

Bridging the Care Gap

Report from the
Roundtable discussion
held on 30th October 2018

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BREAKING BARRIERS
INNOVATIONS

Supported by:



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Background

Our increasing and ageing population means that demand on health and social care services is greater than ever before, yet funding has not increased in line with this, and a decade of austerity has resulted in slower funding growth for healthcare and cuts in social care provision.

This has clearly resulted in enormous pressures on frontline staff and services. The NHS has tried to manage the slow growth in funding by delivering ‘more for less’. As a result, significant efficiencies have been achieved in the NHS, but this has been accomplished by holding down costs, such as staff wages. In social care, the past six years of real-terms budget reductions have led to similar efficiencies, but left 400,000 fewer people receiving essential help and destabilised care providers, leading to many ceasing operations.

There is therefore a growing need to find innovative ways of organising and delivering health and social care to better meet the diverse and often complex needs of individuals and their families.

NHS England’s Five Year Forward View¹ recognised the urgency of the situation and the need for radical solutions, but the gap between the demand for care services and the capacity of the current system to meet the needs of people safely and effectively continues to grow, for example:

- Councils in England receive 1.8 million new requests for adult social care a year – the equivalent of nearly 5,000 a day.
- By 2019/20, councils could be spending as much as 38 pence out of every £1 of council tax on adult social care.
- The funding gap for adult social care was at least £2 billion in 2017/18².
- Demography, inflation and National Living Wage pressures mean that the gap in adult social care funding will grow to £3.6 billion by 2025 just to stand still.³

Despite this, health systems continue to deliver care that predominantly focuses on one illness at a time or prioritises the management of disease and symptoms over the individual’s quality of life and social support needs. It is, however, recognised that in order to manage increasing demand and improve care for those with complex needs, the whole system must change and health and social care must be better integrated.

International experience

The King’s Fund compared the health and social care systems in nine countries and found that while many developed countries offer universal healthcare funded by taxes or social insurance, far fewer provide comprehensive social care⁴.

¹ NHS England, 2014. *The Five Year Forward View*, available at: <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

² The Health Foundation, March 2017. Briefing: *The social care funding gap: implications for local health care reform*. available at: <https://www.health.org.uk/sites/default/files/SocialCareFundingGap.pdf>

³ LGA, November 2018. *Predicted rise in care needs: full comment* by Cllr Nick Forbes, available at: <https://www.local.gov.uk/about/campaigns/lives-we-want-lead-lga-green-paper-adult-social-care/predicted-rise-care-needs-full>

⁴ The Kings Fund, 2014. *The social care and health systems of nine countries*, available at: <https://www.kingsfund.org.uk/sites/default/files/media/commission-background-paper-social-care-health-system-other-countries.pdf>

Sweden and the Netherlands are among the few countries with universal government-funded social care insurance programs. Both had the highest rates of public spending on social care of those reporting data to the Organisation for Economic Co-operation and Development (OECD)⁵. Japan and France introduced mandatory long-term care insurance (LTCI) schemes in 2000 and 2002 respectively. The UK and Germany spend the highest share of GDP on long-term care, primarily through out-of-pocket spending, although Germany introduced a mandatory LTCI scheme in 1995. By contrast, Switzerland has the highest level of private spending on social care as a percentage of GDP.

However, these countries all face increasing financial pressures on their systems, and many have been forced to tighten benefits or raise contributions to maintain their viability. According to a report from The Health Foundation, in many European countries, local governments have been managing more stringent budgets in part by reducing fees paid to social care providers, putting pressure on the companies providing carers. In the UK, this presents risks to the whole system, including to new models of care:

“because the precarious state of the social care provider market is threatening plans to support people in non-hospital, lower-cost environments.”⁶

The UK experience and the way forward

In the UK, the gap in funding for social care has been subject to twelve Green and White papers and five independent commissions over the last 20 years. Clearly, across the political divide, successive governments have failed to effectively tackle the crisis in social care, which has continued with all the consequent harms and issues for healthcare, and ultimately, for individuals and their families.

There can be no doubt that the combined issues of increased demand for more complex care needs across all age groups, but especially in the elderly, alongside reduced capacity to address the deficits in the current market for residential and nursing care will continue to put pressure on acute hospital services. Solutions to bridge the care gap are needed urgently and they must come from new approaches that effectively integrate health and social care provision.

With the publication of the new NHS Long Term Plan and the publication of the Green Paper on social care from the current government, we hope a greater emphasis on collaboration, prevention and a focus on community health and social care provision will be realised.

⁵ The OECD is an intergovernmental economic organisation with 36 member countries, founded in 1961 to stimulate economic progress and world trade.

⁶ The Health Foundation, March 2017. Briefing: *The social care funding gap: implications for local health care reform*, available at: <https://www.health.org.uk/sites/default/files/SocialCareFundingGap.pdf>

Any new models must involve health and social care delivery that crosses the traditional boundaries and places an emphasis on preventive health and rehabilitation, e.g. delivering care in or close to the homes of patients, reorganising hospital services, and making effective use of digital technology such as telemedicine. Policymakers also need to address the impact of separate funding streams for health and social care budgets and to find ways of helping local areas to integrate these budgets, for example, through greater devolution.

Focusing on one part of the system alone will not meet the growing crisis and will risk leaving many thousands of vulnerable people with unmet needs while further exacerbating the funding problems for both the NHS and local authorities. Therefore, we need to start a new dialogue, which ensures that new models and funding initiatives are focused on improving the health and wellbeing of individuals and communities, not just tackling illness.

If the upcoming NHS plan and the Green Paper for social care fail to do this then an opportunity to underpin and strengthen the integration of health and social care will again have been missed. Just as with treatment for medical conditions, while addressing the symptoms can bring much-needed immediate relief, if the root problem is not addressed, the illness is likely to recur and be more prolonged.

A bold reform plan is needed to ensure our health and social care services are fit for the 21st century. Urgent action must be taken to address the root problem of the lack of a fully integrated health and social care system. This is vital if we are to ensure that the health and social care needs of our communities are being met, at the right time and in the most sustainable and cost-effective way.

Introduction

This report captures a Roundtable discussion on how health and social care leaders are attempting to bridge the care gap between an overburdened acute hospital sector that has seen exponential increases in demand and a care system that is struggling to cope. While this is not the first report to consider these issues, there is an increasing recognition of the urgency of the issues confronting leaders and practitioners in health and social care and amongst those who are dependent on these vital services.

The Roundtable was chaired by Professor the Lord Patel of Bradford OBE and was attended by representatives of a wide range of health and social care organisations from the public and independent sectors, including NHS Commissioners, NHS Trusts, local authorities, Health Education England and industry partners.

Participants were keen that the discussions and issues raised were not 'left on the shelf' but formed part of the planning and thinking behind solutions that were currently occupying leaders in health and social care.

Therefore, this report is intended as a thought piece and to stimulate thinking, strategy and action that can address the significant problems in health and social care, which have been identified.

Outline of the report

This report summarises the discussions by setting out the common themes and critical issues that were identified. These have been grouped into five sections:

- Delayed Transfers of Care
- Viability of the social care model
- Workforce
- Prevention
- Innovations in service delivery and practice



Delayed Transfers of Care

A delayed transfer of care (DTOC) occurs when a patient is ready for discharge from acute or non-acute care but is still occupying a bed. Delays can occur when patients are being discharged home or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to a community hospital or hospice.

A DTOC can cause considerable distress and unnecessarily long stays in hospital for patients. They also affect waiting times for NHS care, as delayed transfers reduce the number of beds available for other patients. The proportion of DTOCs due to social care has risen steeply since 2014, but the majority of delays are still attributed to the NHS. From October 2017 to October 2018, the latest data available at the time of writing, the NHS was in some way responsible for 65% of all delays, and solely responsible for 57%.

DTOCs need to be minimised through effective discharge planning and joint working between services to ensure safe, person-centred transfers.

Accuracy of recording and data integrity

The King's Fund had previously questioned the accuracy and integrity of data for DTOCs⁷. In particular, they challenged the notion that figures accurately reflect user experience and questioned why certain categories were omitted.

Since April 2017 changes have been made to the way DTOCs are calculated. NHS England currently defines a patient as being ready for transfer when:

- a clinical decision has been made that the patient is ready for transfer, and
- a multidisciplinary team has decided that the patient is ready for transfer, and
- the patient is safe to discharge/transfer.

As soon as a patient meets these three conditions and remains in a bed, the 'clock' starts, and they are classified as a delayed transfer. The definition of DTOCs used by NHS England is very specific. For example, data on delayed transfers does not include delays in transferring a patient between different wards in the same hospital, or between different hospitals, if the patient still requires acute hospital treatment.

There are nevertheless limitations to the national data on DTOCs. It is not clear whether all providers are using the definition of delayed transfers of care or reasons for delay in the same way; small differences in interpretations could lead to large changes in reported numbers.

National data may also understate the number of patients who could be cared for safely and effectively out of hospital. This is because the 'clock' for measuring delayed transfers only begins when a full multidisciplinary team has assessed the patient's needs – for example, to determine if a patient needs further therapy or social care input – before deciding when the patient can be discharged. Patients in hospital who have been assessed by a consultant or other clinician as being 'medically fit for discharge' will not be counted as a delayed transfer before this fuller assessment takes place⁸.

⁷ The Kings Fund, January 2018. *Delayed transfers of care: a quick guide*, available at: <https://www.kingsfund.org.uk/publications/delayed-transfers-care-quick-guide>

⁸ Ibid.

All these concerns were echoed by the participants attending the Roundtable. Despite revision made by NHS England to the definitions, participants still questioned whether the right things were being recorded:

“If we are not measuring the right things, we won’t be able to make the right interventions.”

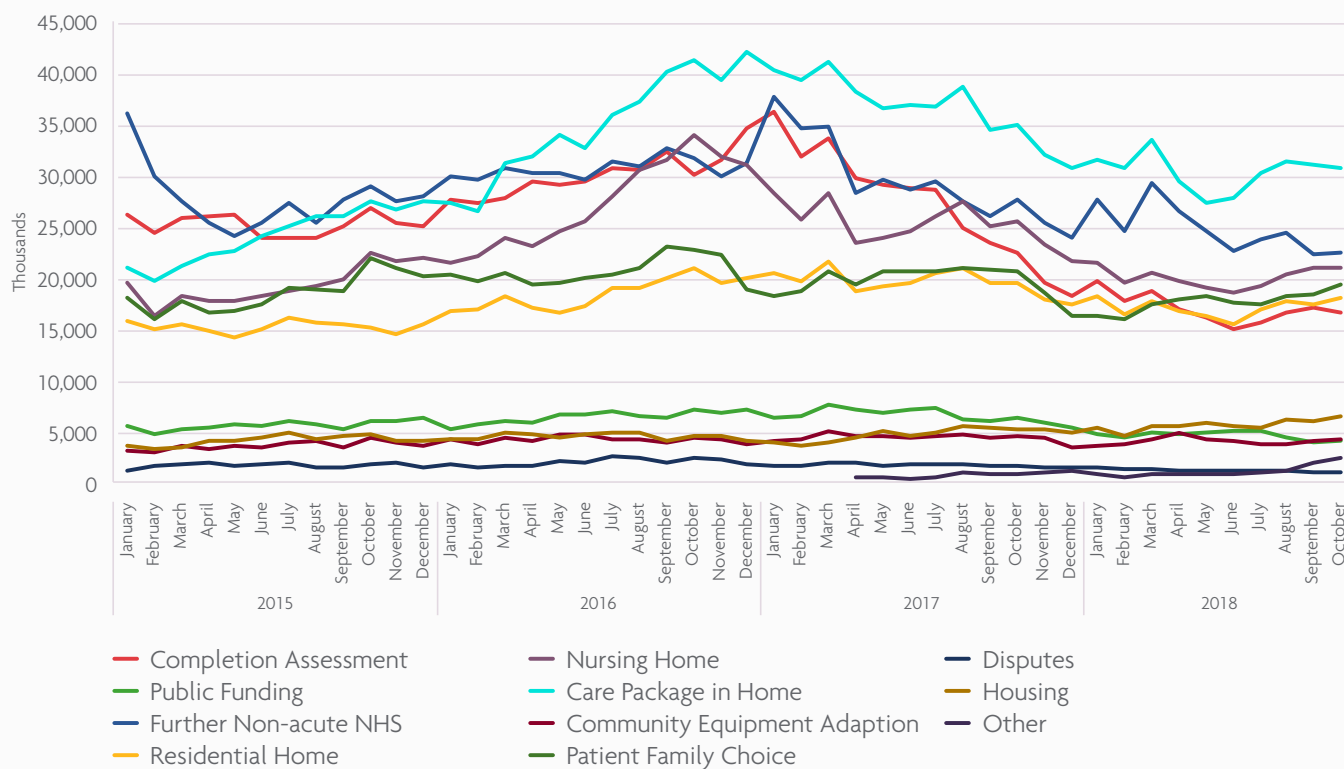
Breaking Barriers Innovations data on DTOC days

Breaking Barriers Innovations has undertaken its own tracking of the number of days in the hospital sector that constitute DTOCs. Some of the headline findings from this analysis show that:

- The decline in DTOC days is slowing, with the figure plateauing at approximately 14,000 days

(38 years) of patients’ time wasted per month in England. The decline in days from 2016/17 to 2017/18 was 12.2%, while the decline between Q4 2017/18 and Q1 2018/19 is half that.

- In every month since March 2016, the largest number of DTOC days are attributable to the lack of a home care package – this accounts for 19.5% of all days since January 2015.
- The second highest cause of DTOC days is for patients awaiting further non-acute (including community, mental health, intermediate care, rehabilitation services etc.) NHS care – 17.5% of days since January 2015.
- The third highest cause is for patients awaiting a nursing home placement – 14.3% since January 2015.



The fourth highest cause is the result of patient or family choice⁹, at 11.9% since January 2015; however, taken together with the third-greatest cause and the availability of residential homes these factors – all of which point to issues of capacity and quality in the care sector – amount to an astonishing 37%, way in excess of any other cause.

The clear message is that only an integrated health and social care system can address the myriad causes of delayed days and any solution must be supported by patients and families. However, there is another message – that injecting supply and quality into the care sector, while not a silver bullet, might alleviate a substantial part of the problem and do a great deal of good to patients and those in care.

Getting the measurements to match needs – a whole system approach

Although there has been an increasing focus on the need for an integrated response to managing DTOCs, as evidenced by the Better Care Fund and the additional £2 billion allocated in the 2017 Spring Budget to support adult social care, the reality is that the targets and policy drivers have remained largely siloed within the NHS. As pointed out by the CQC, the system needs to support collaboration, rather than act against it and the measurements should be focused on the whole system response, not that of individual organisations:

“To drive collaboration, there needs to be a transformation in the way the performance of health and social care services is measured. Currently, performance is measured in individual organisations, working separately. We need to see a shared approach that measures how well a whole system is working to meet the needs of people using health and social care services.”¹⁰

Participants at the Roundtable strongly echoed this view, arguing that there is still insufficient focus on the role and contribution of local authorities and the wider social care system:

“We need to think more about the whole system, place more emphasis on the other parts of the system aside from DTOCs. Councils can play a huge role if they have an agreement that that’s what they should be doing.”

Some participants indicated that part of the problem is perceived to be the way in which DTOC targets and policy promotes a narrow focus on bed occupancy, which is, in fact, a reflection of medical rather than social and wellbeing priorities. This reinforces a focus on acute care management rather than prevention and community-based care:

“If the pressure is only on measurements for DTOCs, then the desire to create a more preventative system goes out of the window. It makes people focus on the wrong things.”

⁹ These occur when a reasonable offer of services (such as a residential or nursing home place) has been made but refused by the patient or family; often this is an exercise of patient choice, when the chosen provider has no immediate availability.

¹⁰ CQC, July 2018. *Beyond barriers: How older people move between health and social care in England*, p.5, available at: https://www.cqc.org.uk/sites/default/files/20180702_beyond_barriers.pdf

In tackling DTOCs, it is vital that the data and information gathered accurately reflects the root causes of problems and can be trusted. Some participants would like to see more radical changes to the definitions for DTOCs that emphasises the needs of patients rather than the system:

“There should be a more holistic approach to measuring DTOCs that focuses on wellbeing and prevention rather than illness.”

“DTOCs are a limited measure, it would be more useful to look at how many days someone is at home rather than the number of days in an acute care bed.”

One participant likened the required shift in performance measurements to that in the fire and rescue service, which in the past was determined by the speed of response but is now more focused on the number of fires that occur and preventing these in the first place.

Arguably, the top-down, target-driven system for measuring DTOCs has aggravated attempts to create greater collaboration on the ground, with NHS organisations set against local authorities in determining responsibility for delays in the system. Areas that have successfully reduced delays have done so despite this system rather than because of it, largely because of the drive and commitment of local system leaders to overcome these systemic barriers.

NHS England and NHS Improvement have stated in their Winter 2018/19 Planning Update¹¹ that they expect to see important progress delivered in several key areas. This includes increasing available hospital capacity by reducing delayed discharges and long stays in hospital. They reported that between February 2017 and July 2018, around 2,200 beds were freed up by reducing delayed discharges – equivalent to opening four new hospitals.

However, three of the largest barriers identified by participants at the Roundtable included the viability of the social care model, workforce development and the need for a paradigm shift away from acute care to prevention. These are discussed in detail below.

¹¹ NHS England and NHS Improvement, September 2018. *Meetings in Common of the Boards of NHS England and NHS Improvement*, available at: <https://www.england.nhs.uk/wp-content/uploads/2018/09/01-a-MiCIE-27-09-2018-winter-2018-19-planning.pdf>

Viability of the social care model

The economic models for health and social care are diametrically opposed. Healthcare, which is funded by general taxation, is based on the principle of universality and is free at the point of delivery; social care is stringently means-tested and reliant on contributions from individuals. This dichotomy has increased as local authorities have cut back on social care spending in response to austerity, and people have had to contribute more to the costs of their care.

The Dilnot Commission, established in 2010 to advise government on the reform of the social care system, estimated that in the absence of reform, spending on social care would have to rise from £14.6 billion in 2010/11 to £23 billion by 2025/26¹². The Commission found that the current system is not fit for purpose, and highlighted that:

- eligibility is dependent on where people live and there are wide variations between areas with no portability of assessments between local authority areas;
- the provision of information and advice is poor;
- services are disjointed and rarely work in an integrated way;
- uncertainty about the funding structure means people cannot plan for long-term care needs; and
- those born with care needs or who develop them early in life have no opportunity to plan for care needs.

All of the above was thought to be contributing to widespread poor performance of the social care system in 2010. Nine years on, we are still waiting for the government to address these concerns.

In the interim, the care system has continued to suffer, and this has undoubtedly contributed to the problems of delayed discharge from acute care and inappropriate admissions for hospital and nursing care.

Participants at the Roundtable were concerned that the viability of the social care model is now significantly at risk and that we will experience more care providers leaving the system as they are finding it harder to operate under the current climate of funding restrictions.

Providers of residential care homes have been greatly impacted by cuts and freezes in local authority fees, rising costs, and the introduction of the National Living Wage, leading to a precarious situation in which local authority-funded placements must be effectively subsidised by individual and family contributions.

The Local Government Association (LGA) reported that in more than 100 council areas residential care homes and home care providers have ceased trading, affecting more than 5,300 people over a six-month period. This is a direct result of funding pressures¹³.

¹² Commission on Funding of Care and Support, July 2011. *Fairer Care Funding – The report of the Commission on Funding of Care and Support*, available at: http://www.ilis.co.uk/uploaded_files/dilnott_report_the_future_of_funding_social_care_july_2011.pdf

¹³ Local Government Association, August 2018. *The Mental Capacity (Amendment) Bill Committee stage*, House of Lords 5 September 2018, available at: <https://www.local.gov.uk/parliament/briefings-and-responses/lga-briefing-mental-capacity-amendment-bill-committee-stage>

The critical nature of this crisis has been exposed by recent reports that bring into question the future of two major care providers, Allied Healthcare, a provider of care for 13,000 older people and disabled people, and Four Seasons Healthcare, which looks after 17,000 residents in 300 care homes and is the UK's second-largest provider of residential care for the elderly.

Of those care homes still operating, there are questions regarding their efficiency and the quality of care they provide. An analysis of 642 Care Quality Commission inspections in November 2018 revealed that 38% of care homes were rated as 'requires improvement' or 'inadequate'¹⁴. It is not difficult to see how an offer of a place at one of these homes might lead to a delayed transfer on the grounds of patient or family choice.

Participants at the Roundtable questioned whether the residential care home model is efficient, not simply in terms of the funding, but also in terms of physical infrastructure. Many care homes are said to be providing services in buildings that are no longer fit for purpose or energy efficient:

"Many care homes are fundamentally inefficient, too small, ergonomically inefficient, energy inefficient, and any margin is lost through heat and light and poor design."

"The care home sector needs to recognise that old Victorian buildings are not the place to deliver care. Local authorities could help them move to efficient estates using land banks. They've got to be more efficient."

Participants at the Roundtable suggested that care homes need stronger, dedicated financial advice:

"Price and workforce issues are very challenging, care homes do not get good financial advice, which affects costs and expenses. They should have a finance officer who works alongside care homes and support them."

This goes beyond even the care system. Many areas have seen charities having to cut back on services that were addressing isolation and loneliness in the elderly, without which they are more likely to need emergency and care services as their health deteriorates:

"We have seen a lot of charities struggle. One used to see 1,000 people a month. When they stopped delivering services, as a result of cut backs, those 1,000 people had nowhere else to go; many were elderly, left lonely and isolated, and it increases the chance of them turning up at A&E."

There is little doubt that this crisis in capacity and widespread poor quality in the care system is leading to significantly increased DTOCs, and people's needs going unmet.

¹⁴ Care Home Professional, November 2018. Almost four out of 10 elderly care homes underperforming, research finds, available at: <https://www.carehomeprofessional.com/almost-four-10-elderly-care-homes-underperforming-research-finds/>

Age UK estimates that 1.4 million older people do not receive the help they need. That includes 164,217 people who need help with three or more essential daily activities like washing, dressing and going to the toilet, but receive no help at all from either paid services or family and friends¹⁵.

With the prospect of more providers leaving the market and increasing numbers of vulnerable adults and elderly people being left without sufficient care and support, it is clear that a new model of care provision is urgently required. It is also apparent that solutions cannot be the sole responsibility of any single agency or one part of the health and social care system.

Solutions must come from more integrated and collaborative approaches that can address the system as a whole. This includes the need to address workforce development and recruitment, alongside new care models that prevent acute crisis and the build-up of higher-dependency needs.

¹⁵ Ibid

Workforce

The King's Fund¹⁶ has stated that the health and social care system of the future will require staff who are team players and are able to adapt their skills to changing patient needs. Therefore, changes to the education and training of health and social care professionals, including closer integration of training, are needed to facilitate team working. The King's Fund highlighted several examples of staff being used differently to support moves in this direction, including the use of care co-ordinators with no formal professional training to support nurses, allied health professionals and social care professionals working in integrated community health and social care teams.¹⁷

However, in its report on the social care workforce in 2018, the National Audit Office (NAO) stated that the Department of Health and Social Care was not doing enough to support a sustainable social care workforce. They concluded that the number of people working in care is not meeting the country's growing care demands and unmet care needs are increasing¹⁸. Three of the largest challenges are illustrated in the following graphic from the report:



National Audit Office

Department of Health & Social Care

The adult social care workforce in England

1.34m

was the estimated number of jobs (excluding personal assistants and NHS jobs) in the adult social care sector in England in 2016-17

2009

was the last time a national workforce strategy was published by the Department of Health & Social Care

6.6%

was the vacancy rate for jobs across the care sector in 2016-17



¹⁶ The Kings Fund, 2012. *Transforming the Delivery of Health and Social Care: The Case for Fundamental Change*, available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/transforming-the-delivery-of-health-and-social-care-the-kings-fund-sep-2012.pdf

¹⁷ Thistlethwaite, P., March 2011. *Integrating Health and Social Care in Torbay: Improving care for Mrs Smith*, available at: <https://www.kingsfund.org.uk/sites/default/files/integrating-health-social-care-torbay-case-study-kings-fund-march-2011.pdf>

¹⁸ NAO, April 2018. *The adult social care workforce in England*, available at: <https://publications.parliament.uk/pa/cm201719/cmsselect/cmpubacc/690/690.pdf>

The turnover rate of care staff per annum has been increasing since 2012/13 and in 2016/17 reached 27.8%, highlighting the pressures that care organisations are under.

Participants at the Roundtable identified similar challenges, and suggested creating a social care career path that is more attractive to prospective employees:

“Workforce is one of the main issues – especially how we present health and social care jobs as something to be proud of and seen as a career route.”

Some providers are developing Teaching Care Homes, and this was raised by participants as a model that could help to address the shortfalls in entry and career progression for care workers.

The Teaching Care Homes programme is led by Care England (the leading representative body for independent care services in England). The programme was conceived after the Care Sector Nursing Taskforce called for a programme of work to respond to some of the most complex challenges facing the sector.

Nurses in care homes are at the forefront of delivering health, wellbeing and end-of-life care to residents and yet access to NHS funding for professional development is often closed for registered nurses in care home settings, a contributing factor in the sector’s poor training and development and therefore recruitment and retention. The Teaching Care Homes programme recognises workforce training and development as key to sustainability, but also the delivery of improved health and social care outcomes.

Participants also highlighted problems with the NHS workforce, in particular, the difficulties that the NHS faces in retaining staff:

“The NHS are going through a crisis in terms of workforce – retention rates are at crisis level. A huge amount of money goes into training, but people are only staying with NHS for a very short time.”

Participants identified changing circumstances and preferences amongst the workforce, for example, the demand for greater flexibility. The Institute for Employment Studies¹⁹ likewise reported that the factors important to older workers may differ to their younger counterparts and include the need for flexible or reduced working hours, or part-time working; being part of an organisation with values that they identify with; and, responsibility and autonomy in their work, and the ability to pass knowledge onto others.

¹⁹ The Institute for Employment Studies, May 2017. *The Challenges of an Aging Workforce*, available at: <https://www.employment-studies.co.uk/news/challenges-ageing-workforce>

The need for more flexible shift patterns was particularly raised by several participants:

“There is a shift in expectations – what people coming into the workforce want is changing. Twelve-hour shift patterns are being questioned, they want to have shifts that are closer to eight hours, more flexibility, and the ability to roster on and off.”

Closer working between the NHS and the social care sector was viewed by participants as one way of trying to address the problems, including better career progression between the two sectors:

“People entering the workforce want to know where they are going in a job. There is a huge opportunity for health and social care homes to work closer together. People should be able to move freely between one sector and another.”

Recently, however, the House of Commons Committee of Public Accounts²⁰ examined the adult social care workforce in England in May 2018 and found that the social care workforce suffers from low pay and low esteem, which leads to recruitment difficulties for providers. The Committee stated that this also impedes efforts to join up health and social care workforces, as it makes it less appealing for NHS staff to move into social care.

NHS England acknowledged to the Committee that a career ladder for care assistants in social care should be developed, similar to the apprenticeship and on-the-job type models that enable care assistants in the NHS to become nursing associates or registered nurses. This would need to be developed in a way that allows staff to switch between health and social care, rather than as parallel models.²¹

²⁰ House of Commons Committee of Public Accounts, October 2018. *Interface between Health and Adult Social Care*, available at: <https://publications.parliament.uk/pa/cm201719/cmselect/cmpublicacc/1376/1376.pdf>

²¹ Ibid

Prevention

Prevention is about helping people stay healthy, happy and independent for as long as possible. It means stopping problems from arising in the first place and focusing on keeping people healthy, not just treating them when they become ill. If they do become ill, it means supporting them to manage their health earlier and more effectively. This means giving people the knowledge, skills and confidence to take full control of their lives and their health and social care and making healthy choices as easy as possible.

Research also shows that prevention works. A review of international studies suggests that past investments in prevention have had a significant long-term social return on investment – around £14 of social benefit for every £1 spent across a broad range of areas²².

However, in the UK, we spend 60% of public funding for healthcare on cure and rehabilitation, and only 5% on prevention. This means we are spending £97 billion a year on treating diseases, and only £8 billion on preventing them²³.

In addition, a 2017 research report from the Social Care Institute for Excellence²⁴ found that while local authorities across England have made efforts to implement preventative services, and there are examples of innovation and good practice, the Care Act's vision for prevention is not being fully realised.

Local authorities in England need to provide more services that prevent, reduce or delay the need for care and support. The report also identified shortcomings in plans for integrating health and social care. Barriers to implementing preventive services include a lack of clarity on what is meant by prevention and integration, resistance to cultural change and reduced resources.

Ultimately, participants at the Roundtable viewed prevention as the only effective 'cure' for the challenges facing the NHS and the social care system:

“Building up community assets is seen as a powerful way to ensure prevention.”

“It's not about buildings, it's about supporting people to stay well in their own communities. The local authority has a long history of commissioning an asset approach for older people's care – run by older people for older people. This kind of community engagement can help to tackle loneliness. It builds on people's strengths, rather than isolating themselves in their own home.”

This approach is also viewed as one that saves money and reduces the costs of longer-term care and crisis.

Prevention and intervention at earlier points is something that works for the whole population, not just with older people, for example, working with schools to prevent mental health problems:

²² Masters, R., et al., March 2017. *Return on investment of public health interventions: a systematic review*, available at: <https://jech.bmj.com/content/71/8/827>

²³ The Office for National Statistics, April 2018. *UK Health Accounts: 2016*, available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/ukhealthaccounts/2016>

²⁴ Field, O., 2017. *Prevention in action: how prevention and integration are being understood and prioritised locally in England*, available at: <https://www.scie.org.uk/prevention/research-practice/getdetailedresultbyid?id=a110f00000RCupWAAT>

“There are 36 schools in our area looking at mental health. Early intervention in this is key – training teachers to have the skills to identify problems and issues much earlier.”

However, while there was widespread recognition amongst participants that prevention is vital, it is not viewed as something that is easy to do. Problems include having to shift funding to support prevention from other areas and changing the mind set of commissioners and service providers to think more collaboratively about prevention:

“Integrated care systems are key for prevention. We also have to realise that people are fearful of the consequences so we have to manage the strategy, as some people will always be reluctant to try something new.”

The concentration on DTOCs was seen by participants as a good example, because it is focused at a point that is too late to intervene successfully, so the system is left responding to the crisis rather than preventing problems. Participants called for a step-change in prevention, and the need for a new, radical approach to prevention is increasingly being recognised at the level of government policy. The Department of Health and Social Care published its Green Paper on prevention in November 2018, in which it states:

“Securing our nation’s health requires a significant and sustained effort to prevent illness and support good physical and mental health. We need to see a greater investment in prevention – to support people to live longer, healthier and more independent lives, and help to guarantee our health and social care services for the long-term.”²⁵

The paper argues for an integrated approach to prevention that:

- picks up problems earlier;
- stops people from deteriorating by providing the right care in the community, and putting more people in control of their health; and
- treats the whole person, across mental and physical health – not just their symptoms.

For participants at the Roundtable, the ability to identify and predict demand earlier is essential for prevention. However, there needs to be a more robust system on an integrated care basis to make this work:

“If we could foresee the demand we could work better. In hospitals you can predict this, but we’ve not found a way to share this with the integrated care teams. With the right system we could foresee the changes.”

²⁵ DHSC, November 2018. *Prevention is better than cure. Our vision to help you live well for longer*, available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/753688/Prevention_is_better_than_cure_5-11.pdf

“We need communication across the whole pathway. We can assess that there is a certain amount of people that will need care, but these discussions are not being had at the right times and in the right places, we need to be having the conversation about what care needs are coming through.”

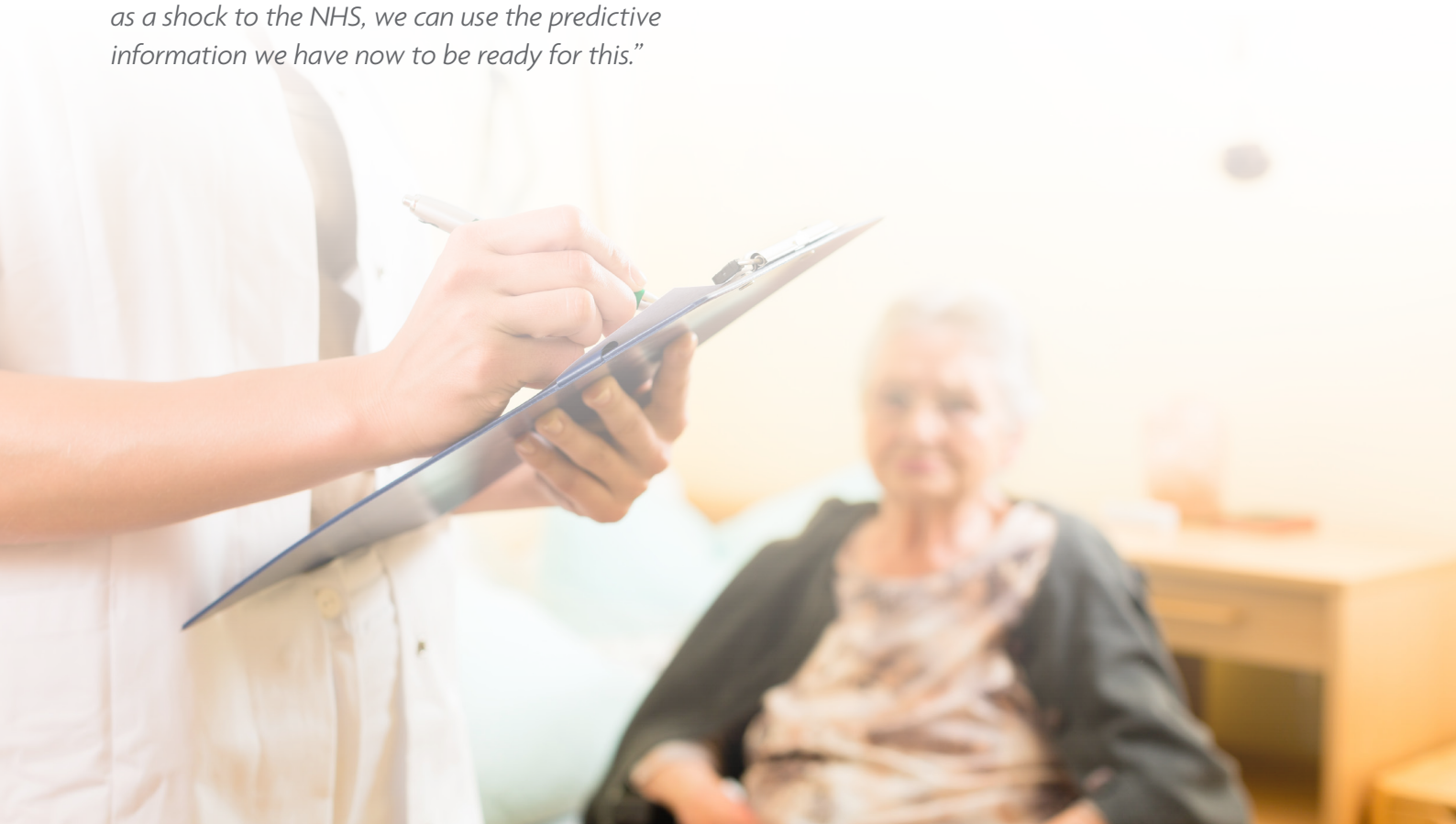
Some areas are looking at this from a whole population perspective, and planning capacity accordingly, but are focused on specific localities and neighbourhoods, or even street-by-street:

“The secondary care discussion starts too late. We need rich conversations between the NHS and parties outside of the NHS; it needs to be based on an understanding about the stock of worsening health in the community, so we can predict what will be coming in to the system. We are trying to develop a street-by-street understanding of elderly health. We started predicting where these people will be in 6 and 12 months’ time. People shouldn’t present as a shock to the NHS, we can use the predictive information we have now to be ready for this.”

More sophisticated approaches to assessing demand, with earlier intervention and engagement with communities and sectors outside the NHS are fundamental building blocks for an effective prevention strategy.

Alongside workforce development, which addresses current recruitment gaps and provides people with a more promising and attractive career pathway, prevention is viewed as the only effective way to ensure a sustainable future for health and social care.

While it is important to have the right strategic focus on this and for it to be supported through national policy and legislation, there is also a need for innovative health and care solutions that can address all of the problems as part of an integrated response. This is discussed further in the next section of this report.



Innovations in service delivery and practice

As funding pressures, population change, and new models of care and management continue to develop in our health and social care system, the ability to encourage and keep pace with innovation is more important than ever.

The aim of accelerating innovation to ‘transform care delivery’ comes from the NHS Five Year Forward View, which suggests that the greatest potential for innovations in healthcare are ‘combinatorial’ – those that combine multiple technologies and approaches to transform services²⁶. Innovation must demonstrate its value through evidence, but organisations must also improve how evidence is collected. Finally, innovation is environmental – steps should be taken to encourage a culture that allows for innovation at every stage in the delivery of services.

Several research studies have reviewed the take-up of innovation within the health sector. These studies usually focus on the early processes of adoption and implementation, however, a successful initial implementation of a service innovation, such as the introduction of new roles or integrated care pathways, does not always lead to sustained, longer-term change. There are a wide range of factors that support the successful adoption, implementation, sustainability, spread and scale-up of service innovations²⁷, which include:

- **leadership and management** at different tiers that are supportive of and committed to change, including the articulation of a **clear and compelling** vision;
- early and widespread **stakeholder involvement**, including staff and, crucially, service users;
- **dedicated and ongoing resources**, including funding, staff, infrastructure and time;
- effective **communication** across the organisation (and, where relevant, between organisations);
- **adaptation** to the local **context** and integration with existing programmes and policies, where appropriate;
- ongoing **monitoring and timely feedback** about progress; and
- **evaluation** and demonstration of effectiveness and value being introduced, including assessment of holistic health and wellbeing benefits.

Evaluation is particularly important because while there is increasingly a drive to identify and apply innovations that will demonstrate better value for money and improve the quality of care delivered, there is a risk that innovation without adequate evaluation can lead to misattribution of effects, and worse, the wider adoption of technologies and practices without proven benefits. Evaluation should enable understanding of the process of implementation, the influence of contextual factors as well as the quantification of effects. Adopting a prospective approach will facilitate more informed decisions in relation to continuation or a wider spread.²⁸

²⁶ NHS England, 2014. *The Five Year Forward View*, available at: <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

²⁷ Nolte, E., (World Health Organisation), 2018. *How do we ensure that innovation in health service delivery and organization is implemented, sustained and spread?*, available at: http://www.euro.who.int/_data/assets/pdf_file/0004/380731/pb-tallinn-03-eng.pdf?ua=1

²⁸ National Institute for Health Research, June 2015. *Evaluating the introduction of innovations into routine health and social care: balancing rigour and resources*, available at: <https://clahrc-west.nihr.ac.uk/Wordpress/wp-content/uploads/2016/05/Evaluating-the-introduction-of-innovations-into-routine-health-and-social-care-May-2015.pdf>

Prospective pathways for undertaking rigorous experimental evaluation are well-established, but time and resources needed to undertake this can be a limiting factor. With the pressures on leaders in commissioning and service provision for health and social care, it is understandable that much of their focus is exhausted by the urgent issues confronting acute care and bed management, including DTOCs. However, there is a growing consensus, clearly evidenced amongst participants at the Roundtable, that there is a need for new ways of looking at the problems and new solutions.

“People want to transform what we do, but I don’t see that happening. People I speak with, with their hands tied, think they want to be transformative, but actually they need to be innovative.”

The view is that innovation is hindered by people’s inability to ‘stick their heads above the parapet’. In fact, the current climate of budgetary cuts and a perception that regulation is becoming more burdensome is making people more risk averse and resistant to new ways of doing things, not less:

“People haven’t got time to spare to think about this. I understand it, but people are not free to make that bold step. That’s the barrier that I find – people’s hands are tied, and they feel frightened to take the next step.”

“We need people to feel more confident to take risks on innovation.”

The areas participants identified where they thought innovations in service delivery and practice were showing promise, or could be developed more included:

- shifting the locus of care assessment
- step-down accommodation from acute care
- step-up facilities based in primary care

Shifting the locus of care assessment

As part of the move towards more integrated ways of working, participants called for social care assessments to be part of the hospital service and not an adjunct to it or a follow-on service, so that admissions could be prevented at source:

“We need additional social workers in the front doors of the hospitals to hopefully prevent admissions of a lot of people, and to try and get homecare packages sorted for people quickly.”

However, for this to be effective it requires shared ownership of the service; it cannot be the responsibility or role of a single provider:

“We had social workers on wards to help with earlier discharge. The difference they make is phenomenal. Having care co-ordinators speaking to people on the wards makes a huge difference. The amount of earlier discharges that happen as a result is great.”

For some participants, the care assessment and the whole locus of control needs to be shifted outside the hospital system completely:

“It is partly about getting the pressure and heat off the hospital, so we need to move the assessment out of the hospital setting. Let the decision to admit in the first place be a social care responsibility jointly with primary care.”

There are examples of both approaches working, but a more comprehensive service offer needs to be part of the approach for it to work, including both step-down and step-up facilities and services.

Step-down accommodation from acute care

As identified in the opening section of the report on DTOCs, there is a wide range of issues that affect delayed transfers of care, but some of the most significant are the availability of a suitable community- or home-based alternative that is acceptable to patients and families. For too many, the step from acute care to home is too great and there is a need for a wider choice of intermediate care options that directly support reablement and independence:

“We need separate facilities, we to build patient centres that take people away from A&E and acute care. Step-down is part of that, but not as another secondary care model of service, more something that supports independence, rehabilitation and reablement.”

Other participants were concerned that step-down facilities will not fully address long-term care or domiciliary needs if they are only an extension of the acute care system. For participants, it was important that step-down facilities are developed as part of new service models, for example, preparing people from the outset for shorter lengths of stay, which can be done if provided with the right kind of focused support:

“In step-down we proposed taking people out of hospital and then into rehabilitative care, but we need to think before that, to prepare people when they know they’re going to go into hospital that they will only be in hospital for a couple of days, so that they see this as part of care planning and progress.”

Step-up facilities based in primary care

Closely aligned to the development of step-down facilities are services that can work as a step-up from primary care, which come into operation prior to an acute care admission:

“We are trying to create step-up facilities as part of our primary care model. There are two GPs who are innovative-minded people to do this. They have set up a pharmacy, a dentist and a training centre within the practice. Their interest is around creating an offering so that people don’t have to travel everywhere to do something. Now the focus is on creating a step-up facility on the surgery land and thinking about how we can use this to improve the way we care for the elderly.”

Enlarging the primary care offer to encompass step-up facilities means thinking much more widely about the environments in which people live and how partnership working with different agencies and sectors can support this. For example, participants spoke about the primacy of housing in care and, in particular, as one of the factors that can lead to delayed discharges from care:

“Housing is a huge issue in delayed discharges from care. The trick for the health community is to recognise the issue, but not to get dragged into solving it. For example, the most problematic housing is in the private rented sector, but it will take a lot to sort this. Housing colleagues have some of the levers to fix problems, but this should be done with the Health and Wellbeing Board to get the full range of agencies behind it.”

“There are lots of resources in housing sector that could be better used to support health and wellbeing.”

Participants also viewed more innovative approaches to problems connected with housing and health as possibly assisting with workforce issues, for example, including key-worker accommodation in housing development plans for healthier environments, and live-in carers and support workers.

Creating the right incentives for community wellbeing

For participants, the most effective innovations in service delivery and practice were those that come from the ground-up, through the engagement and involvement of local people, service users and carers. What is needed is a shift from population-based health assessments to thinking about the wellbeing of communities:

“In the long-term, we have to seriously think about how to shift the paradigm for population health, not just services, and how we start to think about wellbeing more. It actually goes beyond a public health strategy; we need to look at the problems holistically, think about home-first, and drawing on local community resources to keep people well before we draw on social care or health services.”

Such an approach is thought to unlock many of the financial problems in relieving an overburdened care and hospital system, but at the same time it is the financial models for the system that act as one of the main barriers preventing this kind of shift:

“The focus, and with it the finances, are all on emergency care and DTOCs, and now [October 2018] the winter pressures. The finances actually stop people working flexibly together – it all comes down to contracting and finance. The financial model makes people more risk averse.”

“We need to use the money differently to provide better care, not using it all on acute care, but creating financial incentives for keeping people well.”

Even at the level of personal health budgets there is an appetite for doing things differently:

“Personal health budgets are not pushed as hard as they could be because finance directors are nervous about losing control. The voluntary sector is losing grants they had in the past and are looking for new markets to get in to. If we linked personal health budgets together with care-coordination, we could use this as a resource to really help people stay independent.”

Alliance contracting

Getting the financial levers right is important, but this needs to be part of a different approach to contracting. Participants highlighted the value of alliance contracting to bring more agencies into a collaborative model for community wellbeing. For example, it was suggested that alliance contracting, whereby risk is shared across agencies on a more equal basis, can act as an incentive for innovation. This could include participation of further and higher education in developing health and wellbeing learning centres in primary care that put workforce development alongside innovation in service delivery and practice.

This would require existing authorities to rework their financial modelling and possibly move from single-service line budgets and contracting, to one that is place-based.

Rather than viewing competitive tendering as the only way to improve services and reduce cost, collaboration and alliances could maximise the overall benefits across the system and for a whole area, whether that is for a local authority or on a wider sub-regional basis.

New financial models

Wellbeing, viewed from this perspective, becomes much more than care; it is fundamental to the prosperity and the full socio-economic viability and vitality of an area. However, shared risk-taking on this basis will require new financial models, for example, an alliance contracting approach to develop a more flexible range of care accommodation may require guaranteed levels of income and occupancy to work. The current lack of predictability and assurance in the current financial modelling for care is partly responsible for many care providers leaving the system. The alternative will be greater pressure on the hospital system, so it would be cost beneficial to take a new approach:

“You can build new care facilities, including ones that are cheaper and more effective to run, but none of the relevant authorities are prepared to guarantee occupancy. It becomes a vicious circle of risk and debt that needs to be addressed.”

“Ultimately, it is about the money, but there are ways to build more security into the system, if providers have greater assurance that they can plan.”

“We need to think more about how we use the planning system to support care. Local authorities have control of these processes and they need to be thinking long-term, over next 25 years. We should be talking about land use on these terms and how better care facilities can bring social value over the longer-term, it is not just about price.”

“If we get the finances and risk assurance right in contracts, then we can create healthier environments that support and sustain wellbeing.”

Conclusions

At the time of the Roundtable, many NHS Trusts and local authorities were preoccupied with preparations for winter pressures. Exactly what the demands will be depends on several variables, including the weather and severity of winter flu outbreaks. What does not change, however, is the urgency of good patient flow and social care, whether domiciliary or residential, at this time of year. From the early summer time, national performance reports on DTOCs have concentrated on the need to increase the number of available beds to cope with winter pressures. What the system fails to do is to plan throughout the year for more effective ways to prevent these pressures.

It has been argued that the national focus on DTOCs and concerns about performance and targets has aggravated the problem. The NHS and local authorities have too often been locked against each other, incentivised to divert blame and responsibility to the other. Meanwhile, we are witnessing the worst crisis in social care provision in a generation with the prospect of yet more providers leaving the market.

The problems associated with DTOCs and social care only add to a growing crisis in the health and social care workforce, where more doctors, nurses and care assistants are leaving their positions and providers are struggling to find replacements. Considering the NHS is one of the country's most beloved institutions, we seem to be finding it harder than ever to persuade people that it is an attractive place to work.

In the months following the roundtable, we expected two major policy developments – the NHS Long Term Plan and an accompanying response to the Dilnot review in the form of a Green Paper on social care. Only the former has been forthcoming. If the Department of Health and Social Care's paper on prevention is anything to go by, then we can expect prevention to take a much more prominent role in these developments and as part of the solution to the current crisis. We very much hope that some of the issues and innovative solutions highlighted in this report gain greater prominence in the resulting policy landscape, in particular:

- moving the focus away from targets on bed days occupied to other measures, such as the number of days people are supported to remain in the community;
- supporting holistic approaches to care that encompass community asset-building and wellbeing;
- shifting the locus of control for care assessments and planning away from acute care to primary care and the community;
- establishing financial and budgetary systems that support alliance contracting and shared risk across providers; and
- enabling the development of both step-down and step-up facilities and services that can provide greater flexibility and a broader range of care options.

Bibliography

Care Home Professional, November 2018. *Almost four out of 10 elderly care homes underperforming, research finds*, available at: <https://www.carehomeprofessional.com/almost-four-10-elderly-care-homes-underperforming-research-finds/>

The Commission on Funding of Care and Support, July 2011. *Fairer Care Funding – The report of the Commission on Funding of Care and Support*, available at: <https://webarchive.nationalarchives.gov.uk/20130221121529/https://www.wp.dh.gov.uk/carecommission/files/2011/07/Fairer-Care-Funding-Report.pdf>

CQC, July 2018. *Beyond barriers: How older people move between health and social care in England*, p.5, available at: https://www.cqc.org.uk/sites/default/files/20180702_beyond_barriers.pdf

DHSC, November 2018. *Prevention is better than cure. Our vision to help you live well for longer*, available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/753688/Prevention_is_better_than_cure_5-11.pdf

Field, O., 2017. *Prevention in action: how prevention and integration are being understood and prioritised locally in England*, available at: <https://www.scie.org.uk/prevention/research-practice/getdetailedresultbyid?id=a110f00000RCupWAAT>

The Health Foundation, March 2017. Briefing: *The social care funding gap: implications for local health care reform*. available at: <https://www.health.org.uk/sites/default/files/SocialCareFundingGap.pdf>

House of Commons Committee of Public Accounts, October 2018. *Interface between Health and Adult Social Care*, available at: <https://publications.parliament.uk/pa/cm201719/cmselect/cmpubacc/1376/1376.pdf>

The Institute for Employment Studies, May 2017. *The Challenges of an Aging Workforce*, available at: <https://www.employment-studies.co.uk/news/challenges-ageing-workforce>

The Kings Fund, 2012. *Transforming the Delivery of Health and Social Care: The Case for Fundamental Change*, available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/transforming-the-delivery-of-health-and-social-care-the-kings-fund-sep-2012.pdf

The Kings Fund, 2014. *The social care and health systems of nine countries*. available at: <https://www.kingsfund.org.uk/sites/default/files/media/commission-background-paper-social-care-health-system-other-countries.pdf>

The Kings Fund, January 2018. *Delayed transfers of care: a quick guide*, available at: <https://www.kingsfund.org.uk/publications/delayed-transfers-care-quick-guide>

LGA, November 2018. *Predicted rise in care needs: full comment by Cllr Nick Forbes*, available at: <https://www.local.gov.uk/about/campaigns/lives-we-want-lead-lga-green-paper-adult-social-care/predicted-rise-care-needs-full>

LGA, August 2018. *The Mental Capacity (Amendment) Bill Committee stage, House of Lords 5 September 2018*, available at: <https://www.local.gov.uk/parliament/briefings-and-responses/lga-briefing-mental-capacity-amendment-bill-committee-stage>

Masters, R., et al., March 2017. *Return on investment of public health interventions: a systematic review*, available at: <https://jech.bmj.com/content/71/8/827>

NAO, April 2018. *The adult social care workforce in England*, available at: <https://publications.parliament.uk/pa/cm201719/cmselect/cmpubacc/690/690.pdf>

The National Institute for Health Research, June 2015. *Evaluating the introduction of innovations into routine health and social care: balancing rigour and resources*, available at: <https://clahrc-west.nihr.ac.uk/WordPress/wp-content/uploads/2016/05/Evaluating-the-introduction-of-innovations-into-routine-health-and-social-care-May-2015.pdf>

NHS England and NHS Improvement, September 2018. *Meetings in Common of the Boards of NHS England and NHS Improvement*, available at: <https://www.england.nhs.uk/wp-content/uploads/2018/09/01-a-MiCIE-27-09-2018-winter-2018-19-planning.pdf>

NHS England, 2014. *The Five Year Forward View*, available at: <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

Nolte, E., (World Health Organisation), 2018. *How do we ensure that innovation in health service delivery and organization is implemented, sustained and spread?*, available at: http://www.euro.who.int/data/assets/pdf_file/0004/380731/pb-tallinn-03-eng.pdf?ua=1

The Office for National Statistics, April 2018. *UK Health Accounts: 2016*, available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/ukhealthaccounts/2016>

Thistlethwaite, P., March 2011. *Integrating Health and Social Care in Torbay: Improving care for Mrs Smith*, available at: <https://www.kingsfund.org.uk/sites/default/files/integrating-health-social-care-torbay-case-study-kings-fund-march-2011.pdf>

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