this question, this document and the Supporting Analysis focus on older people as the major users of hospital beds and the group whose needs can be expected to continue to dominate future trends in hospital use. There is also a short discussion of services for children and for people with mental health problems (and more detail in the Supporting Analysis). However, **the focus of consultation is the future development of services for older people.**

Developing services for older people

53. That the health and social care systems are not fully meeting the needs of older people is evidenced by the findings referred to earlier, including the shortage of community based alternatives to hospital care, significant inappropriate use of hospital beds and significant levels of delayed discharges.

54. In recognition of these weaknesses, the Government's key aims for the NHS and social services can be translated into service objectives for older people as follows:

- Preventing ill health and reducing inequalities implies **promoting the independence of older people** through rehabilitation, reablement and preventing unnecessary admission to hospital.
- Fast and convenient treatment with fair access for all means making available **rapid, skilled, multi-disciplinary assessment and diagnosis** and active case management for all older people.
- Services that focus on needs of patients and their carers and families imply providing older people with **access to a wide range of convenient services appropriate to their needs** including: preventive interventions; health promotion; support with activities of daily living; specialist treatment; and pro-active rehabilitation and follow-up care.
- High quality standards require that older people experience **prompt stabilisation and access to high quality treatment and care** when problems occur. They also mean reduced waiting times and more responsive emergency care.
- Integrated and coherent services mean **better co-ordination of services across health and social care boundaries**. They also require improving consistency and improving partnerships.
- Rebuilding public confidence in the NHS as a public service, accountable to patients, means **respecting the preferences of older people and their carers** regarding the setting of care (whether at home, in the community or in hospital).

55. Delivering this vision over the next 10-20 years can be achieved in a number of ways. In practice there is a continuum of options but for clarity and to enable effective consultation, we have developed three scenarios which illustrate the challenging choices faced by the NHS and social service departments. Within available resources each of the scenarios would make more progress towards some of the desired objectives than towards others.

56. In summary the **three scenarios** are:

1. Maintain Current Direction

Under this scenario the balance of service objectives and settings would be maintained broadly as at present. There would be no attempt to transfer services from hospital into community settings, and bed capacity in the acute sector would rise slightly (in contrast to the historic trend of reducing hospital beds). In line with current policy however, available additional investment would go towards a higher rate of growth in elective surgery and a *moderate* increase in primary and community services beyond that required simply to respond to demographic pressures.

2. Acute bed focused care

Under this scenario there would be an active policy to increase the number of hospital beds with a view to providing more responsive emergency and specialist care and avoiding premature discharge. So far as resources permitted, the delivery of a wider range of services (including rapid assessment and rehabilitation) would be provided mainly in a hospital setting. The assumption would be that co-ordination of services is best achieved by locating them together. Within given resource constraints an increase in hospital beds would inevitably mean a slow-down in the expansion of primary and community services.

3. Care closer to home

Under this scenario, there would be an active policy to build up **intermediate care** services (i.e. services designed to prevent avoidable admissions to acute care settings and to facilitate the transition from hospital to home and from medical dependence to functional independence). There would be a major expansion of both community health and social care services. In contrast acute hospital services would be focused on rapid assessment, stabilisation and treatment. Hospital day units and community based services would be aimed at maintaining people in their home communities in good health, preventing avoidable admissions, facilitating early discharge and active rehabilitation post-discharge and supporting a return to normal community-based living wherever possible. Over time “places” in community schemes might replace some acute hospital beds.

57. The Government has already taken a number of steps to improve services for older people. These include the introduction of free eye tests for people aged 60 and over, the publication of a National Strategy for Carers, ring-fenced prevention and rehabilitation funds, the drawing up of Joint Investment Plans for Older People and the development of a National Service Framework for Older People. These initiatives are consistent with all three scenarios but particularly support the care closer to home approach. The third scenario also fits with other Government policies for older people which are aimed at helping older people to remain independent while improving support for them by making it easier to access public services.

58. Nevertheless, the advantages and disadvantages of the different scenarios need to be assessed clearly and objectively. How the Government’s vision for older people should be implemented is a major strategic decision for the public and for the country. The choice should not be made by default. Each of the scenarios should be assessed against the service objectives for older people set out in paragraph 54 above. A range of views is to be expected given different preferences over the location of care, variations in local need and the profile of existing services, and different interpretations of the research findings on new service models.

59. Before reaching a decision on which of these scenarios (or variant) should be pursued, it will also be necessary to explore the feasibility of their implementation (e.g. cost, cost-effectiveness, timescale and transitional arrangements) and their flexibility in the face of changing technological and other circumstances. It will be particularly important to assess the workforce implications.

Developing services for children

60. There are no significant mismatches between the paediatric in-patient services needed by children and current patterns of provision. In the future it is likely that shorter periods of greater intensity of care will be needed, implying concentration of services for both surgical and paediatric care. Developments in paediatric intensive care services are being addressed with year-on-year investment.

61. There is, however, potential for more collaborative care packages between primary and specialist teams to deliver greater proportions of care in community settings working with other agencies – social services and education authorities.

62. In the next 10 to 20 years the introduction of new vaccines, more emphasis on other preventive measures and changes in technologies or surgical practice could lead to a further reduction in need for children's in-patient services.

63. There is currently a shortfall in specialist in-patient beds for children and adolescents with mental health problems. The last ten years have seen a steady reduction in bed availability but not all of this has been based either upon an assessment of needs or on the provision of alternative care. The Department of Health commissioned research to address this.

Developing mental health services

64. There is currently a significant mismatch of mental health services and mental health needs. There are too few medium secure and intensive care beds, and a shortfall in supported accommodation in the community, including those staffed 24 hours per day. In some localities, especially the inner cities, there are currently severe pressures on acute mental health beds. At the same time there is evidence of admissions and continued hospital stays which would have been unnecessary if other services had been available. The immediate priority is to use the additional investment through the NHS Modernisation Fund to enable the development of balanced mental health systems. In this first year NHS Modernisation Fund investment has been targeted where the need is greatest. This has resulted in plans for significant numbers of extra secure beds, extra 24-hour staffed beds, more assertive outreach teams, improved 24-hour access and increases in prescriptions of atypical anti-psychotic drugs.

65. There is both a substantial shortfall and an imbalance in the places available for adults of working age. The main focus should be on supported accommodation in the community, medium secure beds, and local intensive care beds. In the longer term this may enable a reduction in acute mental health beds. In the shorter term some health communities may need to invest in additional acute beds to relieve current pressures, although before doing so they should ensure that they have proper bed management protocols in place, and have reviewed all possible alternatives.

66. The Government's vision for mental health and social care is set out in *Modernising Mental Health Services*. There should be rapid assessment and access to a variety of levels of support and care including acute hospital beds. A National Service Framework¹ has detailed the standards of services to be expected. An examination of future drivers of need for specialist mental health services has not revealed any dramatic trends. The real issue is about how to meet the **existing** shortfalls and balance the whole system.

¹ *National Service Framework for Mental Health: Modern Standards and Service Models* (1999) London, Department of Health.

Service implications

67. The three scenarios outlined in the section on developing services for older people can be assumed to cover service provision for all patient groups using general and acute hospital beds. To illustrate the implications for hospital services and for community health and social services we have developed quantifications of each of the three scenarios. The quantifications cover five types of services: primary care, step down and community hospital facilities offering intermediate care; health and social care in home settings; nursing and residential home long term care; and acute hospitals. The quantification is at national level. The resulting illustrative projections are assumed to be of broadly similar long run cost.

68. **The projections for the maintain current direction scenario** assume:

- Rising emergency admission rates (based on the rate of the last ten years);
- Rising ordinary elective admission rates (to facilitate reducing in-patient waiting times), followed by a decline in line with long-term trends;
- Continued increases in day case rates;
- Falling average lengths of stay (based on the slower rate observed over the last few years);
- An increase in primary care, community health and social services beyond that required to meet demographic pressures in line with current policy goals; and
- A shift from institutional to domiciliary settings for long term care in line with current social care policy.

69. **The projections for the acute bed focused scenario** assume that, compared with the *maintain* scenario:

- Emergency admission rates rise at a higher rate;
- Average length of hospital stay declines at a slower rate; and
- Primary, community health and social care stay constant or fall slightly relative to demographic pressures.

70. **The projections for the care closer to home scenario** assume that, compared with the *maintain* scenario:

- Emergency admissions rise at a lower rate;
- Length of stay in acute hospital settings declines by 20% by 2019/20;
- There is an expansion of community health and social care, often in the form of intermediate care (illustrated by district nurse contacts, home help hours and step down and community hospital intermediate care beds) to reduce emergency admissions and to facilitate earlier discharge from acute settings. Intermediate care places rise more than the bed days lost from the acute sector to reflect a greater emphasis on promoting independence; and
- There are further increases in primary care.

71. The scenarios and projections relate to the medium and longer term (i.e. up to 2019/20) as this is the timescale which is the focus of the beds inquiry. But to provide a base, illustrative assumptions about short term trends in hospital activity (i.e over the period up to 2003/4) have been made. On the basis of these, there could be different needs for hospital beds over the next few years. The longer term projections are based on a central estimate of a small rise in the number of beds over the next four years.

72. For the longer term period covered by the scenarios, the main features of the resulting projections are:

- Under the maintain current direction scenario the need for hospital beds rises gradually up to 2019/20;
- Under the acute bed focused care scenario, hospital beds increase from their current levels but primary care and community health services show little if any expansion;
- Under the care closer to home scenario, there could be some reduction in acute overnight beds after 2004 provided that there was a sufficient build-up of community health and social services and intermediate care facilities; and
- All three projections make important assumptions about social services as well as about health services. In particular, the care closer to home scenario requires a major expansion of social care.

The details are set out in the Supporting Analysis and include indicative figures for an illustrative Health Authority.

73. The assumptions on which these projections are based are highly tentative. New service developments should be piloted to inform the scale and pace of any planned change. The assumptions should be reviewed regularly.

d. the consultation

74. In the light of the evidence and analysis presented above the Government has identified a number of **key questions on which it wishes to consult**. Responses are invited from those able to provide either a local or a national perspective. The questions are:

Managing Demand

1. How can we best contain inappropriate emergency hospital admission *rates*, particularly for older people?
2. What scope is there to use alternatives to emergency admissions while securing as good outcomes as hospital-based care? What are the obstacles to such a move?
3. In elective care, what scope is there for the further transfer of in-patient cases to day cases or ambulatory care? What are the obstacles to this?

Improving Performance

4. What measures would most improve the ability of the NHS to respond to peaks and troughs in demand over the year?
5. Is there further scope to reduce the average length of hospital stay by improving the organisation of care, the impact of new diagnostics, therapies and anaesthetics, pre-assessment, the use of care pathways or other changes?
6. Are there good reasons for the large variations between Health Authorities in the patterns of service delivery?
7. Do areas with higher and lower levels of bed availability deliver significantly different outcomes?
8. What proportion of patients currently treated in acute hospital beds can and should be safely and cost-effectively managed and rehabilitated in other settings? What are the obstacles?

Future Scenarios

9. Do the three scenarios identified for the future development of services for older people cover the main service options? Are these scenarios equally relevant to other patient groups?
10. What balance of hospital and other services would be most effective and cost-effective in achieving the Government's service objectives for older people?
11. What steps should the NHS and partner agencies take in the short, medium and longer term to bring about the scenarios?
12. Are the service assumptions used to illustrate each future scenario realistic? Do the resulting projections capture the most probable service futures?

Managing Change

13. What are likely to be the key workforce implications of the scenarios? In particular, what scope is there for using new types of worker, in what key staff groups might there be barriers or shortages and how might these best be tackled?
14. What are the other issues that will need to be addressed to achieve the changes envisaged in the scenarios?
15. Given the uncertain future, how do we ensure that the NHS retains as much flexibility as possible?

Research

16. What should be the priorities for further research on the optimal balance of care for all population groups?

How to respond

75. The consultation period will run from February 10th to May 15th.
Comments should be addressed to:

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133–155 Waterloo Road
London SE1 8UG

Tel: 0171-972 4861
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76. As part of the consultation the Inquiry Team will hold a series of Regional Workshops in order to discuss the key issues outlined above. Further details are available from Charmaine Church at the above address.

77. The consultation document and Supporting Analysis are available on the internet at:
www.doh.gov.uk/nationalbeds.htm

78. The outcome of consultation will be published. This will be followed by guidance on service planning at local level.

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