care mechanism such as the Better Care Fund (or a similar approach) so that areas use existing mechanisms to support this.

NHS paying for packages

This should be legally possible under Section 3 of the NHS Act, which gives the NHS a wide scope for putting arrangements in place where health needs exist. Whilst taking on ongoing care needs is not strictly within remit, given we are providing a funded service to extend free social care, [redacted]

Joint Arrangements

Whilst both the NHS and LAs have a legal basis for arranging Social Care, it may be more expedient to get areas to use existing mechanisms to deliver this. Section 75 arrangements, which underpin the Better Care Fund enable LAs and NHS CCGs to pool budgets as necessary, could be used for the payment of 'free social care'. The Better Care Fund itself may be a useful way to put this money into the system and use the existing governance and reporting to ensure that it is getting to the right places, has appropriate escalation routes and that we can have oversight.

This would also provide areas flexibility over how they route funding to provide this, and would allow them to continue to enhance or use existing local arrangements, rather than specifically asking the NHS or LAs specifically to deliver this additional free care.

To note - We need a clinical decision on whether this is the right thing to do. The policy implies that emptying the hospital is more important than protecting residential or domiciliary care capacity to support people currently in the community. We would need this to be taken on a clinical basis.

**Cost**

A rough estimate of the cost could be based on the following:

- 1,000 people moving to residential care is likely to cost between **£2.0m-£3.5m per month**

## 2. Removing Continuing Healthcare Assessment

The Emergency Bill is making provision for similar practices in relation to Continuing Healthcare. In practice, individuals who may be eligible for CHC would be discharged from hospital without being assessed for CHC. They would either be discharged with CHC funding or onto other NHS funded discharge pathways. After the conclusion of the emergency period, they would be assessed for CHC. The legislation making this possible would only be brought into force during the peak of the pandemic and would be deactivated as soon as the pressure on the system reduced. CHC accounts for just a few percentage of DTOC beds so whilst this would be helpful it would not make a large impact.

## 3. Rollout Capacity Trackers

NHSEI currently have an optional Care Home Capacity Tracker. This is a free web-based tool that could theoretically be accessed by any care home or NHS staff with access to a laptop, phone or tablet. The NHS are considering the feasibility of immediately rolling this out for all care homes and community health beds.

This would allow acute hospitals to easily see capacity both in their local patch and further afield if necessary. This would save a significant amount of time for areas, as they would no longer need to rely on ringing contacts, and should help speed discharge.

4. **Greater use of Independent Sector**

NHSEI is working urgently with independent sector providers (Simon Stevens met with provider CEs this morning) to establish the capacity that is available in their facilities to allow step-down care of NHS non-elective patients from NHS hospitals into the independent sector. This would include patients waiting for adult social care services as well as those needing further non-acute medical/nursing care. NHSEI are aiming to have a mobilisation plan ready on Monday/Tuesday next week.

5. **Live-in carers**

We may also be able to support more people out of hospital by considering live-in carers. We don't generally commission this type of support but for someone on their own, it might be a better option than a care home. We would need to explore this option further.