RADIX

VOLUME SIX

PROFESSOR STEPHEN K SMITH

Tackling the crisis in older people's care

The Best NHS?

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Tackling the crisis in older people's care

RADIX

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SUMMARY

Care homes and domiciliary care are key parts of British society, but are usually viewed as the poor relation of the NHS. There are more than 457,000 beds in the care home sector, and a similar number of people are cared for by home care workers. The sector employs about the same number as the NHS, nearly 1.5 million.

Learning from care homes and domiciliary care

The misunderstanding and poor treatment of care homes by government and the NHS, habeen illustrated in the Covid-19 pandemic when the NHS was prioritised in terms of capacity (involving the movement of tens of thousands of hospital patients into care homes, without being tested for coronavirus) and personal protective equipment for care workers, resulting in at least 30,000 excess deaths.

Despite this, care homes and the domiciliary care sector has become expert in: dementia care, continuous care planning, palliative care (end of life care), 'hands-on' caring and nursing and monitoring technology.

We need to make sure that we:

Provide CQC and financial regulation of the care home and domiciliary market: The CQC (Care Quality Commission) needs to take on responsibility not just for regulating quality, but also for system sustainability in terms of making sure that the rates paid to care home and domiciliary care providers are appropriate to keep both current services open, and to invest in upgrading the physical stock of care homes. Clearly,

Include hospital discharge responsibility for the CEO of Community-based Care: Hospital bed blocking is very expensive. Addressing this alone could potentially save billions of pounds over a few years. Moreover the patient could receive the same or better quality of nursing care in more appropriate care surroundings, delivered by staff with experience in specialist older and dementia care, and with less risk to them of hospital-acquired infections.

Learning from other countries: the Netherlands and Germany

Clearly the UK is not the only country with an ageing population, and other European countries are trying to wean themselves off an economic system that allowed high spending in the short term together with lower taxes, all to be paid for by a demographic quirk that meant the working age population was much larger than the retired, pensioned population.

This demographic quirk has now unwound, and it is now no longer possible 'to kick the can down the road'. It's not easy. But there are lessons to be learnt from other countries. Neither the German nor the Dutch systems are perfect and both face difficult choices. Yet they have managed to develop a system of social care that both raises more money for a better funded social care system (as described in the earlier book (in Book 4 of this series) and one that is more stable and agile in serving the needs of

Learning from care homes and domiciliary care

SECTION 1

Care homes and domiciliary care are key parts of British society, but are usually viewed as the poor relation of the NHS. There are more than 457,000 beds in the care home sector, and a similar number of people are cared for by home care workers.[1] The sector employs about the same number as the NHS, nearly 1.5 million.

The care home sector is often viewed by politicians and senior NHS managers as an unnecessary evil. Some speculate that families should take on more responsibility for their parents, in which case there would be no need for care homes. If there are constraints to having parents living with the family, then the recommended course of action is to put them into assisted living apartments in clustered care neighbourhoods. This is indeed an option for people affluent enough to either be able to accommodate elderly relatives at home - and take the time off work to care for them - or pay for them to be in expensive supported living apartment blocks.

The reality is, however, that for the 50 per cent of residents in care homes and the 70 per cent of people receiving domiciliary care who are local authority funded, that relatives usually cannot support their paren

'This year, for the first time, more older people need care and support than there is family to provide it. In the UK, there are already one million people aged over 65 who do not have adult children. This figure will double by 2030, as one in five people over the age of 50 do not have children.

The one million people over-65s are only those who have never been parents. Many more people are ageing without children for different reasons; by choice, by circumstance, because they are estranged from their children, or because their children predeceased them. Their children may live far away or have physical or mental health problems, which mean they are not in a position to support their parents.'[3]

For better or for worse – and we need to make it better – care homes are here to stay.

This misunderstanding about the need for care homes has combined with rare, but luridly reported, care failings in some instances to make many people

'A secret government report that said the UK was not prepared for a pandemic and forewarned of the Covid-19 crisis in care homes is being published by The Guardian. The report is based on the findings of a government simulation of an influenza pandemic, codenamed Exercise Cygnus. It concluded starkly that Britain was not adequately prepared for a flu-like pandemic's "extreme demands". The 2017 report is likely to raise questions over whether ministers ever implemented key recommendations pertaining to the care home sector. It contained 26 key recommendations, including boosting the capacity of care homes and the numbers of staff available to work in them. It also warned of the challenge facing homes asked to take in patients from hospitals…. Martin Green, the chief executive of Care England, which represents the largest independent care home providers, said concerns raised by the exercise about the social care system's ability to handle patients

A report on Exercise Cygnus was produced in July 2017 and sent to all major government departments, NHS England, and the devolved administrations of Scotland, Wales and Northern Ireland.

It stated as its "key learning" that "the UK's preparedness and response, in terms of its plans, policies and capability, is currently not sufficient to cope with the extreme demands of a severe pandemic that will have a nationwide impact across all sectors".

The report recommended that a comprehensive "pandemic concept of operations" be created and that NHS England should conduct further work to prepare "surge capacity" in the health service.

It explicitly recommended that the social care system needed to be able to expand if it were to cope with a "worst-case scenario pandemic", and that money should be ring-fenced to provide extra capacity and support to the NHS. It also said the Department of Health should consider

Care England's Green said the recommendations for expanding capacity and staff levels were not discussed with providers following the 2017 report.

"Nobody has ever had that conversation with us," he said. "Care England has been talking about providing extra capacity for years. We have been telling them that we have capacity and people don't need to be in hospital. But we have got nowhere."

In response to a freedom of information request by the Guardian last month, the Department of Health and Social Care (DHSC) refused to publish the report on Exercise Cygnus, claiming that it would "prohibitively impact the ability of ministers to meet with officials and external stakeholders to discuss ongoing policy development".

A government spokesperson said that lessons from Exercise Cygnus had been learned and continued to be considered. "The UK is one of the most prepared countries in the world and, as the public would expect,

DEMENTIA CARE

The role of the health and social care systems in meeting the multiple needs of people with dementia and their families is a key policy issue in the UK. The country's lack of preparedness for the scale of this disease is evidenced by the relative shortage of nursing and care staff with comprehensive specialist training in dementia care and of specialist 'dementia-friendly' environments. It is also evidenced by wider society's lack of understanding, which is the consequence of a failure to educate the population at large. Put these factors together with the crisis in funding for older people's care and we have a toxic situation.

Not only is dementia a debilitating and distressing condition in its own right, but it is also one of the 'macro-trends' that is poignantly demonstrating the lack of alignment between the 'system' and 'need'.

The *Telegraph* reported that:

> *'In 2013/14 there were 344,000 people in England who had received a diagnosis - up from 213,000 in 2006/7, the Health and Social Care Information Centre (HSCIC) figures show. However, current estimates suggest at least 670,000 people are likely to suffer from dementia – leaving half of sufferers still undiagnosed.'* [9]

The Alzheimer's Society has commented:

> *'In the UK right now, 60 per cent of people with dementia are struggling in the dark with no formal diagnosis. These people must be helped. Empowered with an early diagnosis, they can benefit from potential treatments and support which could vastly improve their quality of life.*
>
> *'Today's report must rouse us to take decisive action now and transform diagnosis rates everywhere. Alzheimer's Society urges petial*

International comparisons are illuminating, and do not put the UK in a flattering light:

- *The time taken to diagnose Alzheimer's Disease after symptoms were first noticed was considerably longer in the United Kingdom (32 months) than in France (24), Spain (18), Italy (14) or Germany (10).*
- *Fewer carers in the United Kingdom (51 per cent) reported that doctors recommended treatment at the time of diagnosis than those in Germany (78 per cent), France (83 per cent), Italy (85 per cent), and Spain (86 per cent).*
- *The number of carers who believed that governments did not invest enough in Alzheimer's Disease was higher in the United Kingdom (87 per cent) than in Italy (65 per cent), Germany (77 per cent), France (80 per cent) and Spain (82 per cent).*
- *Similarly, doctors had lower expectations from the available drug treatments (68 per cent of UK respondents agreed or strongly*

Dementia is also a major part of the hospital crisis, and solving it not only affects real lives but also saves costs.

It is estimated that a quarter of hospital beds are occupied by people living with dementia. Whilst there is no research yet on the topic, it is likely that these people are the 'frequent flyers' who regularly present at A&E and who 'bounce' around the system. Solving the dementia problem will be a major contribution in avoiding the looming crisis in health and social care. Dementia is a major problem in the context of 'bed blocking'. Many of the frail older people who call the ambulance, arrive at A&E, end up in acute beds and stay there too long. They are insufficiently cared for in the community and whilst they might well not need to go to a hospital, their confusion and inability to explain their circumstances means that the least risky approach is for a relative to call 999.

Four Seasons Health Care: the PEARL dementia care programme

SPECIALISED DEMENTIA SERVICE
Phase 2 report

Dementia care study confirms dramatic reduction in requirement for antipsychotic medication with improvement in wellbeing.

"I really support PEARL as it recognises everyone who lives here to be an individual who is entitled to respect, dignity, privacy or company, love, fun and laughter but at the same time all are safe and secure..."

Manager, Castlegreen Care Home

Dementia care study confirms dramatic reduction in requirement for antipsychotic medication with improvement in wellbeing.

CARE PLANNING

Most care homes and domiciliary care providers use a standard format for care planning, clear for any new staff member to use to give support to a resident even when that resident is unable to communicate. The family, where appropriate, is involved from the start so they can contribute to care planning and in particular record past and present lifestyle, likes and dislikes, employment history and skills they might continue and develop. Assessment of physical, mental, mobility, sight and hearing capacity are made and relatives may also be able to help with risk assessments, such as any history of falls, allergies or choking.

A good care plan allows the carers to see the person and their preferences, not just a list of ailments. It gives advice on how best to meet their needs and support them, so that they can have a good quality of life in their care home or at home. It records medical conditions, such as Parkinson's

One feature that can facilitate the efficacy of the care is the use of ipads and handheld tablets. This allows real-time feedback from residents, carers, relatives and visiting health and care professionals, which is powerful in creating a more open culture – people have become increasingly prepared to highlight where care has not been up to standard. Whistleblowing in most healthcare settings has been very disappointing. One of the reasons is that the process sometimes feeds into a vicious circle triggering a witch-hunt. Better is the real time feedback system that makes reporting of incidents second nature. But there are added benefits:

- *Once an error is identified, there is an action plan to put it right. This action plan is supported by an underlying 'expert system' that guides*

Better care for people living with dementia, through the integrated care organisation, is also an urgent concern with regard to palliative care. Fear of dying in pain is the second most feared aspect in anticipation of death:

- *'One third of the population stated being alone as their greatest fear about dying.*
- *A fifth of the population stated lack of adequate pain relief as their greatest fear about dying.*
- *Not having treatment wishes respected was also a top fear about dying, with a tenth of the population stating this.*
- *Not being able to die in a place of their choice was another commonly stated fear about dying.'*

Most people living with dementia can't express the fact that they are in pain. Dementia care mapping, a feature of the Pearl programme, begins to address

The scheme was implemented by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), itself created in 1983, which became the Nursing and Midwifery Council (NMC) in 2002. State Registered Nurses became Registered General Nurses (RGNs) and State Enrolled Nurses were replaced with healthcare assistants, who had no official training and were not registered.

Project 2000 student nurses studied for three years, splitting the time between class-based learning, and practical placements. The first 18 months of the course was known as the 'common foundation programme' and provided basic grounding in four nursing disciplines: Adult, Child, Mental Health and Learning Disability care. This was followed by 18 months dedicated to the nursing discipline of choice. On successful completion of

includes roles between that of senior carer and nurse must be championed, supported, developed and sustained by the Nursing and Midwifery Council, the RCN, the NHS and the independent and voluntary sectors.

Some UK care home providers are developing their own cadre of 'extended role' carers, where they have introduced the role of 'care practitioners' who are trained to fulfil core nursing tasks including medication rounds, care planning, team leadership and specialist tissue and wound care support.

This new career path should be incorporated into the NHS and complement the nursing degree route. As well as giving a career path for more care-focused nurses, it would also serve to improve the job of working in care homes and domiciliary care, and needs to be accompanied by a levelling up of pay and conditions. Among care workers in care homes and mental health units – that is, care assistants and senior care assistants – there is a high turnover of between 20 per cent and 30 per cent a year, which is largely due to poor pay.

- Mobile Care Worker *helps health organisations carry out their extended mission by building a customised mobile care solution based on a health customer's specific needs and priorities to serve residents in their homes. Additionally, IoT and other technologies, along with the care-giver's mobile device can provide oversight to ensure these visits are carried out when and where they are scheduled (in an electronic visit verification scenario—an important compliance aspect of home care for many public health agencies).*

  EXAMPLE: *Certain countries have begun empowering postal workers with capabilities to check on remote elderly patients with mobile care solutions to collect information to update health records while out on regularly recurring routes. Thie h*

- Operational Analytics *embrace predictive models and innovative technologies to create actionable insights and outputs to better manage individual and population health outcomes.*

  EXAMPLE: *Streamlined operations and reduced costs are benefits of analytics models enabling healthcare care executives and clinicians to share information and analyse structured & unstructured data. This empowers them to make more informed choices at the point of decision by utilising improved KPIs such as medical quality and patient safety.'* [20]

Cera has an app called Smart Care that predicts healthcare deterioration:

'SmartCare utilises machine learning and data analytics to predict the

Managing a major care home company is as challenging as managing a health care economy or a large hospital like King's College. Both are very difficult management challenges. Managing a large hospital is complicated, but most of the activity is at least in one place which makes co-ordination a little easier. The major challenge in hospital management, as will be described in Book 8 in the Radix series, which is on the Emergency Pathway and In-hospital specialities, is about ensuring clear lines of accountability and ensuring co-ordination at hand-off points through processes such as 'huddles' that ensure effective communication (A huddle is a short, stand-up meeting — 10 minutes or less — that is typically used once at the start of each workday in a clinical setting. In primary care, staff can huddle in the morning to discuss scheduled patients as a team).

and 80 care workers. Recruiting and managing care workers is not easy when fee rates barely allow for the payment of a minimum wage. Although the job is rewarding in terms of caring for vulnerable people, caring for a frail elderly person with dementia, who often does not remember who you are day by day, and could well be 'double incontinent', is not an easy job. These patients also have co-morbidities and sometimes quite serious chronic diseases such as cancer or COPD which require frequent visits from GPs, visits to hospital outpatient departments and, not infrequently, hospital admission.

The problem of recruitment is deepening post Brexit. It is urgent both that wage rates are increased and that foreign recruitment is not hampered by Brexit.

> *He said that the carer wage should be "comfortably above £10", adding: "You have to be well above that kind of level that Aldi's paying before you begin to attract workers."* [26]

It is a source of some wonder that vacancies are as little as 10 per cent across the country. Managing the workforce – recruiting staff, retaining them, covering for them when they call in sick – requires advanced management skills. At the same time, relatives are visiting the residents at all times of the day, other healthcare workers such as GPs, ambulance staff, district nurses, physiotherapists and so on, are coming in and out of the home all day.

There is an army of regulators, not only the Care Quality Commission

Managing a corporate entity like a major care home provider with over 350 care homes is also a major challenge. Devising corporate programmes, such as dementia care, that is supportive to care home staff rather than disruptive, is not easy. The biggest headache – after making sure that the company avoids financial insolvency and having sufficient cash to meet requirements in a market where government policy (and especially fee rates) and some ownership practices (by private equity) add to the pressure – is to make sure that quality standards remain high, and that abuse, especially, is avoided.

Keeping an eye on 350 care homes, where, on average the 80 carers are touching the 50 residents many thousands of times a day, is a major challenge. Real-time reporting, as described with the iPads at Four Seasons

CQC and financial regulation of the care home and domiciliary market

SECTION 2

The CQC (Care Quality Commission) needs to take on responsibility not just for regulating quality, but also for system sustainability in terms of making sure that the rates paid to care home and domiciliary care providers are appropriate to keep both current services open, and to invest in upgrading the physical stock of care homes. Clearly, those rates are not even achieving the first of these objectives. In terms of what capacity is required, in future these should be provided by the Integrated Care Systems (ICSs) and submitted to the CQC as the regulator responsible for system sustainability.

Nearly all care home and domiciliary care is provided by the private sector not, as some people think, by local authorities who just channel

This body needs to be given the 'teeth' to manage a utility ROI system. It is currently 'toothless' and sits on masses of data that give it clear visibility of the crisis that many providers are facing, but has no power to do anything about it other than the nuclear option of telling local authorities to stop sending residents to fragile providers – an option it never uses because there are too few beds, and it would mean putting vulnerable elderly people onto the street. The Financial Oversight group currently has a ringside seat to watch the unfolding crisis – it is a ringside seat to watch a slow motion train wreck.

Regulation by utility ROI will both prevent the elaborate, and damaging, financial engineering that some private equity firms have practised. It will also give rates of return that will attract private sector investment

Raise fee rates and invest in the social care sector

SECTION 3

Another requirement, following on the utility ROI regulation, is to raise fee rates so that companies can invest in their workforce, in building their capital stock, in establishing an intermediate care sector, and in leveraging technology.

The first people to benefit from higher fee rates are the care workers who have been underpaid for over a decade, and who, nonetheless, show outstanding commitment to a job that is very tough:

> *'Social care in England is unable to fill posts, retain staff and offer proper services due to low pay and excessive workloads, the National Audit Office (NAO) has found. There are roughly 1.34 million social care*

Clearly, fee rates to care home providers need to be set so that there is adequate money both for maintenance capital expenditure (capex) and refurbishment and new build capex.

This new build activity needs to encompass intermediate care. Care homes in the UK are nurse-led whereas hospitals are, of course, mostly doctor-led. The gap in the market is for doctor-led, intermediate care facilities caring for people who are more acutely ill.

The capacity plan for each ICS needs to include provision of intermediate care capacity. Most likely, putting this capacity in place will be done in partnership with private care home companies. The NHS has failed to build and manage intermediate care capacity. Partly this has been due to constrained funding, itself the result of a lack of clarity about who - local authorities, clinical commissioning groups (CCGs), community providers, hospitals, and so on – is actually responsible for putting the capacity in place.

This contrasts with other European countries. In Italy, for instance, the authority for health and social care is unitary, and the budgets are held by integrated bodies for each of the regions (Lombardy, Umbria, etc.). This means that they can make the trade-off between the lower cost to the taxpayer and the higher utility to the patient of being in an intermediate care hospital rather than in a fully functioning acute hospital. Companies like Maugeri have, therefore, invested in this provision of intermediate care facilities, taking still-sick patients recovering from, for instance, major heart surgery or brain injury.[35] The service at Maugeri is doctor-led. These patients in the UK would have to stay in the acute hospital because no such intermediate care sector exists.

Another reason the intermediate care sector has not developed is because the NHS, as in the 1948 model, is very focused on acute care, and on running big hospitals. They do not have the skills or experience to manage lower intensity intermediate care settings. The care home sector in the UK is largely privately run. These companies do have that expertise and developed a low-cost intermediate care offering with rigorous clinical protocols:

> *'Intermediate care beds are provided in many of our care homes working in partnership with local authorities and the NHS. These intermediate care beds play a vital role in supporting local health and social care services by offering an alternative to an extended stay in hospital for older people who are recovering from an illness or injury, helping to ease the shortage of acute care beds that many hospitals are experiencing…. Intermediate care is also known as 'step-up, step-down' or rehabilitation and our care teams are able to provide a personal level of support where the emphasis is very much on preparing each person to return to their own home….*

We have also opened the Grove Discharge Unit in partnership with Wirral University Teaching Hospital NHS Foundation Trust. It is a dedicated 30 bedded Intermediate Care Unit based in Clatterbridge Hospital to support elderly patients who no longer need to be in an acute hospital ward.

*The **Four Seasons Intermediate Care Framework** forms part of our quality improvement programme that enables and promotes independence and wellbeing in homely and welcoming surroundings. The values and core principles of the Framework underpin all the intermediate care services we provide, helping us to deliver a technologically advanced and consistent service.'* [36]

Unfortunately, the NHS has been an unreliable partner, often flirting with outsourcing the service to private sector companies, but then taking the ideas and protocols with the intention of doing it in-house – but then failing to deliver. In the case of King's, after months of negotiation with Four Seasons Health Care - a drawn-out process because of the NHS' distraction in running an always-on-the-edge operation - the board decided to pull the final contract because of fears that doing business with a private sector company would not 'pass the *Daily Mail* test'. The result was that patients suffered badly through the difficult winter period.

Most developed countries have an intermediate care sector. In the United States, there are two levels of intermediate care. Lower complexity units are called 'Intermediate Care Facilities' (ICFs) and are more similar to UK nursing homes. Higher complexity is handled in 'Skilled Nursing Facilities' (SNFs), which is usually funded by Medicare (the federal programme that covers all people over 65 who have contributed social security and Medicaid in their working lives). One provider of 'SNF' services is Optum, a part of UnitedHealthcare, the largest single health 'carrier' in the United States. Optum describes its service as:

- *'Optum™ providers help medically complex members residing in skilled nursing facilities receive the care they need before events escalate.*
- *Optum provider expertise in skilled nursing facilities.*
- *Shared member identification among Optum, health plan and skilled nursing facility.*
- *Initial comprehensive assessment by Optum provider at bedside, driving care planning and ensuring accurate HCC coding.*

- *Proactive, preventive/maintenance care plan developed collaboratively by Optum provider, care manager, primary care physician and skilled nursing facility.*
- *Family engagement and support of advance care planning.'* [37]

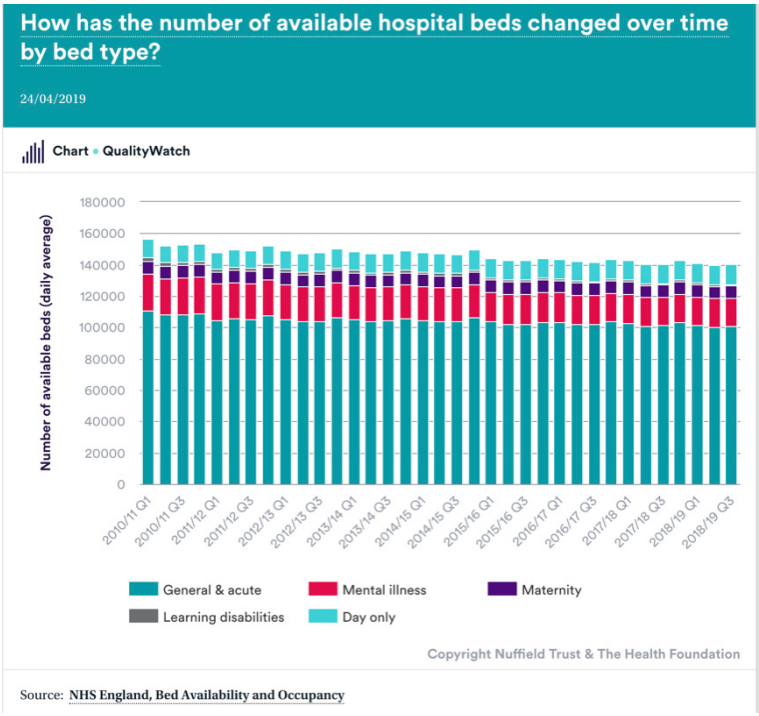
The priority is to invest in more beds out-of-hospital. The aim is to take the pressure off of the acutes and to avoid harm by discharging patients faster from hospital into suitable accommodation. There is a danger that putting more beds in hospital will divert attention from the priority of getting people out of hospital as quickly as possible. Once these beds are in place out-of-hospital, the analysis can be done to decide if more hospital beds are needed, but the decisions should come in that order.

It is likely that this analysis will indicate that more beds in hospital are, indeed, needed. The shortage of hospital beds was highlighted in the Covid-19 crisis. The UK has fewer hospital beds than nearly every other European country. The longer-term impact of Covid-19, due to social distancing rules, the requirement for staff to take time to put on and take off PPE, will likely mean that the UK needs to put more capacity into the system, and operate hospitals at rates of utilisation far lower than the levels of 95 per cent that pertained before the pandemic.

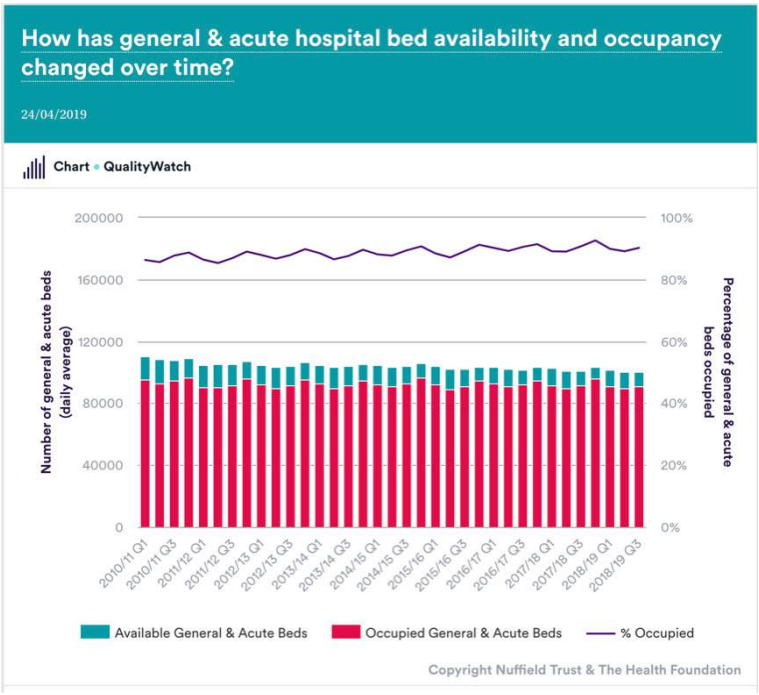
The United Kingdom has one of the lowest levels of hospital beds per capita in Europe. The UK had 2.8 hospital beds per 1,000 people in 2012, compared to 8.3 in Germany, 6.3 in France, 3.4 in Italy, 3.0 in Spain.[38] Given that we have lower levels of health and social care spending than any of our comparable European countries, we cannot afford to have hospital beds inappropriately used.

> *'The number of overnight NHS hospital beds has decreased over time for all bed types. Between Q1 2010/11 and Q3 2018/19, the number of general and acute beds decreased from 110,568 to 100,535 (a 9% decrease) and the number of mental health beds decreased from 23,515 to 18,407 (a 22% decrease). Pressures on the availability of mental health beds can occur because of delayed discharges, which may be a reflection of a lack of suitable community services. A consequence of pressures on these beds is that out of area placements occur, where mental health patients are sent far away from their home and support network.*

The number of beds for people with learning disabilities decreased from 2,465 to 997 (a 60% decrease) and maternity beds decreased from 7,906 to 7,649 (a 3% decrease). A shortage of maternity beds can lead to closures of maternity wards….The number of overnight general and acute beds fell by 9 per cent between Q1 2010/11 and Q3 2018/19, from 110,568 to 100,535. Over the same time period, the number of occupied general and acute beds decreased by 5 per cent, from 95,430 to 90,706. Therefore, the rate of general and acute bed occupancy increased from 86 per cent in Q1 2010/11 to 90 per cent in Q3 2018/19. This is concerning as rising general and acute bed occupancy rates are associated with worsening A&E performance.'[39]



Source: NHS England, Bed Availability and Occupancy



Clearly an investment in beds is likely to be required.

In summary, the UK is unusual in the developed world in that it does not have an intermediate care sector that is doctor-driven - as opposed to the care home and domiciliary sectors which are nurse - or care home assistant-driven). The ICS needs to have a clear, evidence-based view of what the capacity and funding constraints are, and have a plan agreed with corporate NHS to put in place adequate capacity and funding. This should be done, of course, after the inefficiencies in the current operation are eliminated.

Surprisingly, these 'gap analyses' do not exist at the moment. There are 'demand and capacity' plans in most (but not all) hospitals, but they don't exist at the ICS level. This is testimony to the fragmentation and disorganisation of the NHS and local authorities. Perhaps the money is not there, but we need to be rigorous in at least knowing what the gap is. And in doing this analysis we need to face down the politicians - within the NHS and in elected positions - who, too often suppress such information to avoid embarrassment amongst the electorate.

The new ICS system is an attempt to provide an integrated health and social care system. It faces almost certain failure if it does not address this issue of intermediate care.

Finally, the social care sector is ripe for investment in technology in order to both lower costs and improve the quality of care. Remote monitoring to make sure that people are safe when there is no direct human supervision is an obvious technology that would benefit the sector. The problem has been, however, that fee rates have been insufficient to consistently and sustainably fund investment in technology. The CQC has extolled the benefits of technology:

'Technology can:

- *give people more control over their health, safety and wellbeing*
- *support them to be more independent or feel less isolated*
- *link them to services which are important for them*
- *enhance the care or treatment providers offer*
- *help them communicate with families, professionals and staff*
- *help staff to prioritise and focus their attention on people who need it most*
- *capture and compare data, and share good practice with peers.'* [40]

The CQC can make sure these benefits are delivered by fixing fee rates so that providers can afford to deliver them.

The issue of the delivery of care home facilities and the potential development of an intermediary care capacity is poorly understood by the public. It is a perfectly reasonable question to ask if the nation wants its care home provision to be provided by the private sector, let alone private equity companies whose rates of return seem ill-aligned to the care home sector provided in some part by national government.

Similarly, if an intermediary sector is to be developed, and as discussed this does seem a sensible development, but how much money should be directed away from the acute sector in a country with one of the lowest numbers of acute hospital beds and should or could the NHS run such a facility? Whichever way it is approached, this is likely to increase not decrease health costs.

Provide clear executive authority

SECTION 4

Currently, no single person is in charge of the many 'moving parts' that comprise safe discharge of patients from hospital and their 're-entry' into a care home or their own home, and the diffusion of responsibility engenders confusion, misinformation, delay and blame-shifting. The answer is to have one person, inside the hospital, in charge and - by 'in charge' - that means the power to mandate that care packages are available, and that care home places are available. That means the authority over the total discharge and community resources and the process. In turn, this requires that the current budgets and commissioning responsibilities are absorbed into this discharge function from the local authority and the CCG.

This 'Discharge and Community Chief Executive' would have executive authority to manage the care pathways of patients across the various health and social care environments. In the context of the larger recommendations of this paper, the Discharge and Community Chief Executive would report to the chief executive of the Integrated Care System (ICS) who, as will be described in more detail in Book 9 of the Radix series, is the person with the authority and budget to manage across what were formerly responsibilities scattered across multiple NHS providers, CCGs, and local authorities.

A designated executive should be responsible for the entire patient pathway from hospital discharge wards into community-based care. Starting in the discharge ward, regular ward and 'board' rounds with a single authoritative assessment - board rounds are 'huddles' around a whiteboard - electronic bed management system in the future - to plan the rapid discharge of patients from hospital. This contrasts with what we have now: multiple, conflicting assessments from the many cluttered jurisdictions involved - and it will make sure patients are discharged quickly and safely. Information systems will tell the community-based care team where home care and care home beds are available. With care homes an integral part of the system, then techniques such as 'discharge to assess', whereby patients are moved to a care home instead of using a hospital bed as they await an assessment, will begin to have an impact. The executive for out-of-hospital patient flow would have full control of the funds that are currently spread, wastefully, across at least four different organisations.

Executive authority is necessary to:

- *Protect against any high-level turf wars, so that the team can give all its attention to managing care pathways for the 'named individuals' requiring discharge.*
- *Manage resources, especially pooled budgets, that can be deployed without wasting time and effort on cross-jurisdiction negotiations.*
- *Have the power to disband or co-opt overlapping teams or activities. For instance, in past years 'System Resilience Groups' (SRG) have been set up to try to expedite hospital discharges and mitigate the annual winter crisis of 'bed blocking'. Invariably, these SRGs have added more confusion to the problem and made things worse. They have also used up scarce managerial resources.*

There are inevitably limits to what this Discharge and Community Executive can do both if there are real funding and capacity constraints in the short term and when the problem is out of the area of the ICS (when they apply, for instance, to hospitals in Kent in the case of King's in south east London).

The incentives do not align people to work in the best interests of patients - that is, to effect a timely and safe discharge of the patient to an appropriate setting. Hospitals don't have extra beds, but they should not be penalised for that (the lost revenue for a hospital bed occupied by a frail elderly person that could otherwise be used for elective surgery is £1,300 per day). This should be the amount charged to out-of-town integrated care systems, or local authorities and hospitals that do not find a place for one of their returning local citizens.

Giving the funding mechanism to the ICSs will not of course alter the provision of services, nor will it improve the perceived financial returns to the private sector. The long-awaited review of social services which should include these two issues, is awaited with little sign of appearing any time before the next election.

Include hospital discharge responsibility for the CEO of community-based care

SECTION 5

Discharge from hospital is a major challenge – for instance, at King's College Hospital, London, about 150 patients are admitted each day, meaning that 150 have to be discharged given that the hospital is operating at full capacity (at least 98 per cent daily at King's, compared to 90.6 per cent average nationally.)[41] The problem of 'stranded patients' is growing (the hospital has about a thousand available beds):

- *Patients staying more than 7 days: 400*
- *Patients staying more than 14 days: 230*
- *Patients staying more than 21 days: 160*

King's is typical of a country-wide problem:

> *'Up to 18,000 'super stranded' patients remain in hospital after being medically optimised for more than 21 days, NHS chief executive Simon Stevens has stated. This is equivalent to the bed base of 36 acute hospitals being taken by patients who are not in need of acute care, but who are delayed for other reasons (choice delays, assessment delays, community services provision).'* [42]

When he gave evidence to the House of Commons Health Select Committee, Mike Farrar – then chief executive of the NHS Confederation – suggested that an estimated 30 to 40 per cent of beds are occupied by people who are there inappropriately.[43]

Given the way that the health and social care systems work today, getting people out of hospital in a timely and safe manner is not easy. To use the example of King's, but it is similar across the country, there are many things that can go wrong. These include:

- *Insufficient ward rounds where the responsible clinician and multidisciplinary team (MDT) can certify that the patient is fit to be discharged. Ward rounds are only conducted, typically, every 24 hours, which inevitably means that many patients spend an extra night in bed unnecessarily. This would involve a major re-configuration of medical practice as ward rounds are usually only conducted daily. It is of course possible to change the schedule but would involve not doing something else. Also on surgical wards, senior surgeons are usually in theatre and this must not be affected. However, given the will there probably is a way and the large increase in consultant numbers over recent years should ensure that two rounds can be done during the day if one is only to consider discharge.*

- *Often clinicians are, unsurprisingly, risk averse, and unwilling to sign a discharge form if the patient appears not to be stable. Indeed, it would be negligent to do so. At the Princess Royal University Hospital (PRUH), the incidence of decisions to discharge increased when a GP joined the ward round team. GPs tend to be more understanding of a patient's fitness to be discharged, and probably more aware, too, of the dangers of staying in hospital inappropriately in terms of the debilitating effect on the patient. GPs need to be seen as part of the team of the ICS not as independent practitioners who may or may not partake in the care of patients.*
- *Sometimes, there can be disagreement amongst the MDT about whether or not the patient is fit to be discharged, with the most risk-averse view prevailing. Therapists tend to be more risk averse than seasoned consultants. It was not uncommon at King's for consultants wanting to discharge their patients, to complain about being overruled by physiotherapists.*

Finding places for patients in the community is the biggest problem, and this has two drivers:

The first is the shortage of care home places in less affluent areas where there is a shortage of care home beds. The Tory cuts to local authorities have, predictably but still disappointingly, fallen on Labour councils that, obviously, tend to have the most deprived communities. This is certainly the case for King's in Lambeth and Southwark.

The second constraint is the availability of local authority funds to provide care packages for patients either in their own homes or in care homes.

> *'The most common reason for delayed discharge was health and social care reasons, including the lack of a social care package. The total number of days spent in hospital by people whose discharge was delayed in February 2019 was 40,813. This is a 6 per cent increase on the previous year. Of those delayed at the February 2019 census point, 1,122 were delayed more than three days, with health and social care reasons accounting for 808 (72%) patients and complex needs accounting for 267 (24%) patients.'* [44]

- *Even if funds are, eventually, available, local authorities often 'draw out' the discharge process to buy time to find the funds. Getting patients placements can take up to a week. Co-ordination difficulties also put delay into the process. The local authority liaison people have to be in the hospital to agree the decision to discharge, but they are not always there when the decision is being made. There is no penalty on the local authority or the CCG for failing to support rapid discharge of patients.*
- *An additional problem for tertiary care centres is that they take the most serious clinical cases from a region or nationally but the 'local' authorities are not local - adding further complexity and there is no penalty to them for not taking back their patient.*

Three major, underlying problems are contained in the description above and they, in turn, drive the solutions. These three problems/solutions are: the need for a single point of executive authority across all NHS providers and the local authorities; investment in funding and capacity; aligning incentives to support pressures from 'out of area'. Each of these are considered later in this book.

WARD AND BOARD ROUNDS

Ward rounds are not well-managed:

> *'Despite being a key component of daily hospital activity, ward rounds remain a much neglected part of the planning and organisation of inpatient care. There remains considerable variability in both the purposes and conduct of ward rounds, with nurses often invisible in the process. The importance of these clinical events to patients is often underestimated, along with the direct impact ward rounds have on clinical and emotional outcomes for patients.'* [45]

Yet they are a vital part of the clinical and nursing process, especially for elderly patients with co-morbidities, 25 per cent of whom are living with dementia:

> *'Medical ward rounds are complex clinical activities, critical to providing high-quality, safe care for patients in a timely, relevant manner. They provide an opportunity for the multidisciplinary team to come together to review a patient's condition and develop a coordinated plan of care, while facilitating full engagement of the patient and/or carers in making shared decisions about care. Additionally, ward rounds offer great opportunities for effective communication, information sharing and joint learning through active participation of all members of the multidisciplinary team.'* [46]

Ward rounds are when the lead clinician and the MDT move from bedside to bedside. Board rounds are done in a 'huddle' around a whiteboard that contains details about the patients. Medical staff are now increasingly using 'board rounds', usually held next to an 'at-a-glance' white board, away from the bedside. In the future, these board rounds should update an electronic profile that is linked to the bed management system, so that the information is universally visible.

Board rounds provide an opportunity for multidisciplinary teams not only to prioritise bedside reviews, but also to deal with non-medical issues, such as discharge planning, in a timely fashion. These rounds can also provide a chance for the team to rapidly review any outstanding medical or nursing issues, like communications between the nursing staff and the relatives, input from other healthcare professionals. Board rounds conducted at the end of the ward round can provide an opportunity for the team to summarise all the issues relating to patients' care, identify and prioritise tasks, and delegate responsibilities appropriately. The arrangement of board rounds should address the specific needs of the patient, maximise the effectiveness of time spent by the bedside and minimise any disruption to the process of daily patient reviews.

Discharge planning needs to be a core part of the ward and board rounds:

> *'Discharge planning is an integral part of ward rounds and patient involvement should be encouraged. This includes setting an estimated date for discharge, with appropriate multidisciplinary input, such as physiotherapy, occupational therapy and social services support. All too often patients are relied on to convey complex and nuanced information to colleagues and services in the community, without clear verbal or written instructions from the hospital team. Taking a planned approach to discharge helps prevent readmission. This could include: (1) a pre-discharge board round to clarify outstanding issues that require resolution; (2) conducting a discharge meeting in a separate room in the presence of the multidisciplinary team and representatives of the patient; and (3) taking a checklist approach to ensure that key safety aspects of the discharge process are not overlooked. Before discharge, the patient should be provided with a thorough, detailed plan on how to manage his or her care outside hospital. Relatives and carers should be notified of the discharge date and time at least a day in advance, ideally with more notice.'* [47]

A single person needs to be responsible, hospital-wide, for managing ward rounds. Preferably this person is a senior therapist, and their responsibilities are to make sure (a) that ward and board rounds are happening (b) that discharge planning is a key part of the process.

A SINGLE VIEW OF BED CAPACITY ACROSS HEALTH AND CARE ECONOMIES

Much greater co-operation with the local care homes and domiciliary care providers is vital. The Discharge and Community Chief Executive needs to have real-time access to bed availability in care homes, and a deal in place that pays the care home to take patients at all hours of the day. There is more availability of care home beds than is imagined – it's just that people don't know they are there. For instance, CHS Healthcare, a company that manages the discharge process, carried out an audit at King's College, London in February 2018 assessing available care home beds within a 7.5 mile radius of the hospital. Two hundred Care Homes were surveyed, and out of a total capacity of 8,668 beds, 571 - or 6.1 per cent - were empty.

The chaotic and ill-informed operations of discharge teams in many hospitals means that such bed availability is too seldom accessed. The largest four care home providers have visited corporate NHS at the start of the past ten winters, saying that over 20,000 beds are available for patients. The constraint has always been that the chaotic and ill-informed (and often overwhelmed) NHS managers have not agreed to meet and make arrangements with the care home providers. The pandemic has made this even worse but there can be no excuse for not co-ordinating this capacity and for it to be fully shared across the sectors to permit the kind of integrated care advocated in this book.

Sometimes, the reluctance to do business with the care home providers is based on a dislike of the private sector. It certainly is not in the best interests of patients. Sadly, the combination of low fee rates for local authority residents of care homes, and the failure of hospitals and CCGs to use the capacity, and this is despite the attractive economics: hospital bed blocking is very expensive, costing from £1,750 a week up to over £3,000 for an acute bed at end of life,[48] compared to about £800 to £1,000 for equivalent care in a nursing home bed.[49]

A SINGLE ASSESSMENT

One of the problems with efficient discharge is that there are multiple and different assessments made about whether the patient is medically fit for discharge, what care package that patient requires, demographic and personal data, and so on. The Discharge Chief Executive needs to have one person responsible for organising (or making) the assessment and the content has to be universal enough that it is understood and acted upon, without question, by all the players responsible for the process of getting the patient back home and set up with a care package.

> *'A Trusted Assessor carries out assessments of hospital patients on behalf of care homes, who need to consider what the patient's needs are and whether they would be able to meet those needs. One of the main causes of delay to hospital discharge is the time taken by care homes to carry out assessments of individuals who are in hospital and are transferring out into 24-hour care. The hospital may be a distance from the care home location and care providers may find it difficult, with staffing pressures, to travel to hospital to carry out their own assessment within a short timescale. The Trusted Assessor Model is based on having a dedicated person, trusted by care homes and all agencies, who is wholly focused on carrying out hospital-based assessments, covering a number of acute services locations.'* [50]

Another service that is a capacity constraint is the process of 'Discharge to Assess' (D2A). The aim of D2A is to discharge all patients as soon as they are medically fit (optimised) to leave hospital and to make sure that any health and social care assessments are carried out, outside hospital and ideally after a short period of intermediate care (rehabilitation or reablement) that can improve outcomes. Instead of the multiple assessments that currently take place in a busy hospital ward (the hospital team, the local authority team, and so on), the D2A scheme is based on just one assessment and the health and social care teams need to agree the assessment required and who will conduct it. The decision should be primarily based on whether the patient is fit for discharge and which discharge pathway is appropriate.[51]

These pathways are commonplace now in most efficient health economies:

Pathway 1 – *discharge home with therapists or carers visiting to support discharge.*

Pathway 2 – *discharge into a nursing home for 21-28 days with active physiotherapy and occupational therapy aiming to subsequently discharge home or if necessary to a long-term care home.*

Pathway 3 – *discharge into a nursing home restricted to patients who may qualify for Continuing Health Care (CHC) funding as their needs are more complex. This is paid for by the NHS and is for patients who still have acute medical needs.*

THE DANGERS OF EXTENDED HOSPITAL STAYS

There is considerable damage to frail, older patients as a result of admission to busy, crowded acute hospitals that are not designed to deal with this older population, especially if they are living with dementia and are confused and disorientated.

In a Dutch doctoral thesis, it was recorded that:

> *'An especially vulnerable group within the 65+ population are hospitalised older people. Among this group, around 30 to 60 per cent have been reported to develop functional decline during or after their hospital stay.[52 53] Previous studies have claimed that among hospitalised older people, functional decline is only partly (20 per cent) related to the diagnoses for which people were admitted,[54 55] thus implying that hospitalisation itself leads to functional problems as well. Factors associated with functional decline during hospitalisation, such as decreased food intake, long term bed rest, feelings of social isolation and depression are numerous.' [56 57]*

The effect of inappropriate hospital stays for the frail elderly can be deadly.

> *'Stopping bed-blocking can cut a hospital's death rates as well as reduce A&E waiting times, according to research. A district general hospital in Derby introduced a target that only 90 per cent of medical beds should be occupied at any time in July 2013. As bed occupancy fell from 94 per cent to 90 per cent, death rates fell by about 5 per cent. The proportion of weeks in which the trust met the four-hour A&E waiting time target rose, from 33 per cent to 51 per cent. To get bed-blocking down, the hospital introduced daily ward rounds by senior doctors, increased the number of beds in community facilities and made surgical beds available for medical patients….*

….In the year to July 31, hospital beds in England were blocked for the equivalent of 1,685,604 days by patients who were ready to go home, an increase of 16 per cent on the previous year.' [58]

The point about the damage caused through inappropriate hospitalisation of frail, older people has been well researched, as is referenced in this piece from the King's Fund:

'Many older people with multiple medical problems are also frail. The impact of contact with a hospital – how they come into it, what happens when they are there, and the process of leaving – can determine the direction their life takes thereafter…. Too often, for many older people, a stay in hospital is disempowering: the environment itself, the noise, and the routines on the wards overwhelm and undermine them in ways that affect their ability to recover who they were and how they were living before they were admitted.

There is mounting evidence that the standard of care received by many older patients is unacceptable, and part of that picture is that care is fragmented and lacks continuity… Patients are moved around very frequently – from bed to bed and bay to bay on the same ward, and often from one ward to another. Handovers between professionals and teams are poorly planned and executed, and care is also poorly planned and co-ordinated.

Patients and staff report the dehumanising experience for patients of being moved around inside hospitals 'like parcels'.[59]

The result of bed shortages and bed blocking is dangerous not only from the perspective of lack of availability of beds for patients with acute needs, and not only for the harm that it does to frail elderly patients, but it is also far outside of safe levels of infection control:

'Infection control experts advise that bed occupancy should not rise higher than 85 per cent because of an increased risk of superbugs when there is not enough time to clean beds properly between patients.' [60]

As stated above, hospital bed blocking is very expensive, costing from £1,750 a week[61] up to over £3,000 for an acute bed compared to about £800 to £1,000 for equivalent nursing care in a nursing home bed.[62] Addressing this alone could potentially save billions of pounds over a few years. Moreover the patient could receive the same or better quality of nursing care in more appropriate care surroundings, delivered by staff with experience in specialist older and dementia care, and with less risk to them of hospital-acquired infections.

> *'It's been estimated that the problem is so bad it costs the NHS around £3bn a year and cancelled operations, due to bed blocking, are thought to cause around 8,000 deaths each year.'* [63]

Learning from other countries: *The Netherlands and Germany*

SECTION 6

Clearly the UK is not the only country with an ageing population, and other European countries are trying to wean themselves off an economic system that allowed high spending in the short term together with lower taxes, all to be paid for by a demographic quirk that meant the working age population was much larger than the retired, pensioned population. This demographic quirk has now unwound, and it is now no longer possible 'to kick the can down the road'. It's not easy. But there are lessons to be learnt from other countries. In this section, the systems in Germany and the Netherlands are examined. Neither system is perfect and they face difficult choices. Yet they have managed to develop a system of social care that both raises more money for a better funded social care system (as described in the earlier book in the Radix series on funding) and one that is more stable and agile in serving the needs of the vulnerable adult population.

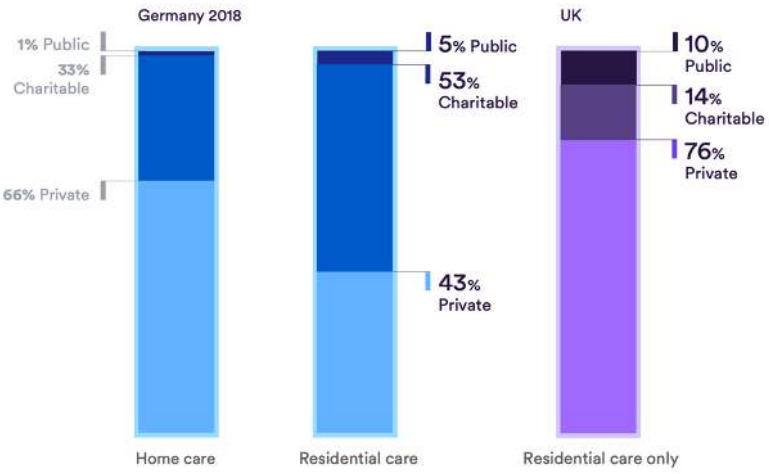
SOCIAL CARE SERVICES IN GERMANY

In Germany, to deliver services within the Long Term Care Insurance (LTCI) framework, providers must be registered with LTCI funds at a state level.[64] Providers of home and residential and nursing home care come from the public, voluntary and commercial sectors, as shown in the chart below. It is a plural system, which is also true of healthcare providers such as hospitals, and such plurality creates firmer foundations for new entrants to refresh the market.

This differs from the UK where the healthcare market is almost totally state-owned, which constrains innovation, and the social care market is largely an unregulated private sector, one that permits destabilising financial manipulations that profit private equity companies. The extreme calls to nationalise the care home market in the UK are unnecessary – and would in fact be very costly, disruptive and ultimately result in public sector waste and underperformance. Germany shows that a mix of providers is not only possible but desirable.

The market for care in Germany is stable and buoyant and there are few concerns about provider instability. There is light-touch, but rigorous, regulation and an inspections regime intended to give a marker of quality to providers.

Care providers by ownership: Germany and UK, 2017



Source: Germany: Statistisches Bundesamt, 2018 ; UK: Laing, 2018, table 2.3.

Individual providers or provider associations negotiate the fees they are paid for services with LTCI funds and social welfare authorities. Although these fees are negotiated on a local level – in order to offer flexibility to meet local needs – they are governed by state and national-level contractual frameworks. This is the type of 'national platform' that the UK needs. Fee negotiations happen regularly and consider current and future cost pressures, which ensures that provider costs are adequately covered. Negotiations also set the prices that providers can charge individuals for bed and board. This means that individual providers cannot charge differential rates for the same service, but there are regional variations in prices.[65]

People in need of social care are assessed by the Statutory Health Insurance Medical Review Board and, if they meet the threshold for care, are put into one of three levels, according to their needs.[66] Eligibility for support is dependent on how often help is needed with personal care and housekeeping and also the amount of care provided by informal carers.[67] Germany operates a system of personal budgets which puts money into the hands of the users so that they can choose which provider they want to use. This is an important process for making sure that providers of good care grow and prosper and that the providers of poor care go out of business.

There is a limited application of personal budgets through local authorities in the UK, but their introduction, championed by the Labour government (1997-2010), has been consistently resisted by the NHS. In Germany, people may receive benefits in cash, which they can use to pay family carers, to pay an agency for care or even to carry out house renovations to make their accommodation accessible; or they can choose to receive in-kind service benefits, where care is provided by an agency under contract to the insurance company.

They can also choose a combination of both.[68] The direct service benefit is financially worth more than the cash payment. For example, a patient who needed 24-hour care at home would receive in-kind benefits to the value of £1,200 per month, but would receive cash payments of only £550.[69] Levels of support range from £370 to £1,300 for services in-kind, and are between £870 and £1,280 per month for residential care.[70] Payments are not made until six months after an individual is assessed as being in need of care. LTCI benefits are not expected to cover the full costs of care, and the scheme does not cover the cost of accommodation in institutional care, so people are advised to buy supplementary private insurance to cover these costs.[71]

In 2009, around 3.5 per cent of the German population aged over 40 had this type of LTCI plan, which is an indemnity plan that pays out a set annual sum once someone is considered to be 'dependent'.[72] There is a safety net in the form of means-tested social assistance administered by the Laender (federal state), for those who are not able to cover non-insured costs. The number of people relying on means-tested assistance has fallen since the introduction of Supplementary Health Insurance.[73] All benefits are universal across the country. They are reviewed to check that they are adequate every three years.[74]

Germany has a devolved system of government. Federal states are responsible for providing the infrastructure for social care, for example, making sure that there are enough nursing homes.[75] Nearly all social care, including institutional and home care, is delivered by private providers – either for-profit or non-profit organisations. In 2003, there were 9,200 accredited nursing homes: 8 per cent were owned by public providers, 36 per cent by private for-profit providers and 56 per cent by non-profit organisations.[76] Today the number of care homes has risen to nearly 14,500, many of them new build. Clearly, Germany is doing a good job at caring for its vulnerable adult and elderly population by providing the funds for well-regulated private sector companies to invest in new stock, and to provide services without making excess profits through financial manipulation.

LTCI benefits are not expected to cover the full costs of care. They are well below the benefit levels in Japan, for example. However, the LTCI fund faces shrinking revenues and increasing expenditures. Many commentators believe further reforms will be necessary.[77] One estimate is that the payroll tax rate for LTCI will have to increase to 4.5 and 6.5 per cent by 2055.[78] The German social insurance system is built around the contributions of family as care givers, the algorithm used to assess the level of care awarded takes into account informal carers. Childless people are required to pay 0.25 per cent more in insurance contributions than those with children, and benefits in cash (which can be used to pay family carers) are of less value than those given in services.[79]

During the Covid-19 crisis, the Germans put a protective ring around their care homes and treated them exactly the same as they did their hospitals. Care home deaths in Germany were far lower than in the UK.

SOCIAL CARE SERVICES IN THE NETHERLANDS

Similar to Germany, the universal social insurance scheme, called AWBZ, pays for care of older and disabled people. It covers home care and care provided in residential facilities, including accommodation costs. It also has close links with the health insurance system as long-term hospitalisations, rehabilitative services and nursing care are also covered by the programme.[80] The extent of care provided is determined by a single needs assessment, and a complex set of cost-sharing arrangements apply.[81] In the Netherlands, the various parts of the system are joined up – in the way advocated earlier in terms of a single 'Discharge and Community CEO' – so that customised and integrated care pathways can be managed across hospital discharge and care in the community,

Patients have the option to receive services 'in kind', or to receive a personal budget to pay for personal care, home nursing, and support with daily activities. The budgets are calculated based on the number of hours of care needed, and patients must top up their budget with income-related contributions to buy the level of care they are assessed to need. As recommended earlier, this system of co-payments brings more money into the health and care system. The budget can be used to pay relatives for providing informal care, and carers can also apply for a 'compliment for carers' payment worth around £200.[82]

Demand for personal budgets has, predictably, been high and the system has struggled to cover costs. The Netherlands is not immune to the pressures that the UK is facing. In July 2010, the programme ran out of money and 13,000 applicants had to join a waiting list to receive their benefits.[83] The government has restricted eligibility to help it meet rising demand.[84] The Netherlands was the first country to establish a universal social insurance scheme for social care needs in 1968.

Dutch expenditure on long-term care is the highest in the OECD at 3.7 per cent. Recently the government restricted eligibility criteria for personal budgets, explicitly detailed the 'customary care' that family members are expected to provide that would not be covered by the programme, removed services such as home cleaning from the programme, and targeted care on those most in need through stricter needs assessments. There is debate about how to make sure the future system is sustainable. Cost control proposals include no longer reimbursing residential costs in nursing and residential homes, or merging the programme into the national health insurance scheme.[85]

The compulsory social care insurance scheme is administered by private insurance companies and paid for via an income-related premium deducted from the wages of all citizens aged 16 and over, and an employer contribution paid for via payroll taxes.[86] Individuals who use services also have cost-sharing obligations that vary depending on their income level, their family status and the location of their care. Approximately three-quarters of the programme's costs are paid for by individuals via co-pays or premium contributions, with the rest covered by the general insurance fund.[87]

In 2009, the social care system contained 479 nursing homes for people needing constant nursing care, and 1,131 residential homes for those with lower level care needs. This has risen by about 10 per cent since that time to cater for the ageing population.[88] There are also 290 combined institutions. Home care is provided by residential homes, nursing homes and home care organisations. The level of support they provide varies but, for almost 40 per cent, the support is very low level help with housework.[89] The number of people receiving home care is on the rise, while the numbers in residential and nursing homes has been falling.[90]

The Dutch system of plurality of providers – state, non-profit and for-profit – creates a competitive environment with low 'barriers to entry'. In these circumstances, innovation is enhanced. The case of Buurtzorg, a private sector company that has found novel ways of delivering domiciliary care, is set out on the following page.

BUURTZORG: THE DUTCH APPROACH TO COMMUNITY CARE

The UK system of community care is messy and inadequate. It not only suffers from chronic underfunding, but it is also based on outdated and chaotic practices. Carers are poorly trained, they are task- (rather than patient-) driven and there is very little continuity of care.

One of the most celebrated international models is the Buurtzorg approach in the Netherlands. Buurtzorg is a competitive private sector company, and it has grown through innovating the way in which care is delivered – and maintained.

Buurtzorg operates in a competitive insurance-based marketplace where patients can choose their provider based on a number of considerations, including: cost, extent and quality of cover provided and reputation. Buurtzorg's approach has enabled it to outmanoeuvre many of its competitors in all three of these areas.

Nurses lead the assessment, planning and co-ordination of patient care. The model consists of small self-managing teams, each with a maximum of 12 nurses. Sometimes a team will also oversee Nursing Assistants (the Dutch equivalent to Health Care Assistants). Teams provide co-ordinated care for a specific catchment area, typically consisting of between 40 to 60 patients. The composition of these teams in terms of specialty and level of practice varies according to the needs of each catchment area.

A significant reason why Buurtzorg has managed to provide excellent patient-centred care at competitive rates has been its approach of putting patient self-management at the heart of its operation. How this works is that each new patient relationship begins with high levels of support provided by the team. This is then gradually withdrawn as self-management aids and supports from social care, voluntary and third sector organisations are identified, assessed and put in place. This approach cuts long-term care costs by between 30 to 40 per cent and supports a national policy aim of delivering care closer to home or in a homely setting. In the Netherlands, integrated care is easier to deliver because district nurses tend to be well-known in the small neighbourhood in which they work. This helps them to build good working relationships and strong dialogue with GPs, welfare and social care providers, police and paramedics.

Buurtzorg offers six key services. These are:

1. *Holistic assessment of the client's needs which includes medical, long-term conditions and personal and social care needs. Care plans are drafted from this assessment.*
2. *Map networks of informal care and assess ways to involve these carers in the client's treatment plan.*
3. *Identify any other formal carers and help to co-ordinate care between providers;*
4. *Care delivery.*
5. *Support clients in their social environment.*
6. *Promote self-care and independence.*

Buurtzorg cares for patients who are terminally ill, suffer from long-term conditions, dementia or require home care following major surgery. Most of the nurses who join Buurtzorg are trained at a 'generalist' level (similar but not directly equivalent to a UK Registered Nurse in Adult Care). This allows them to deliver treatments from wound care and diabetes monitoring to intravenous infusion therapy and end-of-life care.

CONCLUSION

Whilst the gap between the provision of medical care between the UK and Germany and the Netherlands is recognisable, the gap between social care in the three countries is of a different order of magnitude.

The quite legitimate argument is that many of these differences arise from a chronic underfunding of the NHS, and that if this simple issue was addressed all would be well. Nothing could be further from the truth. There is a fundamental underlying flaw in the way that the UK pays for and runs its health and social care system that is itself a product of the Beveridge/Bevan solution.

The Beveridge solution is predicated on the payment for health and social care from direct taxation. Quite a reasonable proposition in 1948 when the age distribution of the population provided for a small number of elderly patients who needed health and social care and a large number of younger citizens who did not need them. This luxury has now been completely transformed and the population distribution has become inverted with a large number of elderly non-working population needing health and social care and a small and diminishing number of a younger population expected to pay for them from their direct taxation.

Effectively, it is a large social experiment comparing Bismarckian, social insurance solutions with a Beveridge direct taxation solution. The former permits a measure of accumulation by the individual over their own lifetime to accrue at least some funds to cover their health and social care needs for their later life. The latter has no such possibility and worse, it is open to the economic vagaries that are inevitable to arise to a nation, such as a war in Ukraine. The insurance model can of course be dealt with either by personal insurance rather like the United States, or a government funded system as in social insurance as practiced on the continent or a mixture of the two. No other country has copied the UK in its model except New Zealand.

An even more malignant consequence of this truth is that it has driven the growth of an over-centralised Soviet style caucus, currently NHSE, which desiccates local innovation, hinders co-operation between the NHS and local authorities and worst of all prevents a rational and perhaps even more cross-party support for long term investment in the NHS in the form of buildings, equipment and most important of all workforce. It has bequeathed the country a dysfunctional healthcare system.

These matters will be considered in greater detail in the ensuing books.

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Professor Stephen K Smith (DSc, FRCOG, FMedSci) has a wide international experience in transformation of healthcare systems and led the creation of England's first Academic Health Science Centres with the merger of St Mary's Hospital and the Hammersmith and Charing Cross Hospitals to create Imperial College Healthcare NHS Trust.

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His pioneering role in establishing AHSCs was recognised in the NHS Leadership Awards, where he was named as the Innovator of the Year in 2009. His contribution to this book-series is solely in a personal capacity.

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