DELIVERING CARE IN EVERY SETTING: RESULTS OF A SURVEY OF NHS TRUSTS AND FOUNDATION TRUSTS

INTRODUCTION

An online survey was sent to chief executives, chief operating officers and finance directors of hospital, mental health and community trusts on Wednesday 7 December and closed on Friday 9 December. We received 109 individual responses, representing 97 providers – 41% of the total provider sector. Responses were received from all provider types and all regions. The survey asked them about capacity and supply of 'out of hospital' care and the impact on their services – termed as 'intermediate' care.

It is important to note that the interpretation of 'intermediate care' by respondents was varied and therefore the services referred to here cover a broad spectrum that includes step down and step up bed capacity, as well as social and home care.

CONTEXT

Trusts are facing significant increases in demand for their services as a result of demographic factors and pressures on primary and social care provision. This rising demand comes at a time of severe financial constraint and has resulted in clear pressures on A&E departments and other frontline NHS services. A key priority for the NHS, as set out in the *Five year forward view*, has been to move care out of hospitals both to alleviate this pressure and deliver care in the most appropriate setting.

However, this priority is being undermined by reductions in the number of beds and other community provision which appear to stem from a combination of factors. These include the incorporation of dedicated financial support to ease 'winter pressures' in to the baseline of clinical commissioning group budgets alongside the overall reduction in both local authority and CCG budgets. These have impacted on the overall provision commissioned.

Furthermore structural issues are also having an impact on capacity. Commissioners report that the way the payment by results tariff works means that they tend to consider direct hospital activity first, before decisions about community provision and intermediate care are made. Finally recent evidence has shown that the Better Care Fund allocations are not necessarily making the anticipated impact on managing demand for hospital services.

KEY MESSAGES

1. Mismatch between demand and capacity – The survey responses show that there is a clear mismatch between current demand for services in the community – such as step-up and step-down beds, rehabilitation services, care at home – and the ability of providers to meet it due to capacity shortages.
   a. 46% of respondents reported that the current intermediate care capacity in their area doesn't meet demand.
   b. For nearly half of respondents (48%) this mismatch is a combination of both increases in demand and capacity being taken out of the system.

c. 52% of respondents reported that over the last two years intermediate care capacity in their area has changed and they are now less able to meet demand.

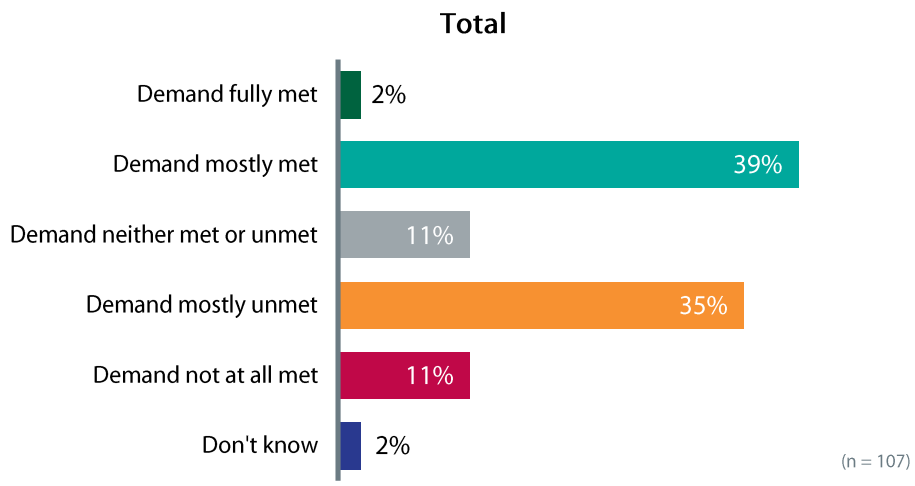
2. Care at home – There was greater concern around lack of resource for providing care at home services than for intermediate care beds: *"intermediate care capacity would be sufficient IF ongoing social and community care was available to support discharge from intermediate care beds."*
3. Variability – Many respondents mentioned variability within their area in the availability of services: "*Capacity in [the county] is all in the wrong place with too much provision for the population needs in the south and not enough in the north."*
4. More complex needs – While many referenced an increase in demand for many it was about increases in the acuity and complexity of patients requiring intermediate care: *"The complexity of patients is much higher requiring specialist equipment and more intense therapy."*
5. Staffing – As with many areas of the NHS, staffing issues were raised: "*A unit was closed over 12 months ago due to staffing issues"* and *"Main issue in this trust is difficulty recruiting and retaining district nursing staff."*
6. Reduced capacity – Many respondents noted that bed capacity had been reduced; this was across a range of services including nursing home beds, care home beds, intermediate care beds, community beds, and rehabilitation beds. Bed capacity has been lost due to decommissioning of services, lack of funding, lack of available staff and also restrictions placed on providers by the Care Quality Commission.
7. Transformation – When asked whether reinstating the lost capacity would enable them to meet the demand the majority said it would only partly meet demand or that transformation was needed to make it effective: *"Not sure capacity ever met demand so would need more than previously but also its about the right type of capacity (social worker and package of care would make the biggest difference for this system)."*

SURVEY RESULTS

Figures 1 to 3 below show the results of the quantitative questions in the survey; each question shows the overall response and is then broken down by trust type and region. Sample sizes for ambulance providers and specialist providers were too small to be included, and the data for mental health trusts should be used with caution due to the small sample size.

FIGURE 1 – CAPACITY VS DEMAND

To what extent does the current intermediate care capacity in your area meet demand needs?



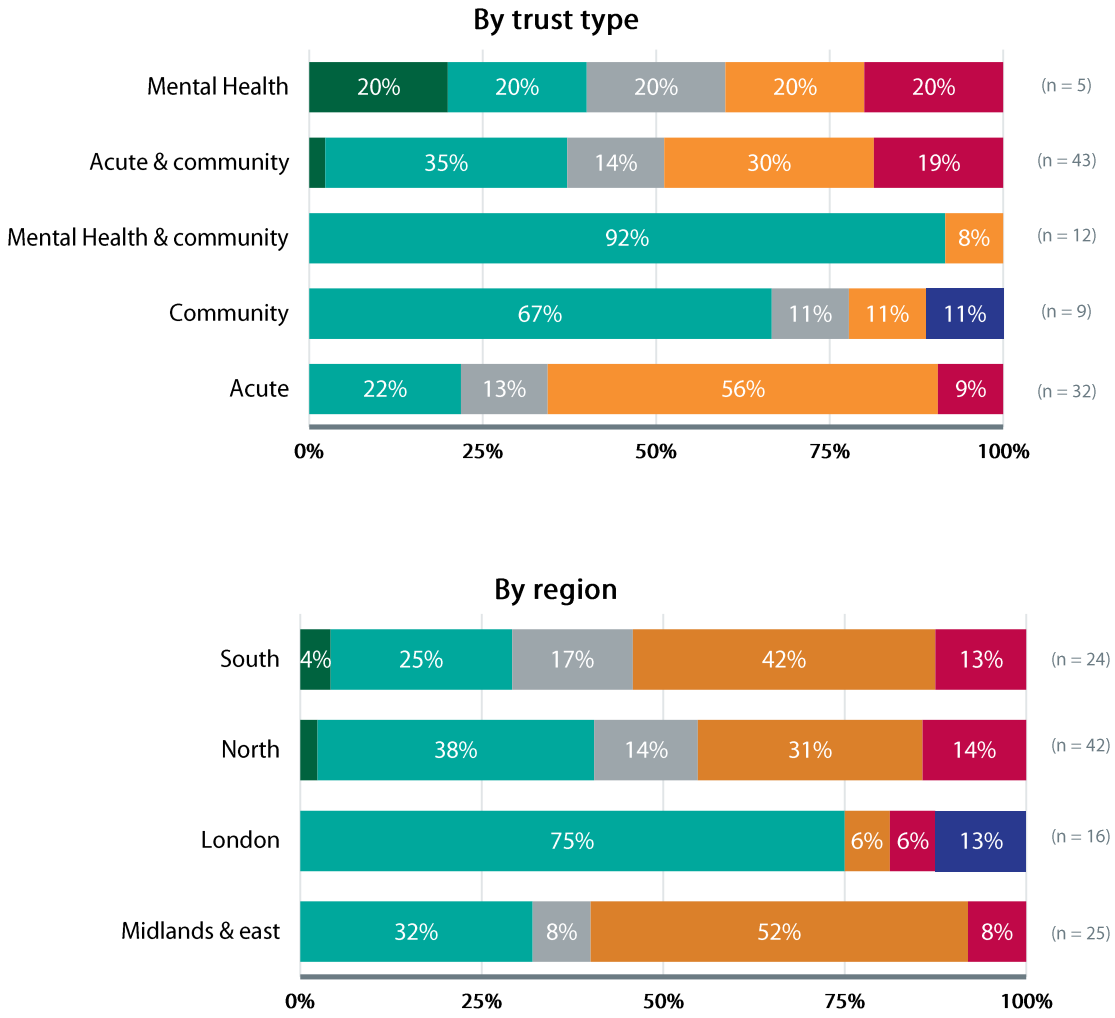
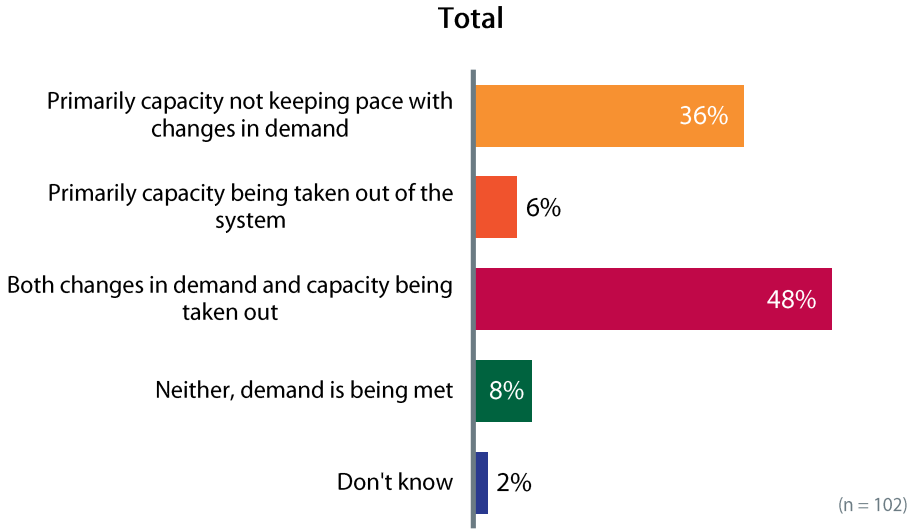


FIGURE 2 – REASONS FOR MISMATCH

If there is a mismatch between intermediate care capacity and demand to what extent is this:



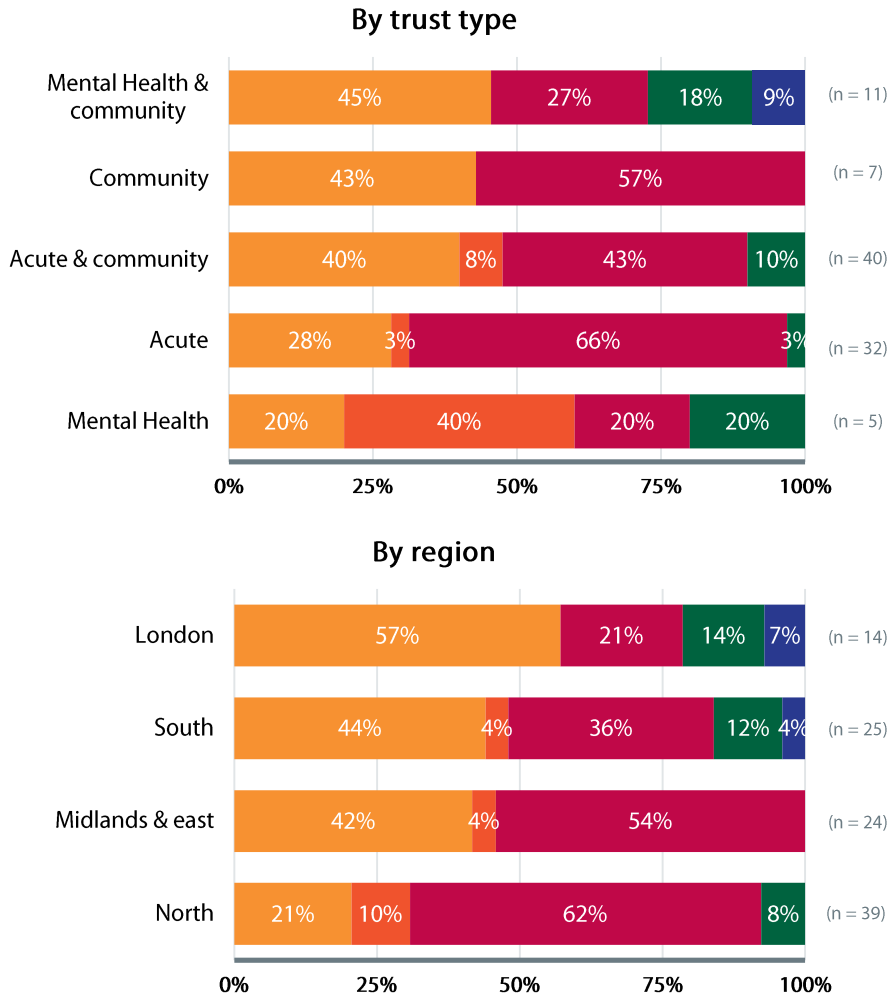
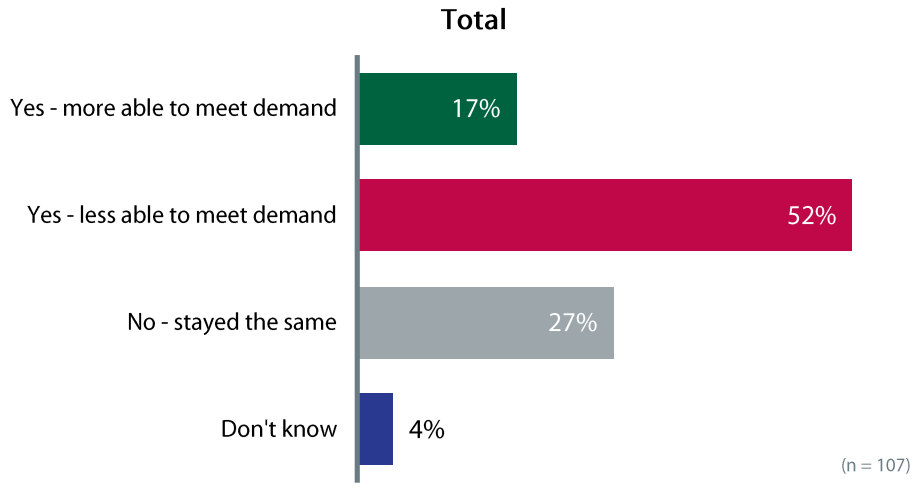
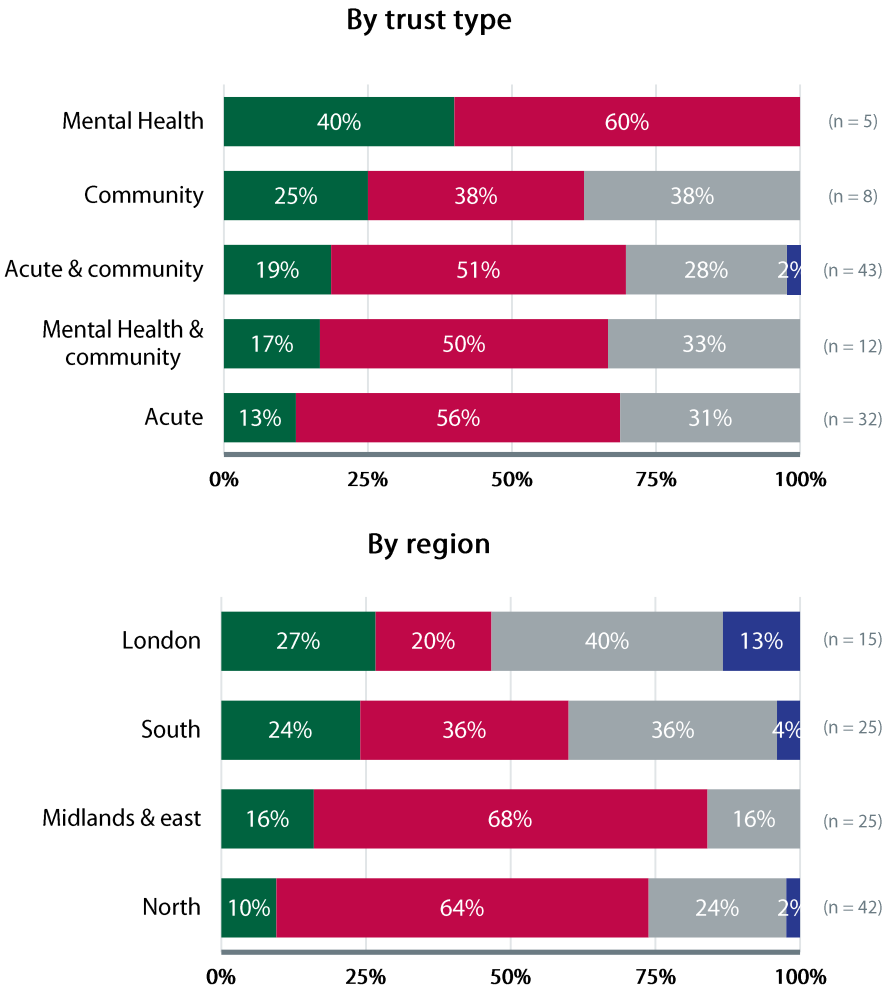


FIGURE 3 – CHANGE OVER THE LAST 2 YEARS

Over the last two years, has immediate care capacity in your area changed?





LOST CAPACITY

In the commentary trusts noted that where intermediate care capacity had been lost this included pure decommissioning of bed stock (e.g. community step down and step up beds, residential care home beds, and rehabilitation beds within NHS providers); workforce reductions in intermediate care services; and higher referral thresholds for intermediate care services. Respondents detailed:

- Reductions in bed numbers of between 5 and 100 beds, depending on trust size. One trust has lost almost half of their available intermediate care beds.
- Two mental health and community providers had lost 5 or 6 whole time equivalent (WTE) posts.
- One trust noted that six large nursing homes have closed in their area.
- Others commented on the reduction in acceptance of new referrals into domiciliary (i.e. home) social care.

We also asked trusts what level of investment would be required to reinstate intermediate care capacity. Several trusts noted that significant financial and workforce investment would be needed to return service levels to previous levels:

- Some trusts provided an annual cost to reinstate intermediate care capacity, this ranged between £0.5 million and £5 million.
- Others indicated it would be the full cost, including all equipment and overheads, of employing, for example, six additional WTE staff.
- And others described it in terms of the number of beds; with one respondent saying they would need funding for an additional 90 community beds to support flow out of the acute hospital.

However, many providers also noted that while this return in capacity would be welcome it would need to be supported by more fundamental service redesign and transformation of services to ensure patient needs could be met sustainably in the future.

ILLUSTRATIVE EXAMPLES

Acute and community provider in the south

For the past three years this trust has contracted a number of residential care home beds and employed a dedicated team to support a significant number of patients in assessment and longer term rehabilitation. This is the only significant capacity for non-weight bearing patients in the area. The beds have been de-commissioned and from early next year there will be no further admissions. This is expected to have a significant impact on acute beds as no other procurement of beds for these patients is planned.

Acute provider in the south

One provider in the south told us that *"there is currently no formal intermediate care provision locally provided by the community provider or social care"*. The trust has procured intermediate care from a local nursing home, supported by hospital staff delivering rehabilitation therapy into the nursing home.

Acute provider in the midlands and east

This trust estimates that at any one time 40% of patients who are medically fit to leave hospital are waiting for intermediate care, with a particular need for care in patient's homes. Financial pressures have seen a rehabilitation unit close and a decrease in the number of nursing home placements. Rather than re-opening the unit at an estimated £2 million, the trust said *"the funding would be better spent enhancing domiciliary care and home based therapies services."*

Acute and community provider in the north

This trusts' local authority has been reducing its own intermediate care capacity, planning to replace it with private sector capacity. However, this hasn't happened and capacity has therefore steadily declined as private providers are not entering the market. The trust currently has over 70 surge beds open to try and deal with demand.

Mental health and community provider in the north

This trust is working across the system to change the offer for intermediate care to focus more on rapid and medium term response in the community to prevent admission to acute care and discharge straight home. Plans are in place to reduce bed base and increase community but resources need to be shifted to facilitate this. However, the increasing complexity of patients is placing pressure on staffing and the skill mix required.

Acute and community provider in London

This provider has developed a range of home based intermediate care services. Their biggest challenge at the moment is recruitment and retention of staff to deliver the services. The impact of the restrictions to recruiting agency staff has made this more difficult as they find that many therapists in London are not looking for NHS contracts of employment.

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