People first, manage what matters...

Part of the Why not home? Why not today? series



People first, manage what matters... Why not home? Why not today?

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What is best for the person?



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How do we maximise independence for this individual?



Foreword

Over the past few years, the Government has set a clear objective through the Better Care Fund (BCF) for all local Health and Wellbeing Board (HWB) areas to reduce the number of people experiencing delayed transfers of care from hospital. Progress has been made, but a number of areas faced significant challenges in meeting their Better Care Fund expectations. This means people in these areas are experiencing long delays in hospital - and worse health and wellbeing outcomes than they should expect.

To help address this, the national partners of the Integration and Better Care Fund (Department of Health and Social Care, Ministry of Housing, Communities and Local Government, NHS England and the Local Government Association) commissioned and funded diagnostic support to help identify the problems being faced by some of the most challenged health and social care systems.

This report sets out the key findings from the work with 14 systems across 9 Health and Wellbeing Board areas where delayed transfers of care were significantly higher than average. Although these findings relate to some of the most challenged systems, we believe that even in systems where flow and transfers of care are well managed, there is learning from the detailed work undertaken.

Many of these findings chime with the Care Quality Commission findings set out in its report **'Beyond Barriers: how older people move between health and social care in England'** (2018)¹. For example, the need for more system-based leadership with shared approaches to performance measurement and accountabilities, as well as clear and robust governance across the system, which appeared to be lacking in these systems, particularly at the service-level.

This report draws attention to people who were not receiving the most appropriate support to get them back home. This impacted on their health and wellbeing not just in terms of the delays to their transfer but also over the longer-term. On average, across the work programme 44% of people experiencing delayed discharges were subsequently placed in settings of care that were not the best possible for that individual. These people were identified by professionals themselves - many of whom were involved in the original decision - which further underlines that this is not about poor choices from a lack of skill or knowledge, but as a result of the system as a whole not making it simple or easy to help people achieve their best outcome.

The findings from this report show that through the efficient use of resources, more mature crosssystem leadership, and joint working on the best way to manage transfers of care, more money could be released to the wider system for better prevention, ensuring that people do not end up in hospital in the first place. This report sets out some key considerations for all areas, as they progress integrated care ambitions and consider how to work together across the system, to ensure a personcentred focus on improving outcomes.

Better Care Support Programme Integration and Better Care Fund

Integration and Better Care Fund

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Contents

(2)

(3)

(4)

(5)

6)

(7

(8)

(9)

(1) Why read this report?

- The highlights
- The background
- What was done
- The findings
- Extent of the problem
- Causes of delay
- What happens after discharge
- Leadership across systems
- Governance mechanisms

Getting it right

- What gets measured gets manage
- Right first time discharge decision
- Effective cross-system leadership
- Governance mechanisms that wo
- Alignment of resources to achievi

The financial impact

What does this mean for you?

In conclusion

6
10
14
16
20

	33	
ed - improved operational control		
on-making for best possible outcomes		
rk		
ng best possible outcomes		
	44	
	16	

49



Hospitals are the best place to be if you are acutely ill, injured or need an operation. But being delayed in hospital waiting to be discharged home, particularly if you are an older person, risks you losing mobility, your confidence and continuity of care. You may not be able to live as independently as you would like to as a result; family and carers may also lose confidence in your ability to be independent. Other people may well urgently need the bed on the acute hospital ward, where you have little choice but to stay...

Stories of elderly people who had previously been living independently, or at home with support, being admitted to hospital for a relatively minor problem, but then having to wait a long time to be discharged, during which time their needs have changed, and they are deemed no longer able to return home -

are commonplace. They are found in any and every part of the country. It is crucial for the wellbeing of people in hospital, as well as for the safety of others needing urgent acute care, that the flow of people through the system is as efficient as possible.

This report describes a programme of work designed to examine the journeys taken by people through 14 health and social care systems across the country. It outlines the methodology that was developed to identify blocks and delays in these journeys and also provides an analysis of the outcomes for those who experienced a significant delay.

The journeys for 10,400 people were studied. It was found that more than a quarter (27%) of these individuals were declared as being medically fit for discharge, yet remained as in-patients on hospital

wards. Tracking the journeys taken by patients revealed a link between a prolonged wait to be discharged and placement in a setting with services that weren't best matched to their individual needs.

Delayed discharges are not a given. Nor are they the result of faulty decision-making by professionals at the frontline. They are the result of the way the system, as a whole, functions. Clinical and social care professionals are making the best decisions they possibly can, given the disconnect between services, the drivers and pressures inherent in the system and the lack of accurate, real-time information.

This work was undertaken by Newton, in collaboration with local improvement teams, to provide a detailed understanding of the factors that influence discharge decision-making. They supported systems to develop plans to fix them and gained commitment to implementation across each system.



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Given the major impact on peoples' lives of waiting to be discharged from hospital, every health and care practitioner, and every leader in each system, should ensure that the drivers causing delays in the system are understood fully and that the system-wide change necessary to prevent them is prioritised.

Findings from this work indicate that every system might benefit from focusing on reducing discharge delays. Not only will this improve outcomes for older people, it will also reduce the cost of care across the system. Reducing the number of

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The only way to achieve a sustainable reduction in discharge delays is to take the longer-term, whole-system perspective.

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discharge delays is a considerably more complex matter than a short-term improvement of metrics.

The only way to achieve a sustainable reduction in discharge delays is to take the longer-term, whole-system perspective, requiring a detailed understanding of the:

- **Q** operational processes at play
 - organisational behaviours within each of the component parts of the system
- b extent to which the services do or do not work together effectively.

The methodology and findings from Newton's work are shared here to help inform the thinking and decision-making that other health and social care systems may be embarking upon. It is hoped that they will contribute to the growing body of knowledge on this complex issue, and that practitioners and system leaders charged with the task of providing services with the right level of care, in the right setting, at the right time, will find this report helpful.

Mr J – the impact of delays on peoples' lives:

At 79 years old, Mr J was living at home with his wife. He had mild dementia but was functioning well, walking unaided to the shops every day to buy his paper. He did not require any care services.

In April, Mr J was admitted to hospital with a urinary tract infection. He was discharged but readmitted the following day, as his wife was concerned about how confused her husband appeared to be.

10 days later Mr J was declared as being medically fit. His wife was keen for him to be discharged home, but she was worried about how she would cope with his care. A carer's assessment was carried out, which took a week to complete, and finally a package of care was recommended in early May.

Mr J spent 5 weeks waiting for the package of care, by which time it was mid-June. An assessment for dementia was completed. However, further assessments were requested, which were then repeated. By the time a final outcome was decided, it was late July. Mr J had lost both his mobility and ability to live independently. The only location considered was a residential nursing placement, which took some time to source.

He was finally discharged in September to a nursing home, where he died that November.

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Focusing on reducing discharge delays will improve outcomes for older people, and reduce the cost of care across the system.







What was done:

- Working in partnership with local improvement
- Blocks and delays in these journeys were
- The outcomes for those people whose

- The effectiveness of cross-system
- Approaches to reducing delays were discussed

What was found:

- Practitioners at the frontline are not actively making poor or wrong decisions. They are making the best decisions they can given the constraints of systems and services that do not always allow the best decisions to be made for the individual.
- On average, 27% (a range of between 19% and 35% across the areas) of the 10,400 individuals studied were declared to be medically fit for discharge, yet remained in hospital.
- There is no simple, single cause of delayed discharges. Factors contributing to delays are multiple, complex and vary significantly from system to system.
- Case reviews conducted with practitioners, in every system, revealed that of the people whose discharge was delayed (in this programme an average across the systems of 27%), between 32% and 54% were found to be discharged to a setting where the levels of care were not wellmatched to their needs.
- In 92% of these cases, the setting was providing a more intense level of care than would have maximised the individual's independence.
- Individuals achieving the best possible outcomes following admission to hospital were those whose discharges were delayed the least. Individuals achieving outcomes that were not as good as they could have been, in settings where



levels of care were not well-matched to their needs, were found to have been delayed, on average, around twice as long as those who had achieved best possible outcomes.

- Based on the data gathered in this work, achieving best possible outcomes for people whose discharges had been delayed would mean the number of people:
 - returning home with reablement increasing by almost 200%
 - going home with support increasing by almost 33%
 - discharged into residential or nursing care reducing by almost 50%.
- None of the systems involved were found to have processes in place for tracking or measuring outcomes. Nor did any system have accurate, real-time information, on the range of services available and the capacity in them. Sometimes, professionals were under pressure to make decisions about where an individual should live, without the information needed. Similarly, leaders were sometimes making resource allocation decisions without the benefit of either the right or timely information.
- Leadership within individual organisations was found to be strong. However, cross-system leadership was not always well developed.

were not well-matched to their needs

In 92% of these cases, the setting was providing a more intense level of care than would have maximised the individual's independence

In general, across the systems, the governance mechanisms in place would be unlikely to facilitate significant reductions of discharge delays, particularly at pace. Interventions made as part of this programme were designed to enable effective cross-system leadership.

• Nationally reported Delayed Transfer of Care (DToC) statistics were found to be neither interpreted nor applied consistently. National DToC figures alone therefore, do not give a true picture of delays. The implication of this is that all systems, even those apparently without high levels of delayed transfers of care, may benefit from questioning the outcomes achieved for people once they are discharged, and applying a rigorous approach to measuring the impact of discharge decision-making. After all, every person's delay, and any discharge to the wrong setting, is a significant set-back to that individual.

Tackling the problem:

• It is very easy to take a superficial look at any delayed discharge situation and reach a conclusion that the solution would be to provide more acute beds. Previous work³, however, has shown that this approach is very unlikely to

deliver the best possible outcomes for people or the system over the longer-term, and may well cause further pressure elsewhere, thereby preventing resolution of the problem.

- Best practice in terms of tackling discharge delays involves capturing data, from every step in the journey through the system, to create a rigorous, accurate picture of the process. This data is then used to identify the blocks and causal factors.
- Addressing each of the causative factors at source provides the key to identifying and implementing solutions that will work over both the short and long-term, specific to the system. Once the issues causing consistent delays have been identified, effective service-level improvement with a focus on process and decision-making behaviours can be designed and implemented.
- A clear, system-wide focus on outcomes is needed to tackle delays in discharge over the longer-term. However, this is only achievable if the outcomes of decision-making are measured rigorously and systematically, and the resulting data shared system-wide. Action to reduce delays, which may include significant shifts in provision across the system, can then be taken.

Addressing delays to discharge, effectively and for the long-term, may require a fundamental culture change, with system-wide outcomefocused behaviours becoming the norm. Establishing, nurturing and maintaining a genuinely personcentred culture lies at the heart of tackling discharge decision-making.

5 factors are critical to reducing delays to discharge from hospital.

These are:

- Q what gets measured gets managed improved operational control
- right first time discharge decision-making for best possible outcomes
- effective cross-system leadership
- governance mechanisms that work
- alignment of resource to achieving best possible outcomes

Consistent, determined effort across the entire system of health and social care is essential to reducing the numbers of people waiting to be discharged from hospital.

Every case review conducted in this study found that a shift towards home-based services would deliver better outcomes than bed-based services. The findings indicate that the capacity of rehabilitation and by improving their efficiency and effectiveness. This would require:

- requirements change for example, ensuring that reablement packages are terminated at the point that people become fully independent
- challenging the culture, visibility and active management of practitioner caseloads
- through improved workload planning - for example, ensuring that the roster system is up-to-date and efficient
- supervision to enhance the effectiveness of reablement, thereby reducing the package of care required once reablement is completed.





Discharge delays are by no means a recent development. They have presented a major challenge to both health and social care since the Community Care Act 1993. There have been additional moves since then to plan care services around the needs of the individual and better integrate services, including the subsequent 2001 and 2014 Care Acts, 2006/8 white papers, the Integration Pioneers programme from 2013 and the establishment of the BCF in 2015.

In 2016, Newton was commissioned through the regional Better Care Support Programme to assess the factors driving high rates of delays across three local systems in the North of England. The findings from this analysis were published in a report, 'Why not home? Why not today?' (2017)³, describing the range of causative factors underlying delayed discharges and making recommendations for how systems address these.

Since 'Why not home? Why not today?' was published, the processes and thinking outlined have been used by other systems to inform their approaches to improving peoples' journeys through systems of health and social care, particularly on discharge from hospital.

The work described in this larger project, commissioned in 2018 by the national Better Care Support Partnership Programme explores and builds on the findings and recommendations from 'Why not home? Why not today?' in a further 14 local systems across the country. The programme of work was designed to support these systems to improve patient flow, reduce the numbers of delayed transfers of care on the basis of a detailed analysis, and to identify appropriate practical action to address the challenges.

'Why not home? Why not today?' made several recommendations essential to improving flow and reducing delays. These include:

- Delayed transfers of care are symptomatic of organisations within systems that are not wellaligned. Ideally, the pathway resulting in the best outcome for any individual should also be the easiest to put in place; but for this to be the case the component organisations of health and social care systems must work smoothly and effectively together. A lack of joined-up thinking and working, resulting in discharge delays, is a system-wide issue; no single part of the system or organisation is solely at fault.
- A single, shared and agreed set of data must be established to provide robust, accurate evidence - a 'single view of the truth' - across the system and support shared decision making.



- Each system must establish an agreed and shared set of priorities.
- Colleagues from across the system must meet regularly and frequently to find shared solutions to problems as they arise. The process should include criteria and mechanisms for escalation when necessary.
- Total commitment from all parties, with highlevel, consistent and effective leadership is needed to embed this way of working across the full range of organisations comprising any system.

Ideally, the pathway resulting in the best outcome for any individual should also be the easiest to put in place



Newton was commissioned to **support local teams in each system** to reach a point of:

- clarity on the specific challenges, the action needed, and priorities going forward to address delays
- understanding of key issues at operational, behavioural and system leadership-level, with communication of these to all partners in the system
- sharing of expectations, with allocation of responsibilities to deliver plans and commitment to implementation from all partners.

The 14 local health and care systems in 9 local Health and Wellbeing Board areas were selected by the BCF national partners, on the basis of:

- nationally reported statistics on delayed transfers of care
- national-level intelligence of significant and established patterns of challenge
- local intelligence indicating a need for enhanced support.

For the purposes of the project, a system was defined as a partnership between one council, one clinical commissioning group and one acute trust.

The systems selected for inclusion were:

	HWB Area	No. of Systems	Health Sy
	Bristol City	2	North Bri University
	Hampshire	3	Portsmou University Hampshir
	Lancashire	1	Lancashir
	Staffordshire	1	University
	Northamptonshire	2	Kettering Northamp
	Leeds	2	Leeds Tea Leeds and
	Liverpool	1	Royal Live Hospitals
	Sefton	1	Aintree U
	Nottingham City	1	Nottingha

Newton was asked to focus on the events and decision-making following patients being declared medically fit for discharge, rather than any analysis of the factors driving the number of admissions. Whilst decision-making further upstream in the



stems

istol NHS Trust y Hospitals Bristol NHS Foundation Trust

uth Hospitals NHS Trust y Hospital Southampton NHS Foundation Trust re Hospitals NHS Foundation Trust

e Teaching Hospitals NHS Foundation Trust

y Hospitals of North Midlands NHS Trust

gGeneral Hospital NHS Foundation Trust pton General Hospital NHS Trust

aching Hospitals NHS Trust d York Partnership NHS Foundation Trust

erpool and Broadgreen University NHS Trust

Iniversity Hospital NHS Foundation Trust

am University Hospitals NHS Trust

process does impact upon discharge delays, it has been demonstrated in other studies that it is the decisions and actions taken once a patient is declared medically fit that have a major impact on the time it takes for them to be discharged. The diagnostic exercise in each of the 14 systems followed a four-stage approach:

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Engagement: Newton teams worked with stakeholders across all organisations within each system to understand the local context and ensure that everyone involved understood the aims and scope of the work.

Diagnosis: data, gathered from source at the frontline as well as from existing systems, was scrutinised at a granular level, focusing on:

- the way the discharge decision was made, and timeliness
- the subsequent processes and outcomes of the discharge decision
- the flow through the pathways for each of the patients identified as occupying an acute bed, despite being 'medically fit' for discharge.

The data was used to create a detailed understanding of the process, identifying and quantifying every opportunity for improvement. On completion of this stage, a summit was held with senior local stakeholders, where Newton shared the findings.

Implementation setup: with Newton teams sitting alongside practitioners and local stakeholders in each system, a set of solutions to the most significant challenges was co-designed. System leadership and governance processes were also reviewed in detail in each system.

On completion of this phase, Newton and local leaders collaborated to run a second summit. This event was designed specifically to gain commitment across all partners in the system to deliver, monitor and govern the implementation plan, addressing the local flow and delay challenges.

Design of implementation, transition and plan for sustainability: each of the 14 local systems then took on leadership of the implementation plans, delivering the solutions and tracking the impact on the numbers of delayed discharges. The local implementation teams were supported by colleagues at the regional level from the Better Care Support Programme, the LGA and Emergency Care Intensive Support Team (ECIST) to deliver the changes needed and monitor their impact.

Three key principles underpinned the system-wide diagnostic exercise:



Operational intelligence: extensive, in-depth point of prevalence studies, case review workshops, historical data analysis and engagement with operational and clinical staff were combined to develop an accurate, 'single and shared version of the truth' about how the services were functioning across all parts of each system. From this it was possible to identify a shared view of opportunities for improvement and assess potential financial savings.



Analysis of system leadership and frontline staff perspectives: Newton's earlier work in the North of England (Why not home? Why not today?) provided clear insight into the critical role of leadership, governance and the approach to managing change in ensuring a smooth flow when discharging elderly people from hospital. For this study, the diagnostic exercise was extended, with Newton gathering and analysing the views of leaders and frontline staff on how day-to-day services and transformational change are led and managed across the entire local system. These perspectives were compared and then cross-referenced, to provide a full perspective of the culture, values, beliefs and behaviours across the system. The findings also allowed accurate tailoring of implementation plans to the specific local context.



Assessment of governance: an assessment tool was designed to capture information about the effectiveness of governance structures across the system. Key elements of the system governance in place were assessed, allowing performance to be measured from the system-wide issues, right through to the impact of these processes on individual patients.







EXTENT OF THE PROBLEM

The findings suggest that the situation described in the report 'Efficiency opportunities through health and social care integration'⁴, published by the LGA and Newton in 2016, has not improved universally across the country. It appears that the approach to decision-making across the sector of 'fixing' the nationally reported statistics, rather than optimizing the outcomes for individuals, is entrenched within some systems' behaviours and culture.

10,400 patients occupying acute beds (excluding maternity, paediatric and day care) were identified in the 14 hospitals. Of this sample of patients, 27% (range 19-35%) had been declared 'medically fit for discharge' yet were still occupying a hospital bed see Figure 1 opposite.

It is important to consider all delayed discharges rather than simply those reported nationally as DToC. In one authority, across the 3 acute trusts, reporting of DToC varied significantly site by site, with the lowest reporting 22% of the medically fit patients as reportable DToC and the highest reporting 52% of the medically fit patients as reportable DToC. This difference was primarily driven by accuracy of data recording.

PROPORTION OF DELAYS

The percentage of people per area, waiting in hospital, medically fit to go but delayed.



SOURCE: Newton 'point of prevalence' snapshot studies; 10,400 general/acute beds; 14 acute trusts; April-July 2018. SOURCE: LGA Delayed Transfers of Care extended time series (monthly by Council and Trust); July 2018.

FIGURE 1



CAUSES OF DELAY

The work identified the factors underpinning delays to the discharge processes.

The top ten causes of delays, accounting for 70% of all delays, are shown below in Figure 2.

REASONS FOR DELAYS

Across all nine areas, what are people waiting for?



FIGURE 2

Of the 27% of patients who were medically fit but waiting to be discharged, some were waiting for decisions about their ongoing care (usually following an assessment) whilst others were waiting for ongoing services (frequently a package of care or a bed) to become available. Whilst at first sight the findings might lead to a conclusion that a single factor 'is to blame' for the delays, this was found not to be the case in the systems involved. No single, simple answer common to all the systems was found. The causes of delays in each system were found to be a combination of a complex set of factors specific to each system. Furthermore, these factors were observed to change, within systems, on the basis of shifting demand, capacity and behaviours.

At the outset of this programme, professionals and managers in all 14 systems were observed to dispute the validity of the data available to them. None of the systems had regular or consistent access to the detail behind the causes of their delays prior to this work. Whilst every system had a number of improvement programmes underway, only a few of these were targeting the operational root issues. For those programmes that did target the root issue, even fewer had evidenced measures or KPIs associated with them.

Reducing the numbers of people delayed in acute hospital beds requires a robust, rigorous and systematic approach to measuring and tracking patterns of activity in order to identify the key issues contributing to delays, specific to the system.

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No single factor was found 'to blame' for the delays in the systems involved.

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WHAT HAPPENS AFTER DISCHARGE

When the outcomes of decision-making were reviewed by practitioners who had been involved in the relevant discharge processes, it was found that across the 14 systems, 44% (range 32-54%) of people experiencing delayed discharges were subsequently placed in settings providing levels of care that were not the best possible for that individual. None of the systems were found to be measuring the outcome of their discharge decisions.

The discrepancies between actual outcome and what would have been the best possible outcome for the individual were studied in detail.

A series of case review workshops were held in each system, where a large number of delayed discharge cases were discussed by frontline practitioners who had been involved in the original discharge decision-making.

Figure 3 shows the discrepancies between actual and best possible outcomes for the 14 systems.

None of the systems were found to be measuring the outcome of their discharge decisions.



WHERE ARE PEOPLE BEING DISCHARGED **VS. WHERE WOULD BE BEST FOR THEM?**



SOURCE: Newton 685 cases reviewed in 15 workshops with 300 multi-disciplinary staff in 14 acute trusts and 9 local authorities; April-July 2018. The three summary points are based on the sample reviewed in this work

FIGURE 3

Causes of discrepancies

The main reasons for decisions resulting in outcomes that were not the best possible for the

REASONS FOR DECISIONS RESULTING IN PLACEMENTS WITH LEVELS OF CARE NOT BEST MATCHED TO NEEDS



FIGURE 4

(1)

These findings present some fundamental challenges to the system, not least the need to question the extent to which resources are aligned to achieving best possible outcomes. The three main causes of discrepancy between best possible and actual outcome were:

Lack of capacity in the service - real or perceived, particularly for home care, community rehabilitation and reablement services. The perception of a lack of capacity in these services, resulting in patients being discharged to a more intensive setting than required or desired, was a frequent finding. Lack of staff awareness and understanding of the services available was also seen to prevent people from making the most effective possible decisions at the point of discharge.

individual were analysed in detail, as shown in Figure 4.



system into different services. Aligning resources (and therefore capacity) with best possible outcomes presents a significant challenge to systems of care.

b There was no evidence, in any of the systems, of exploring ways of improving flow by increasing the utilisation or effectiveness of existing services.

In one system, a survey was conducted of staff involved in discharges from two hospitals. This revealed that a significant number of professionals involved in discharge decisions had low levels of knowledge of the full range of services available, low levels of confidence in those services, and low levels of knowledge of how to access them.

Given this starting point, it is not surprising that many patients are discharged to the same small group of services that are known and trusted, rather than making full use of the range of services available, which may deliver a better outcome.



- Risk averse decision-making was found (2)to play a significant role. Staff involved in making discharge decisions reported that the risks associated with discharging patients to settings with insufficient levels of ongoing care are key factors driving discharge to a setting with a more intensive level of care than was actually needed - or indeed wanted.
- (3)**Family disagreement** – making the right decision about where a family member should live, either collaboratively with the individual or on their behalf, is complex. Family members may have differing views on what is 'right' or 'best' for the individual. This may result in long delays if expectations are not set from the outset. Wherever possible, the individual and their family members should be involved in the decision-making as early as possible to ensure that they are aware of timeframes and the range of likely outcomes.

Analysis of the data gathered in this work shows that achieving the best possible outcomes for people whose discharges had been delayed would mean:

- the number of people returning home with reablement would increase by almost 200%
- \diamond the number of people going home with support would increase by almost 33%
- the number of people discharged into residential or nursing care would reduce by almost 50%.

It is important to note that the data does not, in any way, indicate that practitioners at the frontline are necessarily making poor or wrong decisions. They are making the best decisions they can, within systems that do not always allow the best decisions for the individual to be made. It should also be noted that less than best possible outcomes occur in many different circumstances and are not solely a feature of delayed discharges from hospital.



In one of the systems, the word 'reablement' meant many things. The council-provided service involved retraining, rebuilding confidence and providing short-term personal and practical care. However, there was another service from the community health provider, also called 'reablement'.

This was a very similar service but specifically did not offer personal or practical care, which was provided by secondment of council staff. Realistically, anyone that needs reablement will need some form of personal care support - but the community service would not provide this.

Consequently, there was under-utilised capacity in the community service, whereas the council service did not have sufficient capacity. There was no functional relationship in place to enable both providers to support an individual jointly, significantly limiting the flexibility of the service.

Duration of delay and outcomes - what happens when someone's discharge is delayed?

The duration of discharge delay experienced by people placed in the best possible settings was compared with that of individuals placed in settings not well-matched to their needs. It was found that an extensive delay in discharge was linked to a two-fold likelihood of an outcome that was not as good as it could have been.

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Practitioners are making the best decisions they can, within systems that do not always allow the best decisions to be made.

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SOURCE: Newton 685 cases reviewed in 15 workshops with 300 multi-disciplinary staff in 14 acute trusts and 9 local authorities; April-July 2018. 'Average delay' is from the point of being medically fit.

FIGURE 5

The impact of being placed in a setting not wellmatched to an individual's needs is considerable:

- Outcome for the individual: people who were discharged to settings where the levels of care were not well-matched to their needs were found to be around twice as likely to have experienced a delay in their discharge from hospital. Individuals in this situation are unlikely to achieve as successful an outcome as they would have done, had they been discharged to a more appropriate environment.
- **Resource allocation:** discharging people to settings not well-matched to their needs was seen to distort the understanding of the true requirement for resources across the system. Scarce resource was seen to be invested in residential or nursing care, for example, at the expense of rehabilitation and reablement services, because the discharge decisions being made gave the appearance of this pattern of demand.

Resources should be aligned explicitly to achieving the best possible outcomes for people, rather than being based on historical patterns of discharge.

- **Budgets:** it was found that discharging people to settings that are not well-matched to their needs consumes significantly more resource than placing patients on the right pathway, to the right setting, the first time. The financial impact of failure to match the level of care provided to peoples' needs at discharge is explored in Section 7.
- **Staff:** retention of staff is a critical issue currently. Seeing or perceiving that system failures are leading to deterioration in peoples' outcomes is deeply troubling to social care and clinical professionals at every level. In discussions with frontline staff, this factor was cited as a major contributor to difficulties in recruitment and to the loss of significant numbers of highly skilled professionals to less stressful jobs.



FIGURE 6



Change at this scale has to take place against a backdrop of multiple competing priorities

LEADERSHIP ACROSS SYSTEMS

Leadership across the entire system is critical to achieving control of discharge delays. Leaders of each of the partner organisations within the systems were invited to complete a detailed and extensive assessment of the effectiveness of leadership across the system as a whole. A 'mirror' study was also undertaken, to capture the perspective of frontline professionals and managers on leadership and governance in action across the system. These views were then collated to give a picture of the effectiveness of leadership and governance mechanisms for each system.

Analysis of these surveys showed that for all 14 systems, whilst there was clarity of vision and considerable commitment to developing capability within individual organisations, this is far less evident across systems as a whole. This finding is in line with the CQC's reported lack of shared vision and leadership across health and social care.¹



However, some systems did voice their enthusiasm to leave the past behind, setting out positive ways forward to achieve an effective and seamless single system of care.

Key issues emerging from the leadership and frontline surveys include:

- Changes of this nature, at this scale, require appropriate levels of support, planning and resource. System leaders recognised a difficulty in acknowledging this scale of change in order to realise the opportunities identified.
- System leaders face considerable challenge as change at this scale has to take place against a backdrop of multiple competing priorities.
- Some leadership groups identified a difficulty in holding one another to account.

Clarity of vision and considerable commitment to developing capability was far less evident across systems as a whole

• Leaders in some systems were seen to be taking on decision-making at the operational individualfocused level rather than addressing wider strategic issues. This not only led to systemwide issues being missed completely, but also disempowered frontline staff from addressing the operational issues themselves.

There was evidence of inequity, with some trusts or councils assuming a superiority over others, creating an atmosphere and culture unlikely to provide a sound basis for constructive change.

Both the surveys and direct observation revealed dynamics between Chief Executive (CEO) and Chief Operating Officer (COO) groups. In some systems the COO group believed that it would be more effective with greater autonomy from the CEOs, allowing it to own and develop its plans and way forward.

GOVERNANCE MECHANISMS

Governance mechanisms to ensure effective management of delayed discharges within each of the 14 systems were analysed as a key part of the leadership and frontline mirror surveys. The views of both leaders and frontline staff, along with direct observation, were used to build a picture of governance mechanisms in action across the system.

The teams examined governance processes at three levels in each system:

- Individual-level (daily focus on individual-level actions). In 8 of the 9 HWB areas, individual-level governance was assessed as 'adequate but could improve'. Individual-level governance in the remaining system was assessed as 'requires improvement'.
- Service-level (focus on taking actions on themes and trends where particular services are causing consistent delays). Effective service-level governance was observable in only 3 of the 9 areas.
- Escalation/leadership-level (setting the correct direction and mindset and ensuring that all governance levels are operating effectively). In 6 of the 9 areas, the leadership-level governance was judged to be 'adequate but could be improved'. In the remaining areas governance at the leadership-level was assessed as 'good'.

None of the systems could demonstrate governance arrangements for managing individual organisations which would actively facilitate the attempts being made to reduce the number of delayed discharges.

Indeed, at some levels, in some systems, the existing governance processes were felt to hinder improvement. For example, in some systems, gaps in governance at the service-level were seen to obscure the key drivers underpinning the delays. Evidence from the surveys showed that in some systems, leaders were taking on decision-making at the level of the individual rather than addressing more strategic issues. This not only led to wider system issues being missed completely, but also disempowered frontline staff from addressing the issues independently.



In some of the systems, existing governance processes were felt to hinder improvement



Across the total sample of systems involved, from both the data captured and the discussions held with staff throughout the programme, the findings gave a reflection of systems that are struggling with:

- capacity (real or perceived) in the services needed to support the best possible placements and outcomes
- failure of parts of organisations to work as effectively together as they might.

Addressing the capacity of support services in the community, aligning them with the best possible outcomes for people (as evidenced by collection of the right data), and ensuring that the various parts of the system are working well together, provides the key to reducing discharge delays. This work indicates that the factors to be addressed to achieve long-term sustainable solutions fall into 5 key areas:

- what gets measured gets managed improved operational control
- right first time discharge decision-making for best possible outcomes
- effective cross-system leadership
- governance mechanisms that work
- alignment of resources to achieving best possible outcomes

WHAT GETS MEASURED GETS MANAGED - IMPROVED OPERATIONAL CONTROL

The priorities and pressures at play within the system have a major influence on the way frontline practitioners make decisions. The factors underpinning these priorities and pressures are complex. They can only be assessed and addressed by gathering accurate data and establishing a robust body of evidence on what is really happening to people in their journeys through the specific system.

Operational control comes from clarity of flow through the system, using this to identify the underlying causes of blocks. Staff in all parts of the system need to see timely, accurate and appropriate information, based on a single, shared set of believed data, frequently and regularly. Given the complexity of discharge decision-making, it is critically important that operational issues are managed as tightly as possible to ensure that core processes do not contribute further still to delays.

Tackling operational control

Effective operational control can be facilitated by these practical actions:

• Establish a single, shared and agreed 'version of the truth' across all partners so that discussions focus on what to do, rather than whether or not the data is right. In the majority of systems, the accuracy and comprehensiveness of data was seen to be a continuing source of contention between the various partners. Long-running debates about the accuracy or otherwise of the data were taking the place of establishing sound operational control. It is essential that what happens to people, not only as they go through the system but also after discharge, is measured, monitored and communicated across the entire system. All staff, whether at the frontline or in management roles, need to know and understand the

outcomes of discharge decisions, so that they can engage fully in the discussions about what can be done to improve the situation.

- Build a clear pathway for data, from the frontline of decision-making at patient-level, right through to leaders, at both organisation and system-levels.
- Create a clear, single, shared agreement on what the terms (DToC, medically fit for discharge, stranded and super-stranded) actually mean, across all organisations within the system.
- Ensure clarity of ownership of every aspect of the discharge process, with named individuals responsible for each step in the process. Communicate these roles and the people responsible for them widely, systematically and often.

One system lacked an agreed DToC dashboard across all partners. Considerable time, effort and goodwill was lost debating the accuracy of the data. A dashboard is now being built, which will allow all parts of the system to discuss action, on the basis of data that everyone accepts and agrees is accurate.

What to avoid:

- **distraction** by arguments about the quality or validity of the data
- preoccupation with discharge speed at the expense of all else it will lead to inappropriate outcomes
- confusion between management of day to day 'business as usual' and longer-term programmes of improvement

In one system, the local authority had strongly prioritised reduction of delays. Clear pressure came from the Director of Adult Social Services for hospital social work teams to improve performance to reduce the time patients were spending 'awaiting social work assessment'. It was hoped that this would enthuse and empower local teams to develop innovative approaches to minimise the wait for assessments.

Unfortunately, the effect was that energy was focused on a complex revision of the categorisation process for recording the reasons behind the lengthy waits. This in turn led to a new process being put in place to ensure that patients were accepted only into a given category if it was the only assessment they were waiting for. As a result, visibility of the true social work delays was poor and progress was hampered.

RIGHT FIRST TIME - DISCHARGE DECISION-MAKING FOR BEST POSSIBLE OUTCOMES

Understanding the factors driving discharge decision-making is critical. Addressing the issues at source is crucial to identifying and implementing solutions that will stick.

It is widely accepted that:

- almost everyone wants to leave hospital as quickly as possible
- almost everyone wants to return to the living arrangements they enjoyed prior to their admission, with the highest level of independence, wellbeing and quality of life possible, given the circumstances
- staff caring for people want them to be discharged to the right place, in the right way, at the right time.

The disconnect, in all 14 systems, between the shared aspirations of patients, carers and staff, and the outcomes of discharge decisions, is striking. Some staff were of the view that rather than being discharged to settings that would be the best possible for each individual, people were simply being placed in the settings that were available, or perhaps perceived to be available.

This is not a result of anyone wishing to discharge people to settings that are less than the best for them. Discharge decision-making is a function of the pressures, priorities and incentives at play in the various organisations within each system and how effectively these organisations interact with one another.

The finding of a link between an outcome that is less than the best possible and an extensive delay in discharge suggests that, in many instances, people are waiting a long time to be discharged to settings that have higher levels of care than they need, rather than to those with lower levels of care that would lead to greater levels of independence and would take less time to put in place.

Although further work would be required to verify, it would seem likely that if the organisational drivers were addressed so as to incentivise every discharge decision being made on the basis of what would give the best outcome for the individual, with the greatest level of independence possible for them, the number of people waiting to be discharged for extensive periods of time would decrease.

Improving discharge decision-making

Local teams across the 14 sites, in collaboration with Newton, arrived at a set of practical actions to improve discharge decision-making. These are:

• Gain agreement at the outset, across the entire system, that everyone involved in the decisionmaking process has a duty to ensure that each discharge decision is driven by achieving the best outcome possible for the individual. None of the systems had mechanisms in place to track whether people were being placed in the best possible settings for their needs. It is difficult

to make improvements to the decision-making process without evidence of outcomes. A fundamental principle of improving discharge decision-making, therefore, is that outcomes are measured, rigorously and consistently. Less than the best possible outcomes were found not to be linked to the nationally reported DToC figures. This implies that all systems, even those apparently without problems of delayed transfers of care, should question the outcomes achieved for people following the decisions made at discharge and put in place rigorous systems of outcome measurement.



- Clarify the full range of services available and their eligibility criteria, communicating this across the entire system, in real time. This means that staff will be aware of all the possibilities rather than defaulting to a small range of 'tried and tested' services.
- Ensure decision-making is collaborative. using multi-disciplinary forums to discuss discharge plans. Each system should work towards collaborative decision-making being the norm, involving the right individuals, in the right environment, with the right data, and with a shared vision of what good looks like. The approach to risk should be shared, and should be based on true capacity of services, rather than on perceptions.
- Establish consistency of focus and language, aligning everyone at different levels in different parts of the system. Asking 'What is best for the person?' and 'How do we maximise independence for this individual?' is helpful, creating a single goal across roles and organisations, at the point of decision-making.
- Set appropriate expectations early on in the decision-making process. A 'good choice' **policy** at the start of the pathway was found to be a sound approach, as was making home the easiest discharge pathway. If discharging people to their homes presents the least difficulty to the service, it becomes the most commonly taken pathway. Providing closer supervision for practitioners, supporting them when discharging a person to a reduced level of ongoing care, will facilitate this.

• Use Discharge to Assess consistently, supported by an appropriate mix of community services, to ensure that assessments take place within the environment in which the person lives rather than in the acute setting. Assessments conducted this way are not only more accurate, but also present less of a barrier to timely discharge.

Establishing, nurturing and maintaining a genuinely person-centred culture lies at the heart of tackling discharge decision-making. Changing the way decisions are taken cannot happen overnight – it takes time and considerable effort to alter entrenched behaviours and attitudes. The approach taken must also reflect each system's culture.

Whilst these steps are straightforward to articulate, they can be a challenge to implement and require long-term culture change, effective leadership and time.

What to avoid:

• underestimating how long it takes to change decision-making behaviours

procuring more services purely to speed up the discharge process in the short-term. Extra services should be procured only on the basis of robust evidence that they will achieve long-term benefits to patient outcomes

Iengthy assessment processes in hospital

complicated assessments and referral forms

• competing incentives between organisations

• multiple services providing similar, but slightly different, interventions

o communicating only when a service is full or unavailable. Staff need to know the true availability of services, in real time

EFFECTIVE CROSS-SYSTEM LEADERSHIP

Driving improvement effectively and sustainably relies on control at every level of the system. Operational control can only ever be achieved as a result of the culture and behaviours set by leaders throughout the various parts of the system. Not only is effective leadership of individual organisations necessary, effective cross-system leadership is also critical to addressing discharge delays. In this work, strong leadership was seen within individual organisations. Leadership across the systems, however, was found to be considerably less well developed.

A number of factors emerged from both the surveys and from discussions on site that may be helpful in achieving effective cross-system leadership.



Tackling cross-system leadership

- A vision of how the entire system should work should be developed, involving every organisation within the system. Across each system the leadership group should establish its role, the culture it will develop and levels of detail at which it will operate, accepting that cultural change across a system of organisations will take time to put in place.
- To be successful in developing different behaviours in staff, leaders must be seen to be united in delivering a new culture, with new objectives. There are many ways leaders can work together to do this, for example:
 - jointly prioritising issues to be tackled
 - developing a cross-system improvement plan
 - celebrating success stories
 - jointly discussing how these successes will lead to achievement of the system's vision
 - sharing the understanding of what good looks like.
- Systems should share performance targets. Separately managed, the need to achieve organisation-specific DToC targets may override the desire and ambition to work together. Even the strongest, most highly principled leaders are conflicted between their own survival and the needs of the whole system. Unless the objective of achieving the best possible outcome for the individual is shared across all parts of the system, individual organisations are highly likely to default to achieving their set targets.

- Across the system, leaders must be confident in encouraging, coaching and supporting their frontline staff to take operational decisions in the right way. Their own efforts should be directed towards identifying and addressing the strategic issues.
- Some systems had developed interesting approaches at the leadership-level. For example, where organisations were observed to be holding each other to account successfully, a role had been created specifically for this purpose. Other systems had put in place shadowing opportunities between hospital and community roles to help understand the respective cultures and practical constraints.

In one system the whole leadership team commented that there is a now more open feeling amongst the group than there was last year. Whilst there is still tension, they now air differences and disagree openly, which enables them to work through the issues. These would have remained silent disagreements a year ago.



What to avoid:

Q underestimating the time, effort and skill needed to bring about effective cross-system leadership

expecting leaders of organisations to change their behaviours without changing the incentives and pressures they face

separately managed, separately funded initiatives to reduce delays

a focus on the performance of individual organisations rather than the outcomes for people

b resources being sucked into 'fire-fighting' and away from delivering change

GOVERNANCE MECHANISMS THAT WORK

The way organisations work is largely the result of the levers, incentives and governance mechanisms that are put in place. No matter how good the intention and ambitions of staff at every level, if the governance mechanisms in place do not drive, support and facilitate the right approaches to decision-making - or worse still actively hinder them – they will be very difficult to overcome.

In addressing delayed discharges, it is essential that the governance mechanisms in place, both in the individual organisations and cross-system, are scrutinised and if necessary changed, to incentivise the required behaviours and decision-making.

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Operational control can only ever be achieved as a result of the culture and behaviours set by leaders throughout the various parts of the system.

Tackling cross-system governance

- To achieve sound operational control of the discharge process, a series of governance meetings should be put in place to ensure that colleagues from all the organisations across the system meet regularly and frequently to find shared solutions to problems as they arise.
- These meetings should establish and maintain an agreed set of criteria, with mechanisms for escalation when necessary.
- Existing 'business as usual' governance processes in all individual organisations should be assessed to ensure that they do not conflict with crosssystem governance of discharge delays.
- Embedding this across the various parts of any system can be achieved only on a basis of total commitment from all parties, with high-level, consistent and effective leadership.

What to avoid:

- lack of clarity around each level of governance
- allowing existing governance mechanisms to interfere with cross-system governance needed to manage discharge delays
- o confusion and distraction of leadership-level governance by individual-level, operational issues

ALIGNMENT OF RESOURCES TO ACHIEVING BEST POSSIBLE OUTCOMES

This project found that almost 1 in 2 people experiencing a delay in discharge from hospital find themselves living in settings that do not have the level of care that is best matched to their needs. If there is a lack of capacity (real or perceived) for the service that would provide the best possible outcome for the individual, the evidence from this work suggests that in the majority of cases (92%) the individual will be placed in a higher acuity setting than needed. This means that the likelihood of regaining their former independence will be slim.

System leaders may wish to re-think the basis on which resources are allocated to services so that they are aligned to the demand in terms of best possible outcomes, rather than the way that discharge decisions are currently made. Providing the mix of services that meets actual demand and ensuring that they work effectively together is not only better for the individual but may also result in significant financial savings. None of the systems had the information that would enable frontline or managerial staff to see the actual demand flows across the system into different services; aligning resources with best possible outcomes is undoubtedly a challenge. The solution however, does not lie simply in investing in additional service capacity. The evidence from this work indicates that services already in place could be utilised more effectively, without the need for further investment in capacity.

Discussions with system leaders revealed that resources are allocated to service capacity on the basis of the current average levels of demand, meaning that the system has little or no flexibility to cope with inevitable peaks of higher demand. Commissioning decisions are similarly based on current levels of demand for services. This means that the services needed to achieve best possible outcomes are not factored into the commissioning process. It is no small task to change the way resources are allocated to services and the way that services are utilised. Effort from all organisations involved is needed - and that takes determination. time and persistence.



Tackling alignment of resources to best possible outcomes

In thinking about realigning resource and best possible outcomes, systems should:

- Establish a view of best possible outcomes achievable for individuals, agreed across the system. On the basis of this, the true, actual demand for services can be established and resources may be realigned. For the systems involved in this programme, an appropriate realignment would involve a gradual reduction in the number of residential and nursing placements, shifting these resources to home-based reablement and support services.
- Build and share an accurate picture of the flows across the system - of both actual demand and the demand that would achieve best possible outcomes. This would include information on the variability of demand across the system so that peaks and troughs can be managed effectively, along with regular and frequent reviews of the numbers of people discharged to settings with levels of care that are not best matched to their needs. Capacity and resource should be assessed across services on a system-wide basis, increasing flexibility and reducing barriers to access. Capacity can then be built on actual demand to achieve best possible outcomes, rather than on the basis of current demand.
- Develop a structured plan to achieve the new capacity based on actual demand.
- Improve the efficiency and effectiveness of existing services, so that more people benefit from these within existing capacity, without additional investment.

With these fundamentals in place, discharge decision-making can be focused on achieving best possible outcomes for the individual and maximising independence.

These changes may take a minimum of 6-9 months to embed across a system. That said, not only will people benefit from being discharged to a setting more closely matched to their wants and needs, a significant financial benefit may also be realised. This is explored further in Section 7.

What to avoid:

- relying on short-term plans to cope each year investing time in fixing the right capacity for the longer-term is the most effective approach
- procuring more beds evidence from this work indicates that any additional resources should be invested in home-based rather than bed-based services
- adding further services without first ensuring that existing services across the entire systems are being used appropriately and to full capacity





Each day that a person is delayed leaving hospital poses a challenge to their long-term health and wellbeing. It also has a significant financial impact for all the organisations within the local health and care system.

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The study looked at the potential financial benefits that could be achieved by each of the systems in the areas and found a significant financial opportunity in each.

The financial impact has several components:

- Ongoing care costs considerable numbers of the people whose discharges are delayed are subsequently transferred to settings providing more intensive levels of care than they need, which is more expensive than care in the right setting would have been.
- Extended costs whilst in hospital looking after people in an acute setting is expensive.
- Loss of income for trusts beds being occupied by people waiting to be discharged means that elective surgery is delayed or cancelled on a regular basis. This leads to a significant loss of trust income. Whilst this was not quantified as part of this work, it should not be forgotten as an additional benefit of reducing delays.

POTENTIAL FINANCIAL IMPACT



FIGURE 7

The study looked at the potential financial benefits that could be achieved by each of the systems in the areas and found a significant financial opportunity in each.

These indicative savings were calculated for each system using the output from the diagnostics. Whilst these figures are based on a snapshot



SOURCE: Newton 2018. Note: the savings have been scaled in proportion to the number of medically fit patients, not the nationally reported DToC number.

view supported by long-term data, the savings identified are merely indicative. The figures show the opportunity it might be possible to deliver, not including income from elective surgery if the right level of support was provided in each system to deliver the necessary operational improvements.



WHAT CAN YOU DO TO ACT ON THESE FINDINGS WITHIN YOUR OWN SYSTEM?

IF YOU ARE A SOCIAL CARE OR CLINICAL LEAD:

- **Q** Review your decision-making processes with a particular focus on who is accountable for the discharge decision and who informs them. Use multi-disciplinary forums to discuss discharge plans as the norm rather than the exception.
- **b** Be open with people and their families from the start that decisions taken will be focused upon enabling them to be discharged to the setting with the most appropriately matched levels of care, to achieve the maximum level of independence for the individual.
- **b** Establish close supervision to provide support when discharging a patient to a less intensive level of ongoing care.

IF YOU ARE AN OPERATIONAL LEAD IN EITHER SOCIAL CARE OR THE NHS:

- **Q** Raise awareness of the breadth of services available, so that those making discharge decisions are not relying on a narrow range of services.
- Establish a project to improve the efficiency and effectiveness of rehabilitation and reablement services so that more people can benefit from these, within existing capacity - without additional investment.
- Review the training provided to frontline practitioners to ensure that longterm outcomes for the individual lie at the heart of every discharge decision. It is crucial to ensure that staff are sufficiently trained and supported to take appropriate levels of risk when discharging people.
- Share success stories so that members of staff are highly motivated and keen to continue in these roles within the system.
- Share real-time, accurate information on the capacity of the various services so that staff can make the best, most appropriate referrals on the basis of fact, rather than on incorrect perceptions.
- **b** Review governance and control mechanisms in place across the system to ensure the best possible control at patient, service and leadership-levels, system-wide.

IF YOU ARE A FINANCIAL LEAD IN EITHER SOCIAL CARE OR THE NHS:

- **Q** Review and challenge the mix of post-acute services commissioned and provided so that they reflect the best possible outcomes that should be achieved.
- Analyse DToC figures (activity, costs and savings) on a system basis, rather than at the organisational-level, so that the true cost of delayed discharges to the whole system is evident.
- **b** Calculate the cost to your own system of discharging people to a setting with a level of care that is not well-matched to their needs, using this to monitor improvement towards reduced costs from improving outcomes.

IF YOU ARE A HEALTH AND WELLBEING BOARD MEMBER:

- **Q** Agree how you will hold system leaders and practitioners to account for discharging people to settings with levels of care that match their specific needs.
- Challenge system leaders to lead by example, behaving in a way that fosters collaboration across the system.
- Support clinicians and practitioners as they change the way in which discharge decisions are made, developing a culture of empowerment and support without blame.
- Review the number of people being discharged to the best possible setting for them on a regular basis, and hold system leaders to account for ensuring that these numbers increase.
- **b** Work with system leaders to ensure that there is a clear and unified vision of success and what that means for the system as a whole.





The findings from this programme give a clear indication that all systems, even those that national data suggest don't have a problem with the number of delayed transfers of care, should:

• ensure that those making decisions about people's discharge from acute settings have robust, timely and accurate information about the flow and capacity within the entire system

• question the outcomes achieved for people once discharged

• put rigorous systems of outcome measuring and monitoring in place

• assess the effectiveness of system-wide leadership

• ensure that the mechanisms of governance in place are aligned with the outcomes the system is seeking to achieve

• align resource allocation with achieving the best outcomes for people, rather than with current patterns of discharge decision-making.

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What is best for the person?

How do we maximise independence for this individual?





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