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Care After Cure:

*Creating a fast track pathway from
hospitals to homes*

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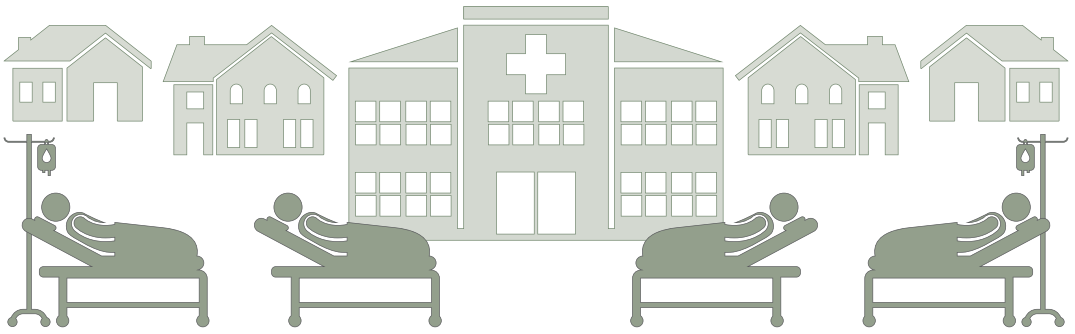
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Executive Summary

Hospitals under pressure – the care ecosystem

Hospitals are under increasing strain, both in terms of capacity and finance. A catalogue of issues is evidence of the pressures:

- Since 2010, the proportion of patients waiting longer than the target of four hours to be seen in Accident and Emergency has increased year on year, from 1.6% in June 2010 to 5.9% in June 2015.¹ This is a jump of a million patients – from 330,000 in 2010 to 1.3 million in 2015.²
- Reflecting this worsening trend, the NHS in aggregate failed to meet the A&E target for the 2014/15 year as a whole, and waiting times in quarter 4 reached their highest point in a decade.
- Bed occupancy levels are rising: nearly 20% more Trusts are reporting occupancy rates of over 90%, well above the recommended occupancy level of 85%.³

- Acute Trusts have reported a combined deficit of £2.3 billion for the nine months to December – £622 million worse than planned – which is projected to rise to £2.8 billion by the end of the financial year.⁴

Hospitals and social care are part of one care ecosystem. Following years of local government funding cuts, unmet need in the social care sector is clearly impacting on hospitals as the number of older, frail patients in hospital beds increases, many of whom have dementia and support needs. Both the NHS Confederation and the Chief Executive of NHS England, Simon Stevens, have recently emphasised this inter-relationship, and how issues in social care have a direct impact on hospitals. The 2015 NHS Leaders' survey by the NHS Confederation found that 79% of health managers believe that social care cuts are causing longer stays in hospital.⁵ Simon Stevens has identified how "many patients are ready to go home, but can't because of delays in home-care adaptations or domiciliary support or finding a care home place"⁶

Bed blocking – a systemic issue

Delayed transfers of care (DTOC) are the crunch point in this ecosystem. Commonly described as ‘bed blocking’, this is where a patient is medically fit to leave hospital but, due to a lack of appropriate support elsewhere, is unable to do so. The outcome is patients trapped in beds they do not require, preventing access for those who really do need hospital care. The cost of delayed transfers is significant, both operationally for hospitals but also for patients in terms of their emotional and physical wellbeing.

Delayed Transfers of Care: How Much Does It Cost?

- Over the past five years (2011/12-2015/16), the health service spent £2 billion caring for patients who are medically fit to leave.⁷
- We forecast that, over the next five years to 2020/2021, £3.3 billion will be spent by hospitals on acute care for patients who have no medical requirement to be there.
- Between 2011/12 and 2015/16 there was a 21% rise in the equivalent number of hospital beds continually ‘blocked’ due to delayed transfer of care, from 3,575 to 4,282.
- There was a 45% increase in the annual cost of DTOC to hospitals in those five years, from £349 million in 2011/12 to £506 million this financial year.

- We forecast a 24% rise in the number of DTOC beds (to 5,300) between 2015/16 and 2020/21. The associated cost to hospitals in 2020/21 will be £763 million, 51% higher than in 2015/16.⁸

A ‘Fast Track Discharge Fund’ – reducing delays, increasing flow, avoiding provider failure

The scale of the delayed transfers problem makes urgent action imperative. We propose to use the funds which would otherwise be spent in hospital on delayed transfers of care to create a Fast Track Discharge Fund, which will pay for out-of-hospital beds and invest in the residential care facilities to care for these patients safely in the community.

We project that a greater role for residential care could make much more efficient use of limited healthcare funds. Caring for all delayed transfer patients in a residential care setting, rather than a highly specialised high cost acute bed, would cost £835 million across the five years to 2020/21. Taken cumulatively across this period, this would generate a surplus of £2.4 billion currently due to be spent on inappropriate in-hospital care for patients.

We propose to ring-fence, out of the existing NHS budget over the forthcoming five years, the £3.3 billion we project will be spent on inappropriate in-hospital patient care to 2020/21 for the Fast Track Discharge Fund. This will enable Clinical Commissioning Groups to both directly commission

residential care beds on behalf of Acute Trusts and, with the surplus identified above, provide investment for residential care to upgrade clinical care staff and facilities.

The Fast Track Discharge Fund makes use of existing resources more efficiently, by:

- Providing quality care in a more appropriate setting;
- Freeing up beds for elective – tariff based – activity;
- Reducing agency staffing for nursing staff no longer needed to care for patients with non acute needs.

We recognise the issue of health versus social care ‘ownership’ for the causes of delayed transfers of care. However, the scale and impact of the DTOC issue are such that jurisdictions must now be set aside for the care of patients affected by this issue, and assertive action taken.

We recommend that the entire value of this surplus is spent within the residential care sector. In this way, CCGs are both opening a channel to reduce pressure on hospitals immediately and, at the same time, investing in the future and ongoing good health of the residential care sector. As our interim report demonstrated, without a strong residential care sector NHS commissioners risk far higher financial impact – up to £3 billion annually by 2020/21 if patients flow through to the NHS as a provider of last resort – if a major residential care provider collapses in the style of Southern Cross.

Residential care – supporting hospitals to save money

Residential care can provide vital services such as step-down care (a ‘stop-over’ between hospital and home) and rehabilitation. It has the scale to support the acute sector across England and the ability to do so at pace. It offers a more comfortable environment in which to await further assessment after an incident requiring hospitalisation. Importantly, the human cost of unnecessary time spent trapped in a hospital bed is avoided, as is the wasted financial spend.

However, to make use of residential care in this way, the sector must be properly funded, and allowed to invest in the capacity, facilities, and workforce development required to allow it to step up to meet this challenge. To date, the Better Care Fund has not done this, as not enough of the funds it promises are reaching the care frontline. The Fast Track Discharge Fund provides an investment pot for this crucial sector.

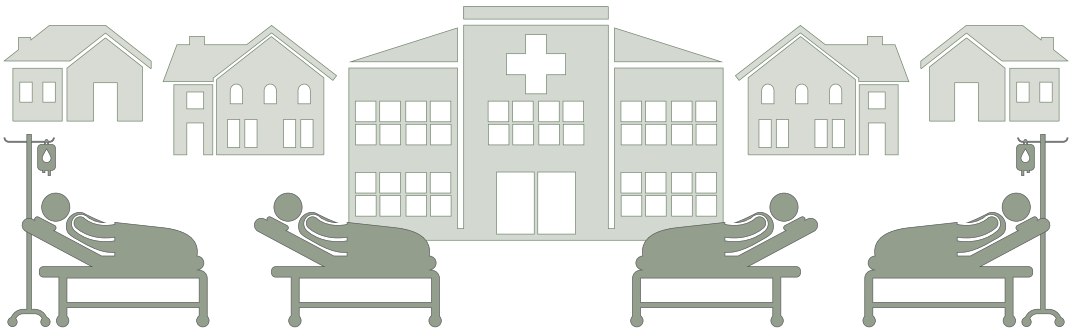
Residential Care – recuperation and rehabilitation in the community

- Caring for all delayed transfer patients in a residential care setting would cost £835 million over five years to 2020/21, compared to £3.3 billion in an acute bed.
- Caring for all delayed transfer patients in a residential care setting would therefore generate a surplus of £2.4 billion over five years to 2020/21.
- Savings would be realised immediately – up to £411 million in 2016/17.

Enabling community based recuperation – patient wellbeing

Beyond the financial, there is an urgent need to consider the wellbeing and comfort of patients, the majority of whom are older, often frail and suffering from dementia and who can benefit from a smaller scale, more home-like environment in which to recuperate. For those patients who are no longer critically ill, long stays in hospital settings are associated with increased risk of healthcare-associated infection, emotional ill health (depression, boredom, frustration and low mood), as well as leading to a loss of independence and confidence.⁹

The pressures facing hospitals and the residential care sector – both key institutions in the health and care landscape – are now so pressing that rapid action is needed to tackle delayed transfers of care. The Fast Track Discharge Fund offers a practical mechanism for policy makers, hospital leaders and care providers to collectively make progress on a systemic and important issue.



Introduction

This paper builds on the findings of our interim report, *The Care Collapse*, published in November 2015. We warned then that the private residential care sector faced “a potentially fatal crisis” as a result of declining funding, rising demand for its services, and increasing financial liabilities due to the introduction of the National Living Wage.¹⁰

The Comprehensive Spending Review that month made available new funding for the sector, but there has been widespread criticism that its provisions are insufficient. We explore the funding settlement in more detail in this report, and share the pessimism of those who question its efficacy.

At the same time however, the scale of the financial and demand pressures on hospitals and acute trusts is now becoming ever more obvious. This is not unrelated to the precarious circumstances of social care: a June 2015 survey of healthcare leaders by the NHS Confederation found that 99 per cent of respondents agreed that cuts to social care were putting increasing pressures on the NHS as a whole, and 92 per cent

that cuts were putting increasing pressures on their own organisations and the services they provided for patients.¹¹

The NHS fared better than social care in the November Spending Review, with the Government claiming that it will receive £10 billion more in real terms in 2020/21 than in 2014/15. We are concerned however that much of this funding will be squandered on patients for whom the specialised setting of hospital is inappropriate and not where they would receive the best quality of care tailored to their needs. Delayed transfers of care will have cost the NHS £506 million by the end of this financial year, and we project that this annual cost will rise to more than £750 million by 2020/21.¹²

Investing in social care capacity could dramatically reduce these costs, as well as providing the source for much needed further additional funding for the care sector. This report makes the case that this is an investment the healthcare system cannot afford not to make.



1. The Context

1.1 The health and social care ecosystem

Health and social care provision is a delicate ecosystem. What happens in one sphere of care directly impacts the other. Austerity has meant funding challenges for our entire care system: while the Coalition government ringfenced health spending, it also froze it. The NHS saw a considerable amount of new money over the years to 2020/21 made available in the November 2015 Comprehensive Spending Review, but in social care, recent years have seen active cuts. Spending began to fall in real terms from 2009 and has dropped steeply since 2010.¹³

As our interim report from November 2015 demonstrated, social care is a sector perilously close to collapse.¹⁴ Local authority spending on older people has fallen by 17 per cent in real terms since 2009/10.¹⁵ The outcome has been that the number of people aged over 65 who receive publicly funded social care has fallen by 27 per cent from 2005/06 to 2012/13.¹⁶ In 90 per cent

of local authorities, only those with “substantial” or “critical” needs are now able to secure publicly funded services.¹⁷ More and more of our older people are struggling to receive the non-medical support they need to stay well and independent.

Such trends place greater pressure on general practice and hospitals. Research by the Nuffield Trust shows more than two fifths of healthcare spending is now devoted to people over 65.¹⁸ Economic analysis for our interim report showed that, if nothing changed, within five years care homes would be underfunded by £1.1 billion per year.¹⁹ We projected a loss of 37,000 care beds as funding failed to meet demand, with residents flowing through to the NHS as a provider of last resort – at a potential £3 billion a year cost to the health service. The growing financial crisis in England’s NHS – with providers facing a projected £2.8 billion deficit by the end of this financial year²⁰ – can in large part be understood as the consequences of a crisis in social care.

1.2 Welcome attention, but inadequate solutions

Our interim report was published at the start of November 2015. The Government's Comprehensive Spending Review followed two and a half weeks later, with welcome focus on the funding crisis in social care. George Osborne was right to recognise "the health service cannot function effectively without good social care".²¹ He was also right to state the unavoidable truth that "many local authorities are not going to be able to meet growing social care needs unless they have new sources of funding".

In response, he announced two such sources: a two per cent 'precept' on council tax, and a £1.5 billion uplift to the Better Care Fund. Unfortunately, we have little confidence either will be sufficient to prevent the collapse we previously predicted. The problem may have been acknowledged, but it certainly has not been solved.

The council tax precept: an unequal and limited funding source

The social care precept gives local authorities the ability to levy up to two per cent on council tax in each of the next four years, specifically to pay for adult social care. The Chancellor reported that, if all authorities levied the precept, almost £2 billion more funding would flow into social care.²²

However, there is little reason to believe all councils will do any such thing. Many are highly reluctant to raise council tax, and some have been elected on specific promises not to do so. Predicting a £2 billion funding boost to social care via the precept therefore appears

highly optimistic. Think tank The King's Fund estimates £800 million a year is the more likely amount,²³ while the Local Government Association has suggested the government's "assumptions on tax base increase seem to be very ambitious".²⁴

There is a further issue that there is a mismatch in the capacity to raise funding via the precept versus the need for publicly funded care. Analysis published in the Local Government Chronicle showed the additional amount councils could raise from the precept varied from less than one per cent of current social care expenditure to nearly three per cent.²⁵ The councils set to benefit most from the precept are those in affluent areas. Yet these are the least likely to need additional funding, since the affluence of their populations means few people will be eligible for state-funded social care.

The limitations of the Better Care Fund

The second social care funding boost announced during the Comprehensive Spending Review was a £1.5 billion uplift to the Better Care Fund (BCF). In announcing the provisional local government finance settlement for 2016/17, the Secretary of State for Communities and Local Government characterised the boost to the Better Care Fund as addressing the lack of equity from the precept.²⁶ Yet the BCF has been criticised for failing to make sufficient impact to date:

Pace and scale: The Fund is poorly equipped to deliver funding to where money is most urgently needed - at the front line of the social care sector - and at the pace and scale required. As noted by Professor Martin Green, Chief Executive of Care England: "There is little

evidence from the way in which the Better Care Fund has been operating to date that this money has gone to the front line.²⁷

Bureaucratic: In a survey of NHS bodies and local authorities operating the Fund, the Chartered Institute of Public Finance and Accountancy and the Healthcare Financial Management Association (HFMA) found that “the BCF is seen as unwieldy, consumes disproportionate management time, and comes with demanding metrics and oppressive reporting requirements.”²⁸ Policy guidance for the 2016/17 BCF released by the Department of Health and the Department for Communities and Local Government also noted “strong feedback from local areas of the need to reduce the burden and bureaucracy in the operation of the Better Care Fund.”²⁹

Former Health Minister Lord Warner has similarly criticised the BCF, observing that “there is too much leakage from these traditional trickle down systems, with too little money ending up in the pockets of those who provide care for vulnerable people.”³⁰

Backloaded: The much-needed extra money allocated to the BCF will not begin to arrive until the 2017/18 financial year (over 12 months from now), and is backloaded such that the great majority of the new money will not be seen

until the end of the Parliament. It is projected in 2017/18 the BCF will receive a top-up of £100 million of new money; this will rise to £800 million in 2018/19, before reaching the headline figure of £1.5 billion in 2019/20.³¹

All these factors lead to the conclusion that the uplift to the BCF does not present a viable solution to the social care sector’s financial crisis, either in isolation from or in conjunction with the council tax precept. Furthermore, as the International Longevity Centre has outlined, even if these two funding streams generate £3.5 billion for social care – highly unlikely – this will still only mean care funding returns to 2015 levels by the end of this Parliament.³² This chorus of critique is building, and we believe an independent review should be conducted to analyse operations, identify funding flows and recommend improvements.

The government’s attention on the crisis in social care is welcome, but its proposed resolution is not fit for purpose. The health and social care ecosystem will continue to suffer as a result.



2. The Problem of Delayed Transfer of Care

2.1 – A growing problem

There are few clearer indications of the symbiotic relationship between health and social care than the problem of delayed transfers of care (DTOC). Commonly described as ‘bed blocking’, this is a situation in which a patient is medically fit to leave hospital but, due to a lack of appropriate support elsewhere, is unable to do so. The outcome is patients trapped in beds they do not require, preventing access for those who really do need hospital care.

The chronic underfunding of social care in recent years exacerbates this dynamic. At a time when demographic changes mean the need for out-of-hospital care has grown exponentially and demand outstrips capacity, older people in a health crisis are taken to hospital for want of alternative support, and have to stay there longer than necessary for the same reason.

- Nearly two thirds of people admitted to hospital are over 65 years old,³³ and such patients now occupy more than 51,000 acute care beds at any one time.³⁴
- People over 85 account for 25 per cent of bed days: a number which has increased by three percentage points over the past 10 years alone.³⁵
- In the past 10 years, there has been a 65 per cent increase in hospital episodes for those over 75 – this compares with a 31 per cent increase for those aged 15-59.³⁶

2.2 – Financial and demand pressures on NHS acute trusts

Delayed transfers of care represent a significant financial cost to the NHS. Our economic analysis shows that in the past five financial years alone (2011/12-2015/16), the health service has spent

£2.1 billion caring for patients who are medically fit to leave.³⁷ We forecast that, over the next five years, to 2020/2021, £3.3 billion will be spent by hospitals on acute care for patients who have no medical requirement to be there.

Worryingly therefore, this is a trend that has been getting steadily worse and is set to worsen still as we look forward to the end of this Parliament:

- Between 2011/12 and 2015/16 there was a 21% rise in the equivalent number of hospital beds continually 'blocked' due to delayed transfer of care, from 3,575 to 4,282.
- There was a 45% increase in the cost of DTOC to hospitals in those five years, from £349 million in 2011/12 to a projected final figure of £506 million for this financial year.
- We forecast a 24% rise in the number of DTOC beds (to 5,300) between 2015/16 and 2020/21.

With delayed transfers of care at this scale, it is clear they contribute significantly to the financial challenges of the NHS. With funding frozen but delayed transfers of care growing, more and more money is being wasted caring for medically fit patients. When large numbers of beds become 'blocked', elective procedures have to be cancelled, meaning delayed revenue and further financial woes for hospitals. It is no coincidence that, as social care has been cut and delayed transfers of care have increased, hospitals have found themselves in ever deepening deficits.

In December, the National Audit Office found that acute trusts' financial position had deteriorated severely, and to a greater

extent than expected.³⁸ NAO Comptroller and Auditor General Amyas Morse commented that "running a deficit seems to be becoming normal practice for an acute trust".

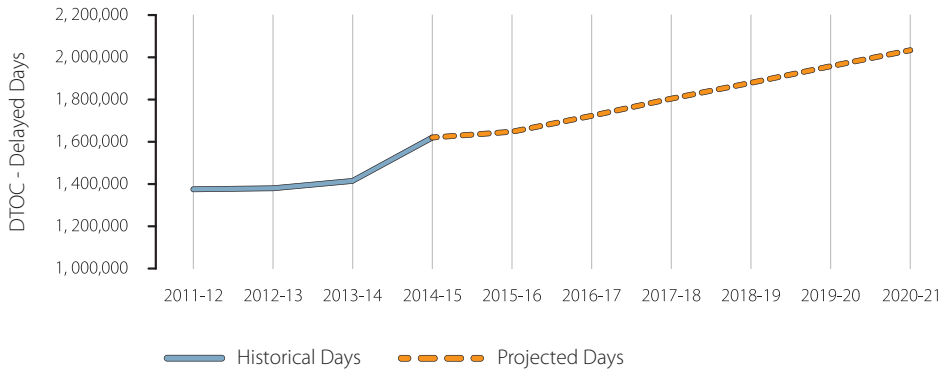
- In 2013/14, the total net deficit of all NHS trusts and foundation trusts was £91 million.
- In 2014/15, the total net deficit of all NHS trusts and foundation trusts had swelled to £843 million.³⁹
- In 2015/16, foundation and non-foundation trusts have reported a collective deficit of £930 million for the first three months of the year alone: more than the entire deficit reported the previous year.⁴⁰ Projections suggest acute and specialist trusts will have a collective deficit of around £2.8 billion by the end of this financial year.⁴¹

Additional funding for the NHS at risk of being swallowed up by delayed discharges of care

While the Comprehensive Spending Review gave social care somewhat complex new funding streams, the NHS received a boost. Chancellor of the Exchequer George Osborne announced the NHS England budget would rise by more than £8 billion by 2020, front loaded to deliver just under half in the next financial year.

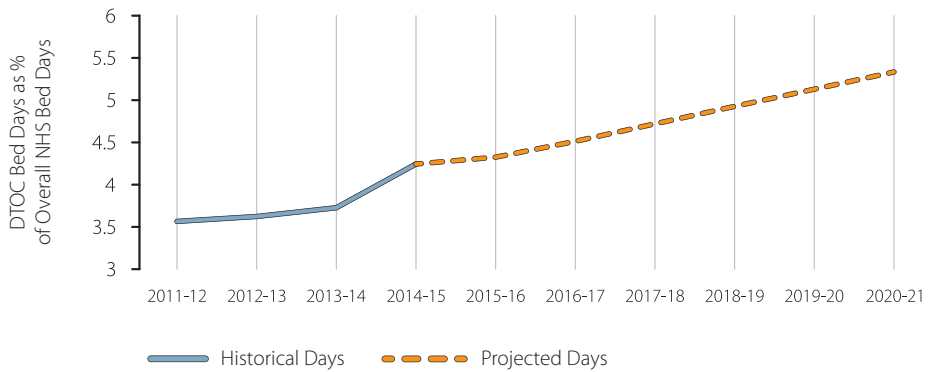
However, we project that a considerable proportion of that £8 billion funding boost will be swallowed up by delayed transfers of care, which are frequently caused by lacking social care. Assuming delayed transfers of care days grow in line with historic trends:⁴²

Figure 1: Number of Delayed Transfer of Care Bed Days in NHS Hospitals



Source: IHP

Figure 2: DTC Bed Days as a Percentage of all NHS Bed Days



Source: IHP

- In 2016/17, £552 million will be wasted on hospital care for people who do not need to be there. That is 15 per cent of the £3.8 billion NHS England budget uplift pledged for this financial year.
- In 2017/18, £600 million will be spent – 40 per cent of the £1.5 billion further budget uplift promised for that year.
- In 2018/19, £651 million will be spent – 30 per cent (or £151 million) more than the £0.5 billion further budget uplift due in that year.
- In 2019/20, £705 million will be spent – 78 per cent of the additional £0.9 billion budget uplift promised for that year.
- In 2020/21, £763 million will be spent – 45 per cent of the £1.7 billion further budget uplift pledged for that year.

At a time of such stretched resources, and when the NHS is pushed to make £22 billion in efficiency savings by 2020, that such large proportions of much needed funding are being used on inappropriate acute care urgently needs to be tackled.

Patient wellbeing - the human cost

There is a real human cost as well as a financial one associated with delayed transfers of care. Too many of our frail older people are unnecessarily in a hospital bed when they would be much better served by expert care in the community, whether in a residential facility or through home-based support. They are the victims of a health and social care ecosystem which does not serve the needs of the population it now needs to care for, and their welfare is suffering as a consequence.

Delayed transfers of care increase the risk of healthcare-associated infection, emotional ill health (depression, boredom, frustration and low mood), as well as leading to a loss of independence and confidence.⁴³ A wait of more than two days has been found to negate the benefit of any subsequent intermediate care – short term support provided in a residential setting or in a patient's own home – and seven days is associated with a 10 per cent decline in muscle strength.⁴⁴

For older people, a hospital stay is often associated with marked functional decline – an inability to carry out tasks, including self-care, which were previously non-problematic.⁴⁵ Lying in a hospital bed typically means a lack of independence, decreased mobility and increased isolation. Research has suggested this, coupled with normal ageing changes, can “result in irreversible physiologic changes [and] poor outcomes at discharge”.⁴⁶ The longer an older person stays in hospital, the higher the risk of functional decline becomes. A delayed discharge can therefore take away day to day life as an older person has known it – irreversibly.

This all equates to a poor patient experience, and people who are dependent on health or social care which may not have been necessary had the right support been in place initially.

Better Care Fund once again insufficient

The problem of delayed transfers of care has not gone unrecognised by central government. Notably, the Better Care Fund has attempted to provide a means by which the NHS and social care can work together better. The concept is that, by pooling budgets, the two parts of the care system

can ensure the needs of local people are adequately met both inside and outside hospital, so reducing delays.

Delayed transfers of care are a performance metric for the fund, and this year's guidance requires each area to develop a local action plan for managing them, including a locally agreed target.⁴⁷ The document describes "unacceptable high levels of DTOC currently" and reports "the government is exploring what further action should be taken to address the issue".⁴⁸

What is clear is the action taken thus far has not sufficiently slowed the growth of delayed transfers of care. As described in the first section of this report, too little of the Better Care Fund is reaching social care providers. The issue of underfunding therefore remains, and delayed transfers of care multiply.

In 2013/14, 507,793 days were unnecessarily spent in hospital by patients awaiting residential home placement or availability; nursing home placement or availability; the arrangement of a package of care to be delivered within their own homes; or equipment and adaptations at home. In 2014/15 – the first year in which the Better Care Fund operated – that number jumped to 637,141: a 25 per cent increase.⁴⁹

2.3 – The role of social care

It is clear an important solution to these escalating delayed care transfers lies in better use of social care, including the residential sector. NHS England Chief Executive Simon Stevens has emphasised this recently, both in advance of the Comprehensive Spending Review and since, saying:

"Go to any hospital in the country and they will show you that often the majority, or a very substantial minority of older people they are looking after, have got dementia. And they will show you many patients who are ready to go home but who can't because of delays in home-care adaptations or domiciliary support or finding a care home place".⁵⁰

For as long as social care remains underfunded, it is going to be immensely challenging to address delayed transfers of care – or for the NHS to make the efficiency savings required for the funding boost announced in November 2015 to make a difference.

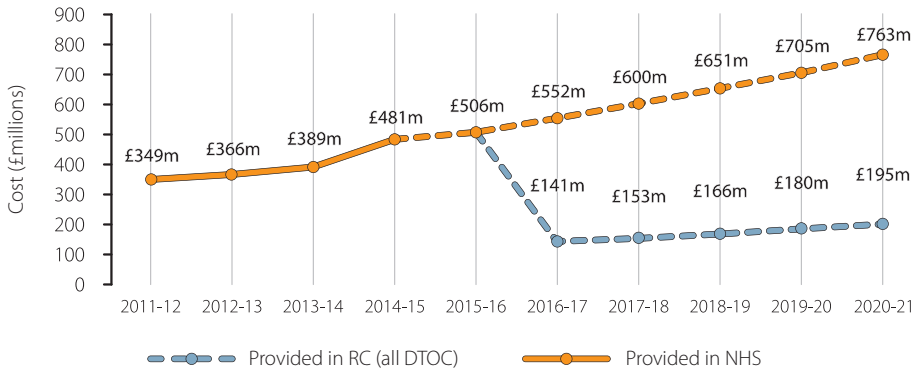
For healthcare to realise savings, investment in social care is needed

Residential care offers the opportunity for older people to be cared for in a home-like setting, and can give temporary support to recover from an episode of illness and potentially return to living independently. When a patient is in a hospital bed, he or she is immobile, isolated and unstimulated, and irreversible functional decline is often the result.

A care or nursing home, on the other hand, provides opportunities to move around freely, to engage in social activities, and to live life in a home like setting rather than an institution. The human cost of unnecessary time spent trapped in hospital – a cost which is both emotional and physical – is avoided, as is the wasted financial spend.

Economic modelling commissioned for this paper demonstrates the scale of the financial benefits which could be realised by better use of residential care. If all delayed days could be provided by residential care instead, reducing

Figure 3: Cost of DTOC Patient Care in Hospital vs. Residential Care (Projected)



Source: IHP

lengths of hospital stay, the spend on these patients within the health and social care system would be reduced by £2.4 billion over the next five years⁵¹ – equivalent to over 10 per cent of the NHS’s £22 billion efficiency challenge. By year, spending would be reduced as follows:

- £411 million in 2016/17
- £447 million in 2017/18
- £485 million in 2018/19
- £525 million in 2019/20
- £568 million in 2020/21

Residential care is more than willing to support the care of our citizens in this way. It is already a well-established sector, home to over 426,000 people in the United Kingdom and to 16 per cent of UK people aged over 85.⁵² There are

an estimated 5,153 nursing homes and 12,525 residential homes across the UK, able to provide expert care to our frail, older citizens. It has the scale to roll out additional capacity and provision at pace.

Yet while residential care providers are willing to offer support, the legacy of years of financial neglect creates significant challenges to doing so. We contend that a new funding stream must urgently be found – one which is sufficient to make a difference to the sector.



3. Creating a Fast Track Discharge Fund

It is our contention that the current situation is untenable. It is unacceptable for delayed transfers of care to grow, wasting taxpayers' money and reducing patients' wellbeing. As we note above, our economic analysis identifies that £3.3 billion will be spent on inappropriate hospital-based care in the coming five years (2016/17-2020/21). We believe that money should instead be specifically allocated to reducing delayed transfers of care.

We propose to use the funds which would otherwise be spent on delayed transfers of care to create a Fast Track Discharge Fund, which will commission out of hospital beds and invest in the residential care facilities to care for these patients safely in the community, where continuing healthcare needs can be met by nursing staff.

A greater role for residential care could make much more efficient use of limited healthcare funds. Caring for all delayed transfer patients in a residential care setting, rather than a highly specialised high cost acute bed, would cost £835 million in the five years to 2020/21. Taken cumulatively across this period, this would generate a surplus of over £2.4 billion within the £3.3 billion due to be allocated for care of these patients.

We propose to ring-fence that £3.3 billion out of the existing NHS budget over the forthcoming five years for the Fast Track Discharge Fund. This will enable Clinical Commissioning Groups to bolster out-of-hospital services for patients medically fit to leave hospital but in need of extra support. The Fast Track Discharge Fund will enable CCGs to both directly commission residential care beds on behalf of Acute Trusts and, with the surplus identified above, provide investment for residential care to upgrade clinical care staff and facilities.

The Fast Track Discharge Fund makes use of existing resources more efficiently, by:

- Providing quality care in a more appropriate setting;
- Freeing up beds for elective – i.e. tariff based – activity;
- Reducing agency staffing for nursing staff no longer needed to care for patients with non-acute needs.

We recognise the difficulties caused by the blurred 'ownership' for the causes of delayed transfers of care. About half of delayed transfers can be attributed to issues that 'belong' to the NHS and about half to local authorities and social care. We argue however that jurisdictions must now be set aside to take assertive action on the growth delayed transfers of care and that CCGs offer the appropriate commissioning structure to enable that.

CCGs would therefore take responsibility for addressing all the underlying reasons for delayed transfers of care, be they explicitly originating in the NHS or from social care. We believe continuing a fragmented approach to the problem of delayed transfers of care is insufficient.

We recommend that the entire value of this surplus is spent within the residential care sector. In this way, CCGs are both opening a channel to reduce pressure on hospitals immediately and, at the same time, investing in the future and ongoing good health of the residential care sector. As our interim report demonstrated, without a strong residential care sector NHS commissioners risk far higher

financial impact – up to £3 billion annually by 2020/21 if patients flow through to the NHS as a provider of last resort – if a major residential care provider collapses in the style of Southern Cross.

It would be an invest to save model. By building out of hospital capacity, less money would be wasted on delayed discharges of care. Demand for costly medical and nursing staff would be reduced. Having the right support in the community would also reduce pressure on A&Es, so decreasing the risk of hospitals missing the four hour target – a failure which comes with financial penalties.

This Fund should represent a multi-year settlement, with the power for this £3.3 billion to be allocated flexibly over this five year period. We suggest however that the money available through this Fund be frontloaded to an extent, allowing this to flow through and fund investment in the social care sector (and so reduce delayed transfers of care) immediately.



4. Conclusion

Much of the new money allocated to the NHS in the Comprehensive Spending Review settlement, intended to address the financial difficulties of acute trusts, risks being spent inefficiently, on patients who would receive more appropriate care outside of a hospital setting yet who cannot for whatever reason be discharged.

At the same time, the provisions contained in the CSR are, we have argued, inadequate to secure the social care sector's financial future. There is growing awareness of and consensus around the inter-relationship of health and social care; it is an ecosystem and interventions need to respond to this and strengthen both sectors.

Our recommendation for a Fast Track Discharge Fund is an effective measure to achieve this. Only the residential care sector has the scale to deliver more quality care in the community at pace while maintaining safety. By commissioning the residential care sector to deliver rehabilitation, the Fast Track Discharge

Fund will use precious healthcare resources more efficiently and in a more preferred community setting.

The issue of delayed transfers of care has become a systemic problem. The deficits many acute trusts are now recording risk becoming 'normal practice'. Urgent action is needed to tackle both the unnecessary delays in hospital settings and the financial fragility of the residential care sector. The Fast Track Discharge Fund is a step towards this.

Appendix - Note on Methodology

Historic data for delayed transfers of care (DTOC) numbers are taken from NHS England data publications for the months between April 2011 and November 2015.⁵³ This provides a monthly breakdown of DTOC days categorised by reason for delayed transfer and organisation type.

In forecasting future DTOC numbers, we assume that the growth in DTOC days from 2015/16 to 2020/21 moves in line with the historic growth trend observed since 2011/12, with differentiated growth rates by reason for DTOC (see below).

Hospital bed day costs have been calculated by using the NHS reference cost data (2011/12 – 2014/15) to calculate the per day cost for emergency admission excess bed days.⁵⁴ For 2015/16 onwards, we assume an average 4% annual inflation increase to this per day cost.

Bed day costs in residential care have been calculated based on a combination of data from the Health and Social Care Information Centre (HSCIC)⁵⁵ and from specific residential care providers.

We have identified 10 reasons for delayed transfers of care:

- Awaiting completion of assessment
- Awaiting public funding
- Awaiting further non-acute NHS care
- Awaiting residential home placement or availability
- Awaiting nursing home placement or availability
- Awaiting care package in own home
- Awaiting community equipment and adaptations
- Patient or family choice
- Disputes
- Housing – patients not covered by NHS and Community Care Act

The savings figures quoted in this report are based on the assumption that all of these reasons for delayed transfer of care could be addressed by better use of residential care facilities, and are calculated using the differential between the forecast cost of a hospital bed and a residential care bed for each year between 2016/17 and 2020/21.



Endnotes

Endnotes

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The UK has one of the most centralised states in the developed world and one of the more disaffected and politically estranged populations in Europe. We hold our leaders in contempt, but despair of doing anything for ourselves or for our community. This dysfunction at every level of society stems from the collapse of our social relations and personal foundations.

We are becoming an increasingly fragmented and atomised society, and this has deep and damaging consequences for our families, our communities and our polity.

At the most basic level, the break-up of families damages everyone, but hurts the very poorest first and worst. Too many children at the bottom of our society are at a significant disadvantage, as too much is borne by lone parents who are trying to do more and more with less and less. We know that the poorer you are, the less connected with your wider society you tend to be and the more removed from the traditional resources of community and kin. Bereft of the institutions and structures that could help them, and cut-adrift from traditions and cultures that once taught skills of survival and self-advancement, too many families and communities on low household incomes are deeply unstable and are facing seemingly insurmountable problems alone, unadvised and unassisted.

We believe that power should be devolved to the lowest appropriate level. Public services and neighbourhoods should be governed and shaped from the 'bottom up', by families and communities and their associations. Neighbourhoods need to be served by a range of providers that incorporate and empower their inhabitants. Moving away from a top-down siloed approach to service delivery, which results in departmental conflicts and different goals being pursued, such activity should be driven by a holistic and integrated vision of overall local need, which is thereby able to ascertain and address the most challenging factors that prevent human flourishing. We believe that neither state bureaucracy nor privatisation of public services can achieve an integrated approach that is attentive both to whole persons and the life of communities considered in the round. Instead, we need new institutions that reflect the priority of direct and inter-personal human relationships. Not only is such a method more humane, it is also likely to be the only approach that works.

The NHS, and hospitals in particular, are coming under increasing financial and demand pressures. There has been a sharp increase in A&E targets not being met, and acute trusts are projected to record unprecedented financial deficits this year. One of the causes of this increased pressure is the significant number of frail, elderly people unable to be discharged from hospitals to settings that are more appropriate to their needs, resulting in so-called 'bed blocking'.

Care After Cure examines how to reduce pressures on the NHS by making better use of existing residential care facilities, and asks what is needed to allow residential care to step up and take on a more substantial role in the health and social care ecosystem through working more closely with providers of healthcare. We believe that by using funds already due to be spent on patients in hospital experiencing delayed transfers of care to bolster residential care provision and invest in skills and facilities, we can both improve the precarious financial position of the social care sector and alleviate capacity and financial strains on hospitals.



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