Right Sizing Community Services to Support Discharge from Hospital

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GIG CYMRU NHS WALES | Delivery Unit Uned Gyflawni

May 2020

Executive Summary

When assessing the capacity required to support discharge and deliver Discharge to Recover then Assess (D2RA) pathways, Regional Partnership Boards (RPBs) need to ensure that; Primary / Community / Third Sector options are optimised. No-one is assessed for long term care (package or placement) in an acute hospital bed; and no-one waits longer than 48 hours, after their acute treatment is complete for their Discharge to Recover then Assess (D2RA) pathway to commence.

Too many people are still bypassing intermediate care. No patient should be assessed for long term care (packages or care home placement) in an acute hospital bed.

Discharge to Recover then Assess pathways should be in place in all RPB / HB areas to ensure 'effective assessment, at the right time, of the right type, and be outcome focussed' to maximise individual outcomes and system flow.

The proportion of people currently placed on D2RA pathway 3 (bedded intermediate care) is greater than good practice would suggest should be the case. Capacity must increase for all patients who would benefit from D2RA pathway 2 (in their own home).

Health Boards should review the service model for Community Hospitals. Community Hospitals in Wales are frequently used as 'step down' facilities and can be the default pathway for complex discharge. However, the environment and variation in therapy input means that the outcomes for individuals are variable.

Regional Partnership Boards should review their services for people with Dementia. People with Dementia can be excluded from current intermediate care service provision. There is early indication that access to specialist Dementia services developed in areas of Wales can produce good outcomes for this client group.

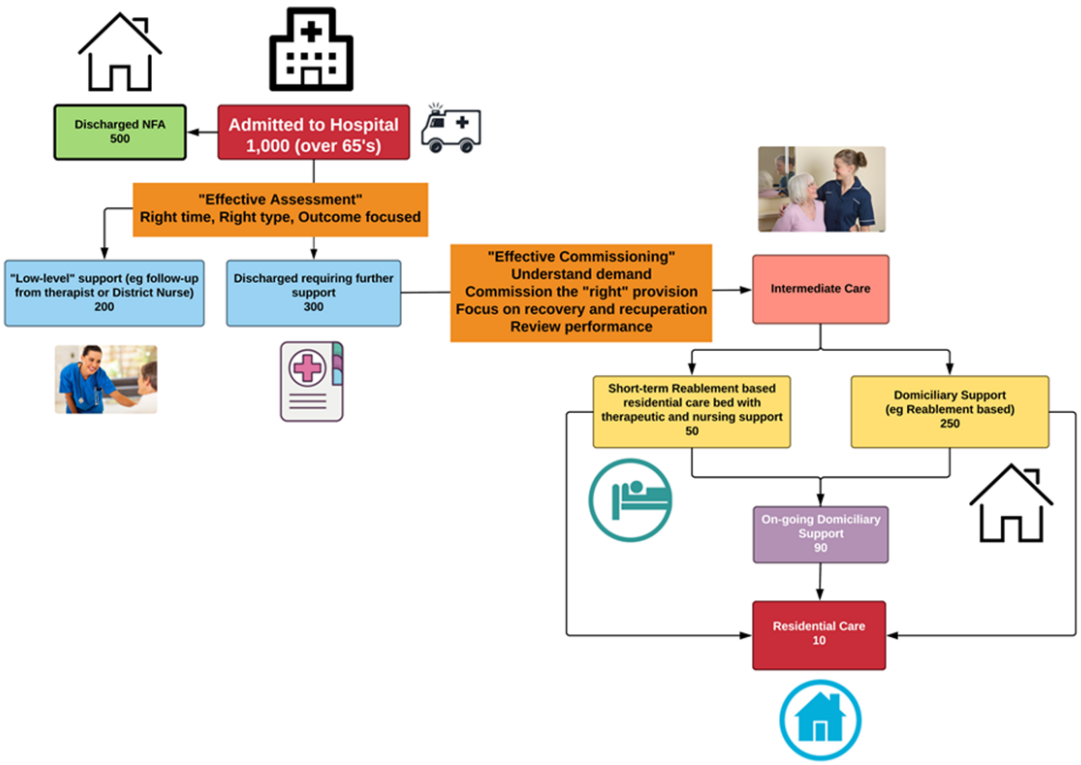
Background

In autumn 2018, the NHS Wales Delivery Unit (DU) published the report of its national review of complex discharge practice in Wales. It identified significant opportunities to improve the experience of the people we serve by reducing harm and improving patient flow.

One of the key themes identified as benefitting from a national approach was right-sizing community services to facilitate timely discharge (including the four 'Discharge to Recover then Assess' pathways – see **Appendix 1**).

This project has been developed to respond, in a systematic way, to that request using the model[1] developed by Professor John Bolton set out below:

Diagram 1: The model



[1] Professor John Bolton, Reducing delays in hospital transfers of care for older people Key messages in planning and commissioning (Institute of Public Care, Oxford Brookes University).

The model had been presented at a number of national events over the previous two years and the feedback suggested that it had resonance amongst those who attended.

In the paper in which this model appears, Prof Bolton explains that it:

"……is designed to describe the system (he) feels should be developed to assist in managing post hospital care. The numbers in the diagram indicate what good practice might look like.

The diagram suggests that about a third of people leaving hospital should need some care and support, and most of those (around 85%) can be helped at home. The numbers ending up in residential or nursing care as a new admission on a permanent basis following a hospital episode should be very low (less than 4%).

The key message conveyed by the illustration, is that ***each component of the model needs to understand the flow of patients, the outcomes achieved and the overall performance of the health and social care system."***

Note: this Project focused on right-sizing community services for discharge. Further work is required to also understand the resourcing required to right-size community services to more effectively manage care closer to home in the first place. This will form part of the NHS Wales Delivery Unit's 2020/21 work programme.

Purpose

The purpose of this national project was to support Regional Partnership Boards (RPBs) to assess:

- How the patient numbers in their region compare against the model;
- The potential variance between current commissioning arrangements and current/future demand if the principles of the model are implemented via the Welsh Discharge to Recover then Assess Pathways 2, 3 & 4. (**Appendix 1**)**;** and
- Whether the services they currently have in place support these patients/customers and deliver good outcomes.

Project methodology

Details of the Project Team, National Advisory Group, definitions and methodology used are attached as **Appendix 2.**

What did the data tell us? (Quantitative Analysis)

It quickly became apparent that our health and social care systems in Wales are not currently set up to systematically collect the data required to inform the integrated commissioning of community services.

There was an initial assumption that the Welsh Community Care Information System (WCCIS) would provide this function, but this is not the case at present. As a consequence, the data collection exercise has been challenging for all areas and continues to be an iterative process.

All of the RPBs have gone on to review and refine their data in order to provide more confidence in their local information and, in response to the project timescales, are currently at different stages in that iterative process.

In the course of the Project, the template and definitions for data collection have also been refined in order to provide greater clarity and to facilitate regular update and review, as part of the RPB integrated commissioning process.

<u>'Support in the Community'</u>

In the original model, this was described as 'Low Level Support'. The terminology has been changed to reflect the feedback that 'low level' could be misinterpreted. The type of service that the newly phrased 'Support in the Community' refers to includes:

- Short-term (usually third sector) services developed specifically for discharge. Tasks undertaken commonly include making sure heating is on, escorted transport home, shopping, meal prep, support to go out, and making community connections. Where personal care is provided, the service would be captured under one of the yellow 'non-bedded intermediate care' boxes;

- Single (usually NHS) profession follow-up post discharge e.g. district/community nurse for dressings, physiotherapy outpatient appointment etc.

<u>Non-bedded Intermediate Care</u>

In the original model this was called 'Domiciliary Support '. This refers to recovery and assessment in an individual's own home (D2RA Pathway 2) and commonly includes an element of domiciliary care reablement plus appropriate multidisciplinary team input as required.

<u>Bedded Intermediate Care</u>

In the original model this was called 'Short term reablement… bed'. This refers to recovery and assess in a bedded facility (D2RA Pathway 3). This can either be commissioned from the independent/third sector or, as is commonly the case in Wales, provided in a Community Hospital.

Diagram 3: Populated Template (showing range across Wales)

Managing the flow out of hospital: (Admissions 65yrs and Over - 2018/19)

Key: Dotted line on graphs is used to depict the reasonable activity level, based on JB model.

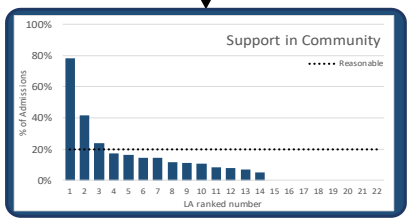
Calculated field - number of patients unaccounted for: 73548 (23.6% - 94.0%)

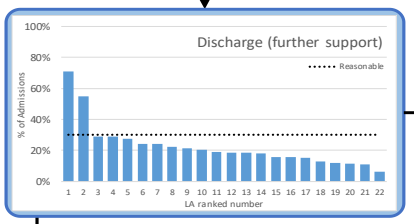
Decision

Number of Welsh resident admissions of 65yrs and over (submitted): 204215

NWIS total: 194567

"Effective Assessment"
Right time, Right type, Outcome focused



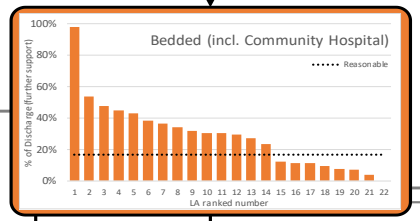


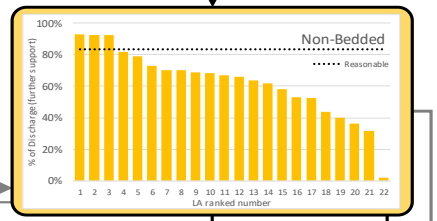
Decision

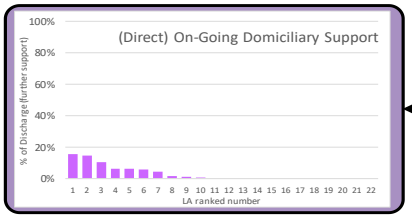
Wales: discharge to recover and assess (Intermediate Care)

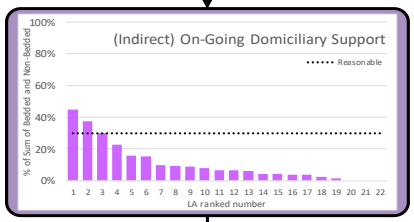
Decision

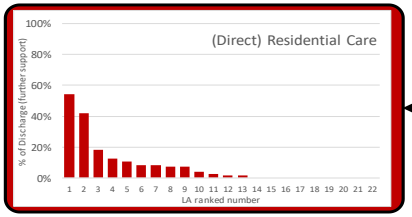
Common but undesirable behaviour

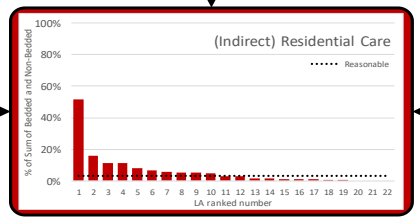












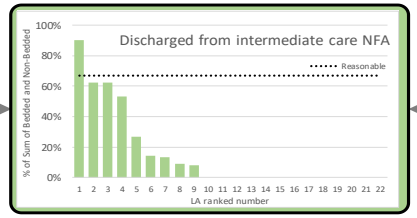
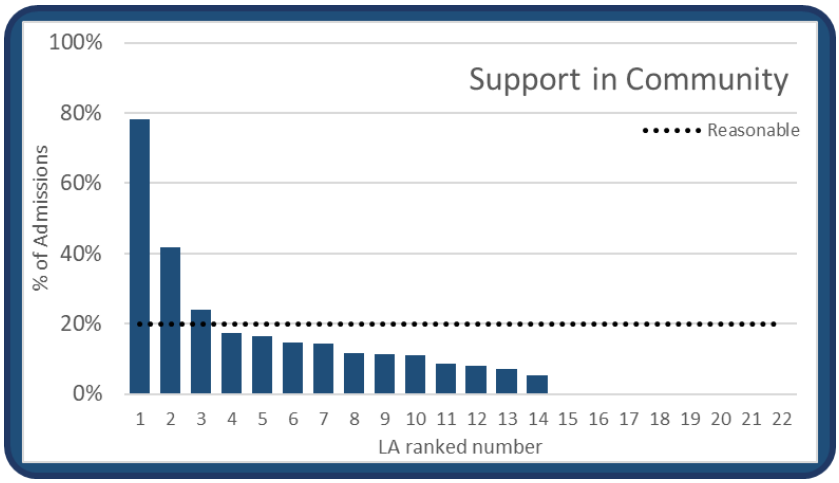


Diagram 3 above is an all Wales collation of 2018/19 data submitted by each of the health boards and the 22 local authorities relating back to the model in Diagram 1, but with On-Going Domiciliary Support and Residential Care split between Direct and Indirect placements where data allowed. The dotted horizontal line on each graph is the suggested level 'reasonable could look like' as detailed in Prof Bolton's paper.

The percentages illustrated in Diagram 3 are calculated using different denominators depending on the stage of the pathway – these are specified on each graph.

The data in each step of the model has been ordered in descending order based on the percentage of services. Due to the above ordering, a local authority may appear as bar 1 in one graph but bar 22 in another, hence the results are therefore pseudonomised.

Support in the Community

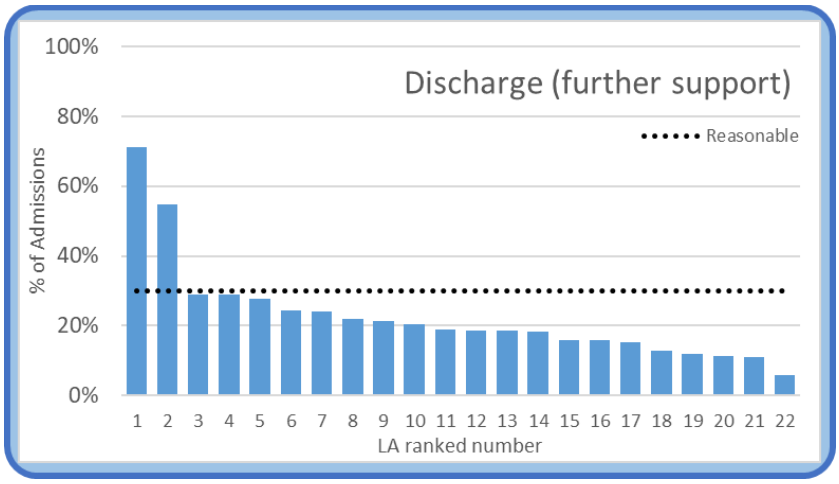


Whilst three local authority areas met or exceeded the reasonable proportion of patients discharged with this type of support (20% of admissions), the (caveated) data submitted indicates that there is significant opportunity to utilise this option more effectively, and to potentially avoid over-referral to intermediate care 'to be on the safe side'.

It is noted that not all areas submitted data for this type of support, and where they did it was not always complete i.e. contained one or two elements only.

Discharged Requiring Support

1. Access to Intermediate Care/Discharge to Recover then Assess Pathways 2 & 3:



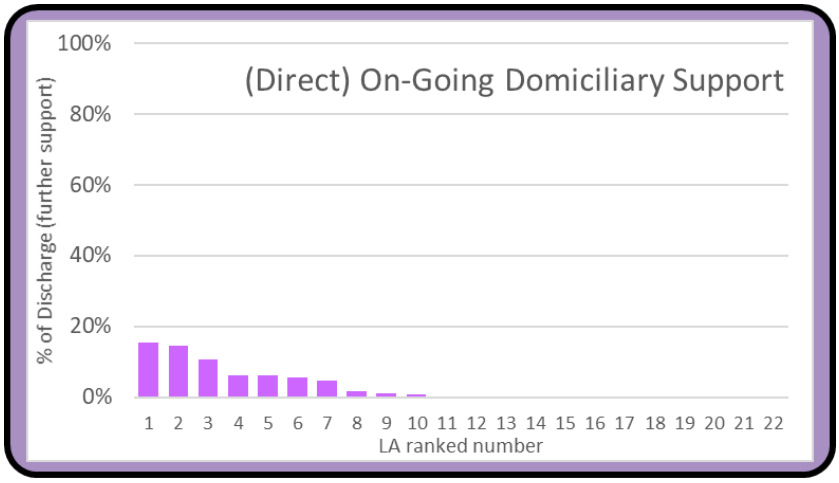
The proportion of older people leaving hospital who were assessed as needing care and support was variable.

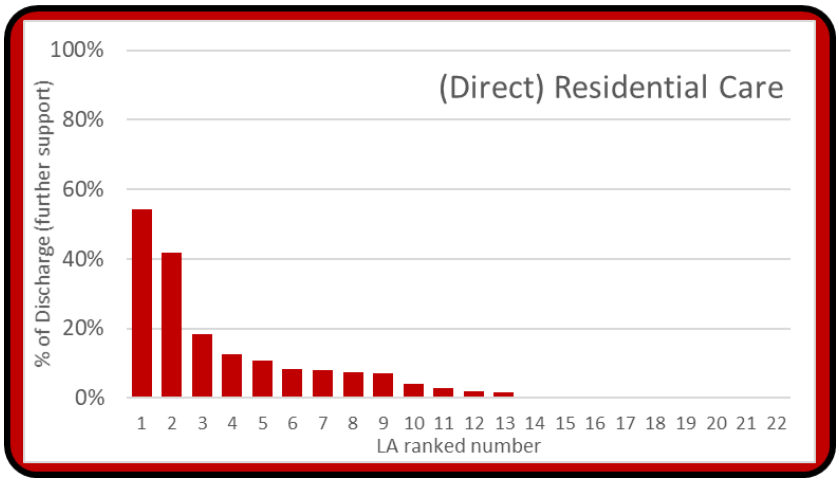
On average in Wales, 1 in 5 older people were assessed as requiring support on discharge from hospital, compared to the reasonable level of 'about a third' suggested in Prof Bolton's paper and quoted on page 4 of this report.

However, caution is needed for this figure at this stage, as some areas were not confident in their submitted data and revised versions may impact on this finding.

What is clear is that the data, as currently presented, showed a very wide range from 6% to 71% of older people leaving hospital currently assessed as requiring intermediate care/Discharge to Recover then Assess Pathways.

The data illustrated below also indicated that too many older people were assessed in an acute hospital bed for longer term care packages or new care home placement. This data further supports previous DU findings in national discharge audits undertaken in 2016 -2018.

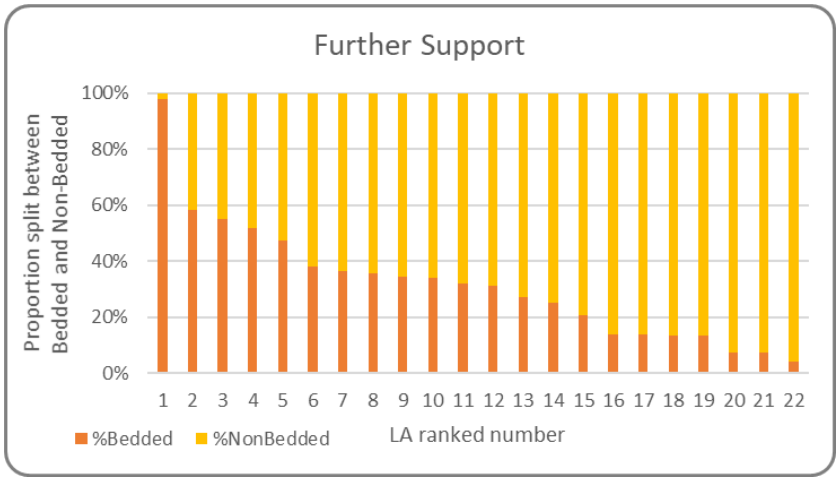




These two ‘direct to’ steps were added in at the template phase to disaggregate between those going through intermediate care and those not. Hence these do not have a suggested reasonable level – other than this direct route being undesirable, so the closer to 0% the better.

However, please note that some areas were unable to disaggregate new and existing care home placements from their current discharge information and so provided no data for this graph. Further work is required to gain a better picture of this behaviour and explore the true extent to which this occurs.

2. Home-based (D2RA Pathway 2) v Bed-based (D2RA Pathway 3) support



As stated previously, there is an expectation that around 85% of the older people needing support following discharge, should be managed at home (the 'Home First' philosophy).

However, in many places in Wales, more people assessed as requiring care and support were likely to be placed in a bedded facility than might be expected.

There was significant variation in what happens in different parts of the country with a range from 4% to 98% of people, on an intermediate care pathway, placed in a bedded facility.

The average is in the region of 30% which still appears high (compared with the model's value of circa 15%).

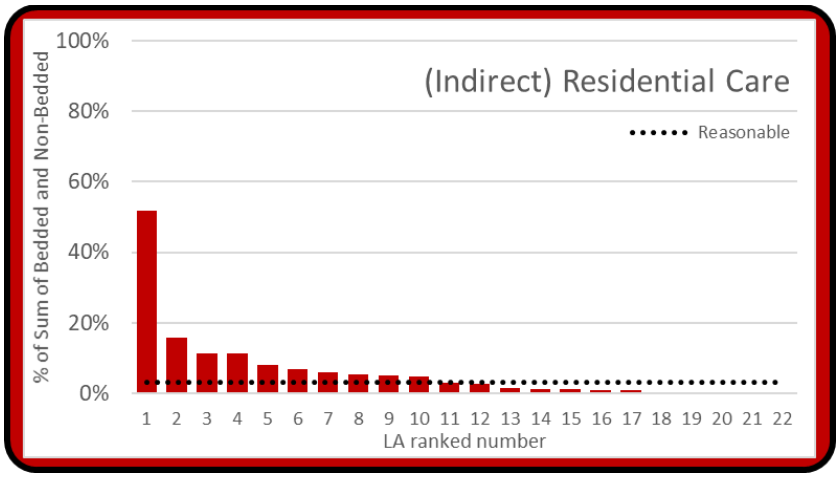
Outcomes from Intermediate Care Services

The paper describing this model highlights that circa 65% of older people receiving intermediate care in their own home should be expected to require no further ongoing care.

Over 70% of older people receiving intermediate care in a bedded facility should expect to return to their own home

Although many services did achieve the good practice standard, this was not universally the case. Potential reasons for this were discussed at the workshops and are reflected in the qualitative analysis section below.

The variation observed across Wales, particularly with regard to the percentage of people going on to care home placement, indicates that there is opportunity for improvement.



Those who received support in the community, including domiciliary care reablement, were more likely to experience a positive recovery. In other words, community/home-based intermediate care services in Wales appear to be generally effective, where people have prompt access to them.

The question is whether such services are available in sufficient capacity to support such recovery for everyone who could benefit from it, in a timely manner (i.e. within 48 hours)?

What did the 'So what?' workshop conversations tell us? (Qualitative Analysis)

The workshop discussions sought to understand the 'story behind the numbers'. Common themes emerged, which generally reflected what the data appeared to indicate.

- There is still plenty of opportunity to maximise personal outcomes and system efficiency through getting the right people onto the right Discharge to Recover then Assess (D2RA) pathway. This will ensure that the support delivered is:
  - ✓ based on more accurate assessment in 'the right place';
  - ✓ co-produced and focussed on the outcomes that matter to the individual.

- In some/many areas however, acute hospital teams continue to over-refer to intermediate care or direct to long-term care pathways, when short-term, 'low-level' support could be a safe and sufficient option.

- In general, we do not (as yet) have the required capacity in the services designed to support people to be discharged to recover and be assessed in their own homes, in a timely manner i.e. within 48 hours of completion of acute hospital treatment. (D2RA Pathway 2.)

- There is of course the question of the over prescribing of care to which the evidence points[2]. Councils and Health providers need to be mindful of this so that episodes of care can be reduced or stopped as soon as it is appropriate. This will require review during the D2RA Pathway, e.g. after 2 weeks, rather than at the end or a pre-prescribed period of intermediate care (commonly circa 6 weeks).

- Where these services are in place in Wales, they are (on the whole) effective and achieve good outcomes for people. Rather than creating new initiatives, there is evidence to support up-scaling what works.

- As a result of lack of capacity for D2RA Pathway 2 (and possibly traditional bed management practices) too many people requiring ongoing support following admission to our acute hospitals are defaulting to bedded intermediate care facilities (D2RA Pathway 3).

- Many areas use community hospitals for this purpose, with smaller numbers commissioned from care homes. There is variation in the reablement approach in both environments, and consequently there is variation in the outcomes for

[2] Why not home? Why not today – Better Care Support Programme (England) 2017.

people on this pathway. There is opportunity, and enthusiasm, for further national work to maximise the effective use of community hospitals in Wales.

- There is evidence to suggest that individuals can be admitted to prematurely to care home placement or require large long-term care packages. In other words, we are creating additional 'failure demand' in an already stretched system.

- People with mental health co-morbidities, NB dementia, are often excluded from intermediate care services and D2RA pathways. Some areas have developed specialist services to support this client group and appear to be achieving good outcomes. All of the partnerships we worked with recognise that this an area that requires further attention.

- A number of people have their pre-admission domiciliary care service reinstated within a set timeframe, e.g. using trusted assessor models. For some this is very important, but for others, they might benefit from a period of reablement to assist in reviewing their life style (to see if some changes may be advised in order to reduce the risk of a further episode of acute care).

- We need national outcome measures to monitor and review the performance of services delivering Discharge to Recover then Assess across Wales. The measures included in the paper cited throughout this report were considered to be reasonable by RPB workshop participants, and are attached as **Appendix 5**.

- There was a repeated perception that sustainable development of, and recruitment into, intermediate care services is challenged by short-term funding mechanisms in Wales.

  There are positive initiatives funded by the Integrated Care Fund and Transformation Fund. However, where proved to be effective, these need to be 'mainstreamed' into core provision if they are to be sustained.

Conclusions

All the Regional Partnership Boards (RPBs) felt that the Prof Bolton model (**Diagram 1**) is a useful guide for integrated commissioning of services to support discharge from hospital.

The data collection and review needed to inform that commissioning will be an iterative process. Further work is required in many areas to get to the point where there is collective confidence in the joint information. The RPBs are, at time of reporting (February 2020), at varying stages in this process.

The learning from the pan-Wales exercise has built on the model and provided further information to inform the evidence-base.

It is clear that balance is required to ensure that the right people are placed on the pathway, so that such services are not over-prescribed where other support in the community (such as third sector) would be as effective for the individual.

Factors that will come in to play when achieving that balance include:

- Risks of deconditioning in the hospital environment;
- The risk averse nature of some assessments (influenced by timing, place and focus);
- 'Low level' service availability;
- Demography and community resilience (NB in rural areas).

The proportion of older people requiring intermediate care support in Wales, via the Discharge to Recover then Assess Pathways 2 & 3, may therefore be considered as being within a range of between 20% and 30%.

When calculating the capacity required in their community teams to deliver D2RA, the RPBs need to ensure that:

- Community/third sector options are optimised;
- No-one is assessed for long-term care (packages or placement) in an acute hospital bed; and

- No-one waits longer than 48 hours, after their acute treatment is completed, for commencement of their D2RA pathway.

This project has highlighted that too many people are still currently bypassing intermediate care and are being assessed for long-term care (packages or care home placement) in an acute hospital bed.

The outcomes for people who are able to access intermediate care/D2RA Pathways in Wales are generally good, though there is variation and therefore opportunity for continued improvement.

For various reasons, the proportion of people currently placed on D2RA Pathway 3 (bedded intermediate care) is greater than good practice would suggest should be the case, and there is currently insufficient capacity for all patients who would benefit from D2RA Pathway 2 (in their own home) to access those services in a timely manner.

Community Hospitals in Wales are frequently used as ‘step-down’ facilities and can be the default pathway for complex discharge. However, the environment and variation in therapy input means that the outcomes for individuals are also variable.

People with dementia are too often excluded from current intermediate care service provision. There is early indication that specialist services developed in Wales can produce good outcomes for this client group.

Recommendations and Next Steps

This is the start of a process.

To deliver for the people of Wales, the following actions will need to be implemented and further NHS Wales Delivery Unit support has been offered to the Regional Partnership Boards (RPBs) to continue this work:

a) RPBs should continue to refine and regularly review the data collected, using the updated template.

b) There is an expectation that this information will be used:
   - Prospectively for integrated commissioning of the intermediate care services required to deliver Discharge to Recover then Assess (D2RA) Pathways 2 & 3 their area; and
   - Retrospectively to monitor performance and outcomes for people using those services.

c) Services to support recovery and discharge, which have been tested and proven successful using short-term funding (including the Integrated Care Fund and Transformation Fund), need to be fully embedded into core service provision.

d) RPBs need to assure themselves that they are maximising the potential of third sector 'Support in the Community'.

e) RPBs need to achieve the recommended balance of community/home-based v bedded intermediate care in their area, including the recruitment and retention of the appropriate workforce.

f) The role and function of community hospitals needs to be considered, potentially on a national basis.

g) RPBs should consider how people with dementia can be offered equitable opportunity for Discharge to Recover then Assess, including the provision of specialist services.

h) RPBs (and potentially Welsh Government) should consider using the measures listed in **Appendix 5**, to monitor and review the effectiveness of services delivering Discharge to Recover then Assess Pathways.

This Project focused on right-sizing community services for discharge. Work is also required to understand the resource/capacity required to right-size community services to more effectively manage care closer to home to avoid unnecessary hospital admission. The Delivery Unit has already commenced scoping this with partners.

It is a vital element of the whole system approach and cultural shift required to deliver care closer to home and achieve the best outcomes for the people we serve. This and other enabling pieces of work will be supported by the Delivery Unit, in collaboration with other national programmes and agencies in 2020/21. For further information or queries in relation to this report, please contact deliveryunit@wales.nhs.uk

APPENDIX 1

‘What Matters to me?’ is established with individual to identify the most appropriate Discharge to Recover then Assess Pathway for them

D2RA Pathway 1: Front Door Turnaround

Is this person fit to admit?

Comprehensive assessment at the hospital front door

Assess, treat and support at home

D2RA Pathway 2: Home First!

Why not home? Why not today?

In-patient treatment is complete

Default pathway for anyone who may need new or increased support at home, or a care home placement

D2RA Pathway 3: IC bed

Are we providing the right conditions to maximise recovery & independence

Should only be considered if Pathways 1 & 2 are not appropriate for this individual i.e. they have high dependency and overnight needs that can't be met with short-term night sitting.

D2RA Pathway 4: Existing Care Home

Providing the least disruptive path & maximising recovery

Same as Pathway 2 , with special considerations for delivering support within an individual's **existing** care home placement

Assessment for **new** placement must follow Pathway 2 or 3

APPENDIX 2

Project methodology

The Project Team consisted of Professor John Bolton (Institute of Public Care) and the following members of the DU:

- Lynda Chandler (Performance Improvement Manager – Unscheduled Care)
- William Oliver (Performance Improvement Manager)
- Jennifer Morgan (Operational Research and Modelling Development Manager)
- Emrhys Pickup (Information Analyst)
- Julie Townsend (Advanced Information Analyst)

An Advisory Group was established to help guide the project and provide critical friend challenge.

The Advisory Group was comprised of representation from the National Programme for Primary Care and Welsh Government policy and professional leads for:

- NHS Delivery & Performance
- Social Services and Integration
- Health, Social Services and Population Statistics
- Healthcare Science and Allied Health Professionals
- Office of Chief Nursing Officer.

In the course of the Project, links were also made with the NHS Wales Informatics Service (NWIS) and the Welsh Community Care Information System (WCCIS).

Stage 1 of the Project

The DU's Analysis Team utilised data from the Patient Episode Database of Wales (PEDW) to populate the (Admitted to Hospital) red box of the original model in order to reflect what each health and social care system might expect in terms of potential demand. The data was patients aged 65 and over admitted to acute hospital either as an elective or emergency admission (see **Appendix 3** for specification).

The purpose of this stage was not to create a dataset or to undertake a data collection exercise. Where possible, data was drawn systematically from existing sources. Stage 1 data provided a template of the model and gap analysis that informed on the data requirements of the other stages of the project and further work.

Stage 2

In March 2019 each Regional Partnership Board (RPB) was approached by the DU to take part in the Project. All RPBs responded positively and preparatory meetings were held in every region between March and September, in which the model and outline project plan were explained.

The West Wales and Cwm Taf Morgannwg RPBs agreed to pilot the process, and those pilots were completed in July and August 2019 respectively.

The Project Team is grateful to those RPBs for their participation and willingness to share the learning.

Stage 3

In Stage 3, the learning from the pilot sites was rolled out to the rest of the Welsh RPBs.

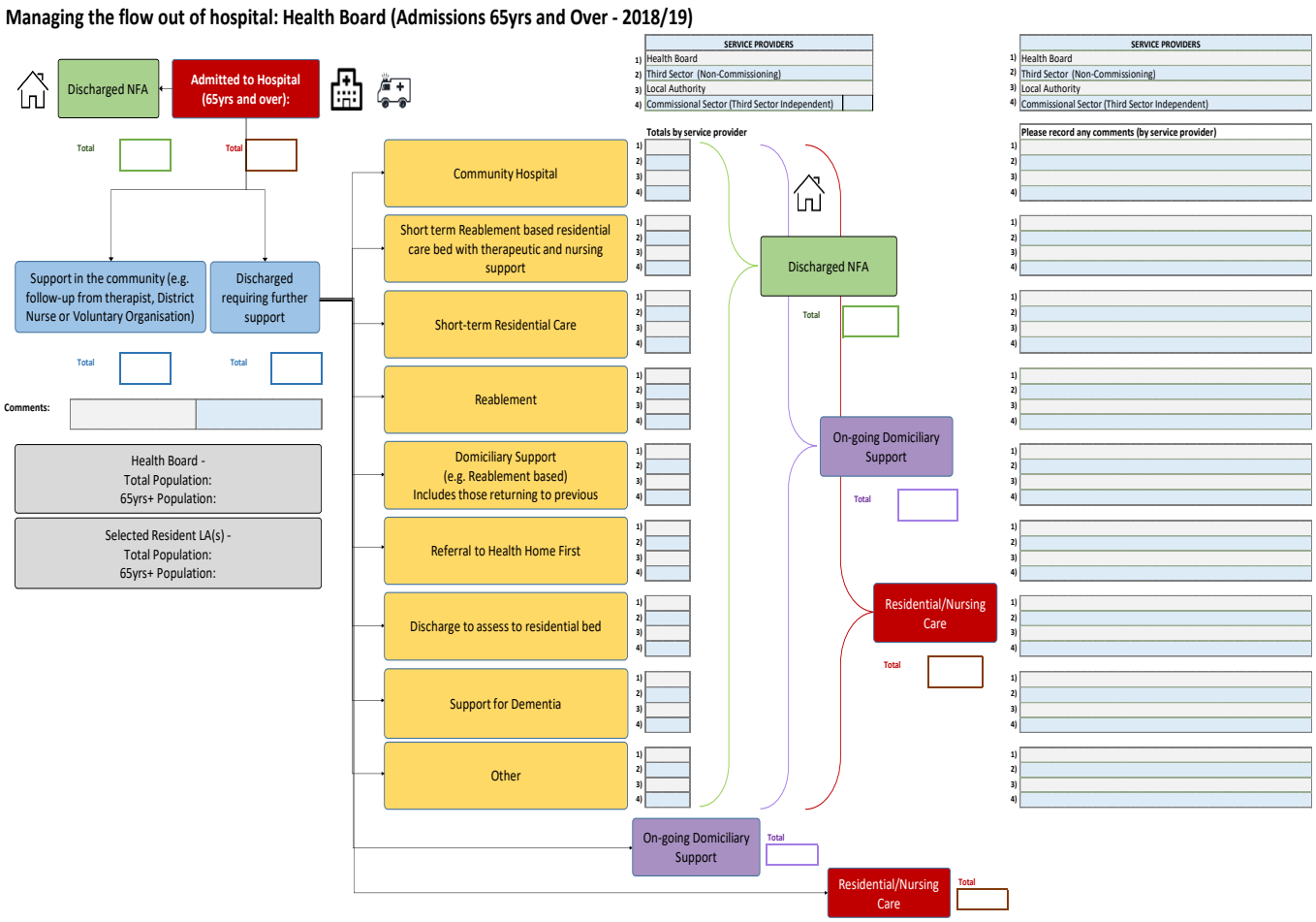
It had become evident from the pilot sites that the system in Wales is currently more complex than that depicted in the original model (**Diagram 1**), and the partnerships required a mechanism of data capture to reflect this.

The DU Analytical Team therefore worked with partners in each region to develop a tailored template to reflect their specific services and pathways. This pragmatic approach was taken to ensure that the data was meaningful and owned by each RPB.

Whilst all the RPBs provided services with the same core functions, each area (even within RPBs) attribute them with different names. This is illustrated in **Appendix 4.**

The template was also adapted to accommodate the fact that, despite policy and good practice stating that no one should be assessed for long term care whilst in an acute hospital bed, there are still a substantial number of older people for whom this occurs in Wales. The final iteration of the template is inserted as **Diagram 2** below**.**

Diagram 2: Data Collection Template



The Project Team provided support on request, throughout the data collection process, which took between 1 and 3 months in each RPB, with the last submitting their data in January 2020.

At the end of the data collection process a “So What?” workshop was held with the RPB to bring together the data submitted, and to consider the following questions:

- Could you count your older people who needed care and support post hospital admission?
- Were you able to track your patients through the care system and discover the outcomes achieved?
- What problems did this exercise pose for you and how did you/will you overcome these?

- Does the information gathered support or challenge your current plans, including IMTPs/ICF & Transformation Fund bids?
- Are there any changes/adaptations you want to make in light of this information?
- What learning from the project do you intend to sustain going forward?

APPENDIX 3

Data Specification

Source: Patient Episode Database Wales (PEDW)

Admissions to Hospital

- Data period - Financial year 2018/19
- Based on patients resident to the Health Boards and Local Authorities
- Patients aged 65yrs plus
- Admission method to include Emergency and Electives
- Admissions to Acute Hospitals only
- Patient classification to include Inpatient Ordinary Admissions
- Patients treatment to exclude Mental Health (7** treatment Specialty codes removed)
- The hospital spell admitting episode (Number '01')

Source: Stats Wales

Population figures

- Population figures obtained from StatsWales for Mid 2017

https://statswales.gov.wales/Catalogue/Population-and-Migration/Population/Estimates/Local-Health-Boards/populationestimates-by-lhb-age

https://statswales.gov.wales/Catalogue/Population-and-Migration/Population/Estimates/Local-Authority/populationestimates-by-localauthority-year

APPENDIX 4

Intermediate Care Service List

Bedded Services

Accommodation Solutions

Community Hospital

Discharge to Assess Extended Stay residential Bed (max 6 weeks)

Discharge to Assess to residential Bed (LOS tbc)

Residential or nursing care placement

Discharge with referral to Rapid Response Services

Hospice

Nursing Care Home

Reablement based - Residential care

Short Term beds (chargeable)

Short Term Nursing

Short Term reablement based residential care bed with therapeutic and nursing support

Short term residential care

Step down from acute

Step down service admissions

Supported Accommodation

Temporary Residential /Respite

Step Down Services - Community Hospital

Bedded & Non-bedded services

Acute Response Team (ART)

Respite

Support for Dimentia

Single Point of Access

Palliative care

Non-Bedded Services

Acute Clinical Team

Day Care

Direct Payment/Support Budget

Discharged with a live in service provision

Discharged with a sitting service incl. respite

Discharge with assistive Technology or other equipment

Discharge with referral to reablement & Falls Service

Domicillary Care

Domicillary Support (Incl. Extra Care & Home Care)

Domicillary Support (e.g. reablementbased) includes those returning to previous packages

Domicillary/Day care

Referrals into social care elemnet of CRT/direct to bridging (i.e. no input from helath therapies)

Full Team reablement CRT

Get Me Home+

IRS

Nutrition and Dietetics

Other

Other Teams

Rapid Homecare

Reablement

Reablement as Primary/Secondary teams

Reablement domicillary Support

Referral to Health Home First

Extra care housing

StayWell@Home

Stroke Pathway

Support@Home

CRT Therapy only/Full Team

Technology pathway

Telecare

Therapy only reablement CRT

APPENDIX 5

Proposed Performance Measures

Copied from Page 20, 'Reducing delays in transfers of care for older people'
https://ipc.brookes.ac.uk/publications/pdf/Some_key_messages_around_hospital_transfers_of_care.pdf

The % of patients who, at the point of discharge, have received an appropriate service within 48 hours. *This figure should be close to 100%.*

Key services are able to respond within 48 hours of being notified that their help is required. *This figure should be close to 100%.*

The proportion of people in any one week waiting for a service that has been agreed by the patient and the multi-disciplinary discharge team. *This figure should preferably be close to zero (with a record kept of reason).*

The proportion of people who are delayed from discharge when they are medically fit. *This figure should be close to zero.*

The proportion of patients who are discharged to a permanent residential care bed without any opportunity for short-term recovery. *This figure should preferably be close to zero.*

The proportion of patients who return home after a short-term period (no more than six weeks) in a residential care bed. *This figure should be close to 75%.*

The proportion of people who receive long-term care after a period of short-term/re-ablement based care (this could be either a therapy led programme or domiciliary care based re-ablement). *This figure should preferably be close to 25%*

The proportion of older people who are discharged from hospital with no formal care services after two weeks/six weeks. *These figures should preferably be close to 40%/66%*

The proportion of people who receive long term support without being offered a period of recovery and recuperation. *This figure should be close to zero.*