Identifying long stay patients in Suffolk and North East Essex

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SUFFOLK & NORTH EAST ESSEX INTELLIGENCE FUNCTION

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Introduction

We analysed characteristics of individuals living in Suffolk and North East Essex that are classified as 'long stay patients (LSP)' according to their historical non-elective bed day usage.

These individuals were thought to have extensive bed use across our three major acute hospitals (Ipswich, Colchester, West Suffolk).

Why is this project important?

- The individuals have extremely poor health outcomes.
- Long stay patients have a significantly disproportionate impact on non-elective bed day use at high cost to the system.

Aims

- Better understand the healthcare needs of these individuals, holistically.
- Identify the impact of these individuals on healthcare resource use.
- Support a strategic response to their care management.

Methodology

- Analyse 10,000 long stay patients at our three acute hospitals in 2024/25.
- Link data across healthcare settings, including primary care, admitted patient care, accident and emergency, mental health, community care, adult social care, and continuing healthcare.

What is the resource use of these individuals and is there a high rate of turnover?

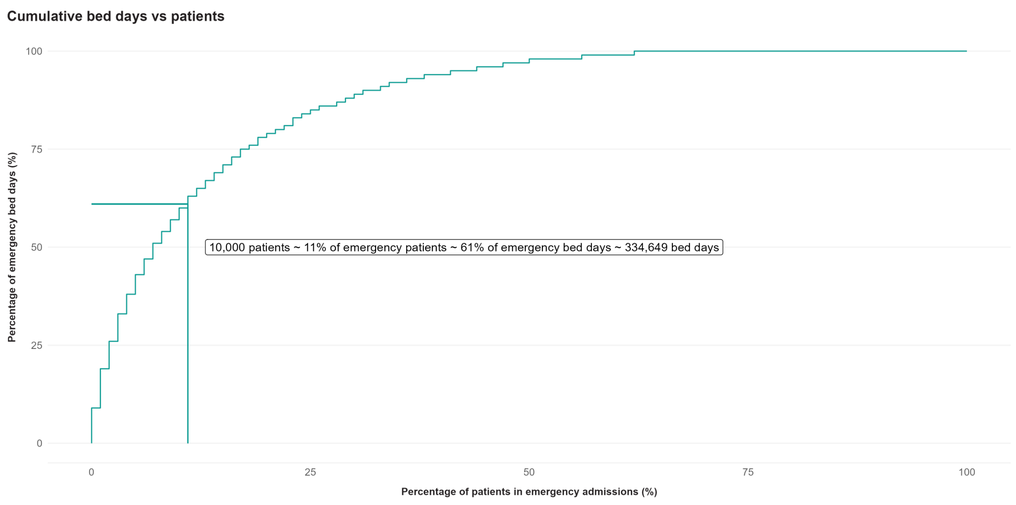

Figure 1: *Impact of patients on bed day use in 2024/25 across SNEE.*

Table 1: *Mortality impact in long stay patients.*

Long Stay Patient Defining Year	Deaths in Defining Year (%)
2022	30
2023	29
2024	28

- Analysis has highlighted the impact of these individuals on resource use. 1% of the population use ~61% of total emergency admission bed days annually at our three acute hospitals (*Figure 1*).
- There is also a rapid turn-over of individuals. 30% of individuals die in the year they are defined as a long stay patient (*Table 1*).

What are the defining features of long stay patients?

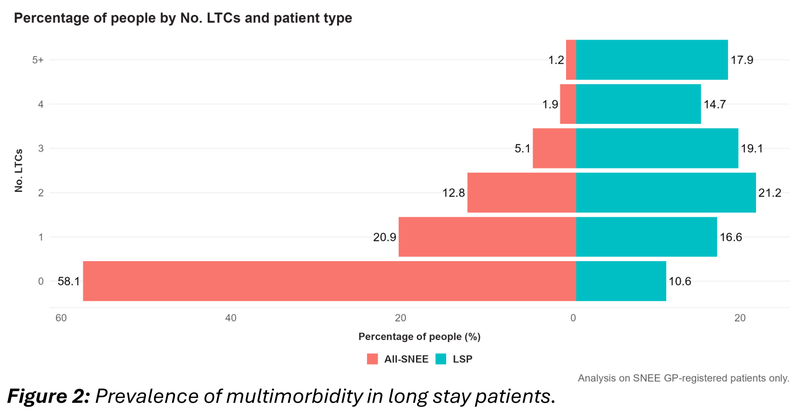

Figure 2: *Prevalence of multimorbidity in long stay patients.*

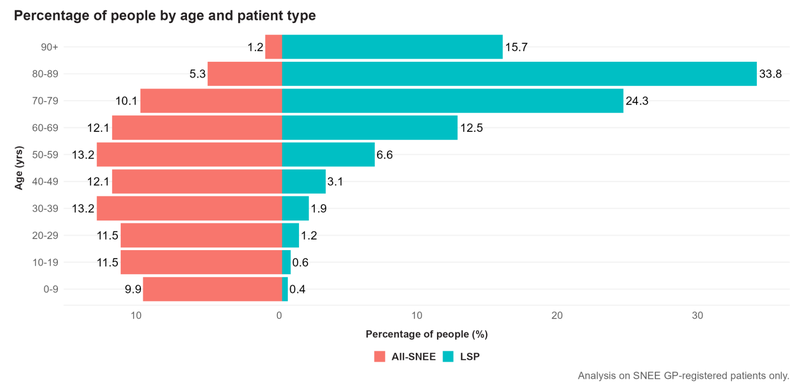

Figure 3: *Age distribution in long stay patients.*

- We find that these individuals are highly complex. 51% of long stay patients are multimorbid (3+ LTCs). This prevalence is much higher than in the wider population (*Figure 2*).
- Long stay patients are also of older age. 74% of individuals are aged 70 years and older (*Figure 3*).

What else do we know about long stay patients?

Table 2: *Long-term condition (LTC) and other indicator prevalence in long stay patients and the SNEE population.*

LTC and indicator prevalence comparison between LSP and all-SNEE			
LTC/Indicator	**Percentage of LSP (%)**	**Percentage of all-SNEE (%)**	**Difference (%)**
70+	73.8	16.5	57.3
Frailty	55.1	7.5	47.6
3+ LTCs	51.7	8.2	43.5
Falls flag	45.8	5.9	39.9
70+ and 3+ LTCs	41.7	4.3	37.4
Hypertension	46.0	14.2	31.8
Is housebound	29.1	1.1	28.0
CKD	31.7	4.5	27.2
Diabetes	28.2	6.1	22.1
AF	24.7	2.6	22.1
Cancer	25.8	4.3	21.5
Moderate frailty	23.2	2.4	20.8
Palliative	21.3	0.9	20.4
Heart failure	21.2	1.4	19.8
Severe frailty	16.0	0.8	15.2
Mild frailty	16.0	4.3	11.7

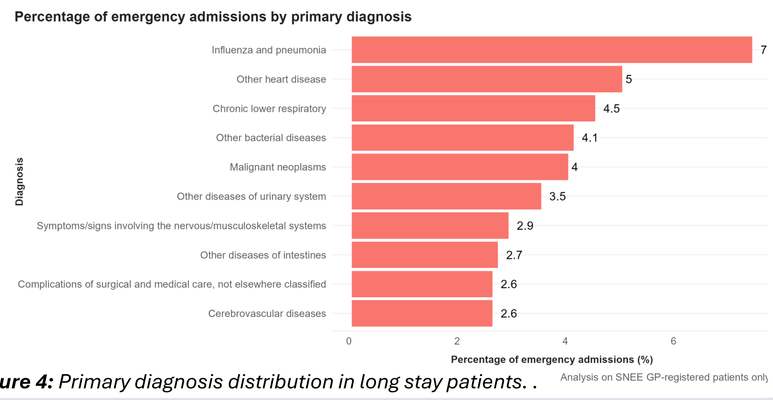

Figure 4: *Primary diagnosis distribution in long stay patients. .*

- They have a high prevalence rate of various conditions, including, hypertension, chronic kidney disease, diabetes, and cancer (*Table 2*).
- Emergency admissions have various primary diagnoses, highlighting the complexity of long stay patients (*Figure 4*).

Recommendations

1 System impact

- A care management service has been scoped to provide wrap-around care for these long stay patients.
- The care management service will likely require a multi-disciplinary approach.
- There is ongoing work around the design of this service to handle the broad complexity exhibited by these patients, as well as the range of services that might be required to best support the individuals.

2 Individual impact

- We have also reidentified ~1000 patients to primary care across West Ipswich and North East Essex.
- This reidentification has supported GPs in providing direct care for these patients and increases the impact of the analysis.
- We anticipate supporting other providers to reidentify long stay patients in the future, particularly as Integrated Neighbourhoods are further established.

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