

Why not home?

Why not today?



Behind every Delayed Transfer of Care, there is a person, in the wrong place at the wrong time.

**“Why not home, why not today?”
asked every day, for every patient
during board or ward rounds**

WHY NOT HOME? WHY NOT TODAY?

Are you looking for practical, rooted-in-reality help, in tackling the complex and long-term challenges of delayed transfers of patients from hospital settings?

Are you thinking about how things work in your organisation – from the importance of changing long-standing behaviours in both leadership and frontline teams, to embracing the principle that the outcome for the patient is more important than the process?

In this report we describe how we have approached these issues collaboratively – and made a start on tackling them.



NEWTON



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THE HEADLINES...

Preventing delays to patients being transferred from hospital settings is achievable. Done properly, not only are health and personal outcomes improved, but net savings for the system may also be generated. Patients waiting in hospital beds for discharge to an appropriate setting is a symptom of systems not working – and can be tackled rather than accepted.

The challenge set for this piece of work was to 'do something different'. So a new approach was designed by Newton and three areas in the North of England, resourced by regional Better Care Fund support monies.

The project team took a meticulous approach to gathering and analysing the data in order to provide an accurate and timely evidence base on what was really happening. This was then used to begin driving changes in behaviours, decision-making and leadership.

When reflecting on all the evidence across the entire project, four leading headlines emerged as being critical to making a positive impact on DToC: achieving a shared understanding; exhibiting the right behaviours; appropriate decision-making and the role of leadership.

Shared Understanding

- The key to preventing delays to the transfer of patients from hospital beds, is to create an environment in which everyone involved has a shared understanding of the best outcome for the patient.
- The critical factors to get right are:
 - measuring the right things
 - focusing on the right things, in the right order
 - sharing ownership of the patient's entire journey through the system
 - putting the patient, and their best possible outcome, at the forefront of everyone's thinking and focus
 - evidencing the impact of changes made.
- It is also critical to be clear about, and agree upon, the definitions and parameters being used to measure delays.

Behaviours

- The system must have a single objective, focusing on the best possible outcome for the patient.
- Five practical behaviours are needed to drive the change:
 - gain buy-in to a cross-system mindset
 - be open when behaviours slip, especially when the system is stressed
 - create a safe environment to share concerns
 - protect time to plan
 - hold one another to account.

Decision-making

- Patients delayed in hospital whilst waiting for transfer to a longer-term care setting is an indicator that the systems involved are not working together effectively. To identify the changes that are necessary to address this, it is essential to analyse the decision-making processes throughout the system, putting the patient at the forefront of the thinking.
- The best way to match care with individual needs, in the most appropriate setting, is to ensure that the decision-making of everyone involved is focused on the patient's long-term outcome.
- Bed-based pathways should not be the default decision. Investment in intermediate care services in both health and social care, such as reablement, can provide better outcomes for patients, whilst also reducing long-term care needs.

Leadership

- No one part of the system is 'to blame' – all the various parts of the system generate delays to patient transfers, and are vital in achieving the solution. But a solution will only work if system leaders model thinking and behaviours that cross the boundaries between health and social care.
- A 'whole-system' approach is needed, despite the organisational drivers that may incentivise compartmentalised working.
- Staff at the frontline of health and social care want to do the right thing – despite processes that might seem to get in the way.
- The onus is on system leaders to create an environment in which frontline practitioners can do the job they want to do, excellently and with pride – despite the considerable pressures of competing demands, which may undermine their best attempts at doing so.

Practical steps to take

Making sustainable progress will take time. Whilst every system will be at a different point in this journey, the points below suggest some specifics which, if they are not already happening, would be expected to make a rapid impact on delays for patients:

1. Systems to agree and align on one joint set of priorities, guided by local evidence and understanding
2. All activities to be framed around improving outcomes for patients – "Why not home, why not today?"
3. Every system to have cross-system access to, and understanding of, a single (ideally live) list of delayed patients – including the length of time each patient has been on it
4. Daily task and weekly escalation meetings to be held with representatives from all partners to take action against the list of delays
5. Weekly face-to-face meetings to be held between a small group of leaders (executive level) from across partners to resolve current blockages
6. Resourcing of reablement to be ensured, to support the aim of more patients recovering in their own homes

Taking a closer look

at three headline findings

39%

of delayed patients could have benefited from a different pathway decision

36%

of delayed patients were found to be waiting for a decision to be made on their discharge pathway

60%

of assessments and/or therapy could have taken place out of hospital; the remaining 40% could have been completed in parallel with other steps

EVERYWHERE YOU GO...

Everywhere you go, particularly if you work in health or social care, people will tell you stories of friends or family members, usually older and disabled people, who are admitted to hospital for whatever reason, and then remain there. This is because the processes that should support them in getting out of hospital do not function as best they could – and should.

First things first:

- On the whole, unless you are desperately sick or injured, most of us do not want to be in a hospital.
- As we get older, one of the things important to most people is to remain independent. We dread being taken away from our own homes, from familiar faces and routines. We particularly dread being dependent on others. There is no bed like our own bed.
- A hospital is a good place to be when you are acutely unwell, but it can bring its own risks, even for the hardy. In every hospital admission, there is a risk of picking up an infection.
- For the more vulnerable, being in hospital also frequently means:
 - losing mobility
 - losing confidence in the ability to live independently
 - losing the continuity of whatever care packages are in place.


Add this to the likelihood of confusion and disorientation in an unfamiliar environment and daily routine – and it is clear that hospitals are not the place to be, once the acute issue that brought the person in to a hospital bed is resolved.

We have all known this for some time. Yet, throughout this work, most of the people involved had a story of their own to tell – two of which we'd like to share with you now...

¹ Findings from practitioner led reviews of 132 cases during this study, see Appendix 2, Table 2.4

² Findings from snapshot studies of 501 delays, see Appendix 2, Table 2.3

³ Findings from one of the areas, see page 32



Tripped over the edge of a rug
and hit his head on the side
of a cupboard

MIKE HOLLINGSWORTH, 89

Enjoying an early evening at home, Mike, aged 89, tripped over the edge of a rug and hit his head on the side of a cupboard. He remained conscious and was able to get to the phone to call 999. He was seen swiftly in A&E and was found to have no serious injuries, just some bruising.


The medical team decided to admit Mike overnight for observation, as a precaution, simply to be sure he was safe to go home. A day or two passed, during which time some tests were carried out. They all confirmed that there had been no serious or lasting damage and no underlying cause for the fall. He had simply tripped.

10 days later, Mike was still in his hospital bed. By this time he had lost a good deal of mobility, so an assessment by the physiotherapy team was arranged. The physiotherapists felt that Mike really needed assessment by the occupational therapists, and also by the social work team. All of these assessments took further time to arrange, and the days turned into weeks.

Based on the assessments, a recommendation was made for 24-hour residential care and that is where Mike was placed.

The occupational therapist (OT) who conducted Mike's assessment felt very strongly that had the physiotherapists, the OTs and the social care team all worked together as a single unit from the outset, this scenario might have been avoided. They could have worked in parallel rather than in series, thereby dramatically reducing the time it all took.

Furthermore, the OTs opinion - like that of the other teams involved - was that, had they worked more effectively together, Mike could have gone home, with reablement support for his mobility issues.



Slipped on a wet floor
and fell whilst
cleaning the kitchen

JANE GLADWIN, 85

Whilst cleaning her kitchen, Jane, who has had insulin-dependent diabetes for 59 years, slipped on the wet floor and fell. At 85, Jane was enjoying living independently with the support of a care package to help monitor and control her diabetes. She was seen in A&E and admitted for observation and monitoring of her diabetic control.

10 days later, Jane was declared medically fit. She was keen to go home.

There was then a series of delays with discharge, as a result of some internal communication processes not working as well as they should. Three weeks following her fall, Jane developed a severe hospital-acquired infection. Two months after admission to hospital, Jane was discharged – to a residential home.

Had Jane's discharge been managed more effectively and rapidly, she would have been less likely to suffer a hospital-acquired infection and far more likely to have been discharged to her own home and independent life – as she had wanted.

In every part of the health and social care system, every day, decisions are being made about where people will be transferred following an admission to hospital. In some areas, these decisions are made effectively and efficiently with great outcomes. But sometimes, they are made on the basis of a set of fragmented services and processes, rather than the needs of the individual concerned or their families.

In these circumstances, the outcomes may cause people considerable heartache and stress. Better outcomes for these individuals might have been reached, had the systems worked more effectively, and together.

A COLLABORATIVE APPROACH

Three areas in the North of England teamed up with Newton – the aim being to provide a combination of analytical and operational evidence to underpin a common understanding on how best to reduce the number of people remaining in hospital, when they could have been cared for more effectively in a different setting.

The team was keen to develop an approach that others could replicate, to understand and address their own DToC challenges. Whilst clearly solutions will differ for each locality, it was felt that the principles and overall approach would be useful in determining the priorities in any system.

The three areas the team worked in are:

- Sheffield
- Fylde Coast
- North Cumbria.

The project, designed to understand and tackle DToC, was financed by regional support monies made available via the Better Care Support Team.

The project team, recognising there was a good deal of information and opinion on the subject available already, were keen to build on this as well as best practices including:

- 8 High Impact Changes⁴
- Emergency Care Improvement Programme (ECIP) and NHS England work⁵
- Right Care, Right Time commission⁶
- Hospital to Home visits.

This is how the team went about it:

1. The system as a whole was analysed – not just looking inside individual organisations, but most importantly, taking a view across and between the organisations. In this way, the team were able to build an understanding of what is actually happening and why, rather than accepting what people think or assume is going on.
2. The issues causing the greatest challenges to the system were identified, particularly those that were crossing organisational or service boundaries. The thinking was that if these could be addressed, they would be most likely to deliver improvements with long-term and sustained impact.
3. Clinical and social care practitioners were then asked to lead reviews of how they work currently, to highlight opportunities in the way that care pathway decisions are made.
4. Taking this intelligence, all the various groups (nurses, physiotherapists, OTs, social workers, doctors, nurses and care workers) were brought together to design a new, shared, rigorously evidence-led approach. This allowed priorities to be agreed and buy-in to be secured across every person and group involved in delivering system changes.
5. At the same time, the key issues were explored with leaders of all the systems involved, resulting in a set of activities enabling them to begin to develop the behaviours required to embed long-term, sustainable change.

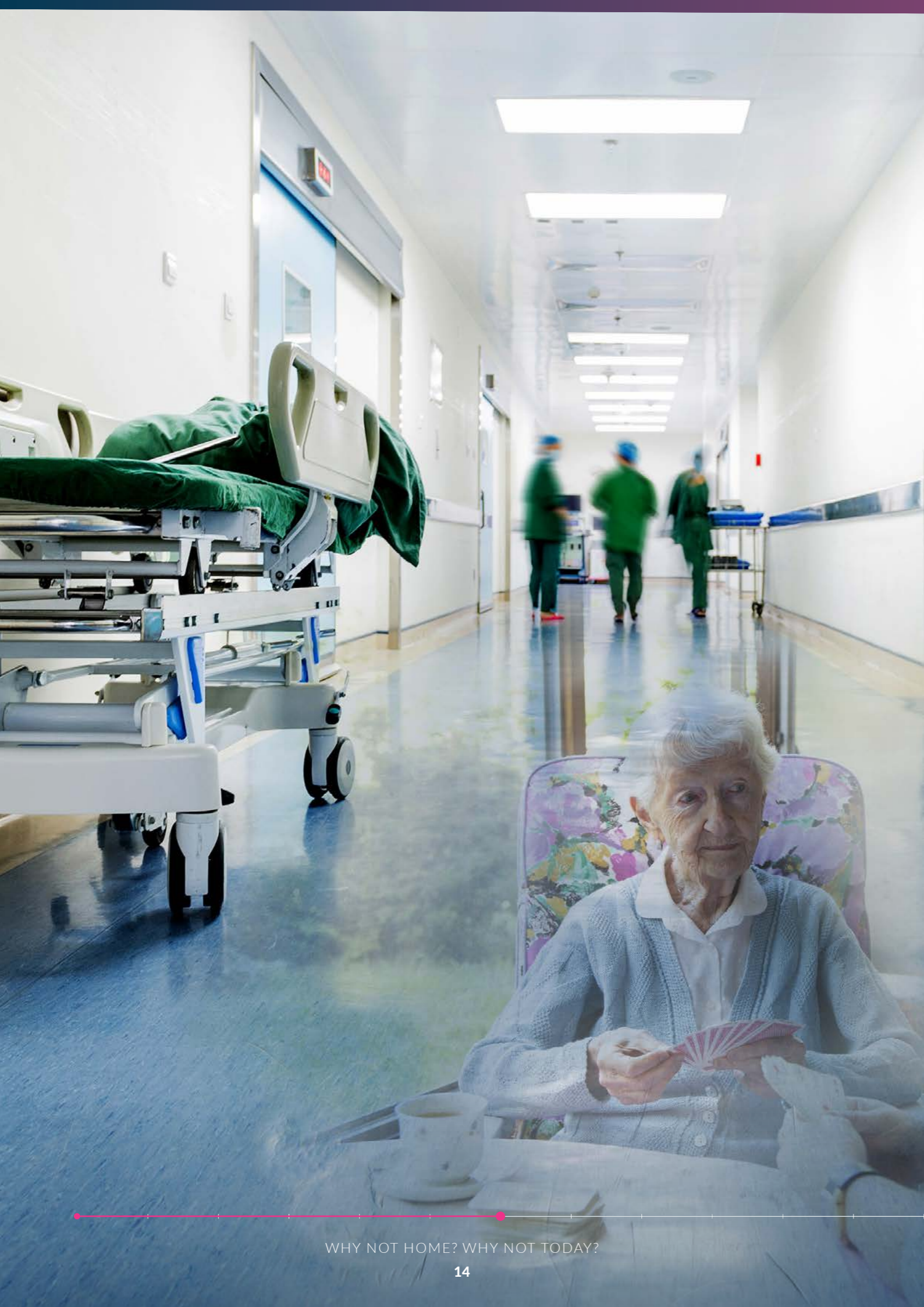
A collaborative approach was taken from the outset and that seems to have been received positively in the local systems, as evidenced by the enthusiastic engagement on all sides, by councils, NHS trusts, commissioners and the voluntary sector.

This report describes the work in detail, to share experience and to make a contribution to national learning on how to tackle this major issue of disjointed systems, processes and decision-making. Every day, this results not only in poorer outcomes and ill-health, but also represents a hugely significant waste of precious resource.

⁴ [https://www.local.gov.uk/sites/default/files/documents/Impact change model managing transfers of care \(1\).pdf](https://www.local.gov.uk/sites/default/files/documents/Impact%20change%20model%20managing%20transfers%20of%20care%20(1).pdf)

⁵ NHS Rapid Improvement guides: <https://improvement.nhs.uk/resources/rapid-improvement-guides-urgent-and-emergency-care/> and NHS Quick Guides: www.nhs.uk/quickguides

⁶ <http://nhsproviders.org/resource-library/reports/right-place-right-time-better-transfers-of-care-a-call-to-action>



WHAT IS THE PROBLEM?

For many years it has been recognised that people are remaining in hospital unnecessarily, waiting for the system to expedite their discharge to the right place. But the challenge of identifying the underlying causes and rectifying them with solutions that will ‘stick’, has yet to be addressed successfully.

Senior leaders to frontline staff across three local systems in the North of England, plus specialists from Newton, joined forces and agreed to:

- explore all the factors underlying delays
- identify what can be done
- test and measure specific changes to:
 - ensure better outcomes
 - represent a significantly more efficient use of resource
 - be sustainable over the long-term.

Is this specific to the North? No – DToC are a national problem.

The National Audit Office (NAO) report published in May 2016 titled ‘Discharging older patients from hospital’ states:



Unnecessary delay in discharge (older people) from hospital is a known and long-standing issue...longer stays in hospital can lead to worse health outcomes and can increase long-term care needs...it is also an additional and avoidable pressure on the financial sustainability of the NHS and local government.



Facts and Figures

In June 2017, the average DToC rate across England as reported by NHS England was **4.9%**⁷.

This means that at any one time, **1 in 20** hospital beds across England are occupied by someone who does not need, or want, to be there. And not only that – these individuals are being put at increased risk, simply by being in hospital.

However, based on the work described here and supported by other NAO studies⁸, the percentage of patients that are delayed in hospital at any one time is estimated to be closer to **8.8%**.

And that is equivalent to **1 in 11** hospital beds.

Given that just **10 days** of bed rest for an over 80-year-old is known to be equivalent to **10 years** of muscle aging⁹, it is very clear that there is an urgent need to put a stop to people being in hospital any longer than is absolutely necessary.



⁷ Percentage of 'occupied overnight beds' as recorded by the NHSE national dashboard June 2017

⁸ <https://www.nao.org.uk/wp-content/uploads/2015/12/Discharging-older-patients-from-hospital.pdf>

⁹ <https://www.ncbi.nlm.nih.gov/pubmed/18948558>

The **25% increase** in reported DToC days across England from 2015/16 to 2016/17¹⁰ has resulted in pressure to reduce delays, with national targets and requirements set by the Department of Health. Funds have been shared through the Better Care Fund (BCF), along with expectations as to how these funds should be spent, to improve the flow of patients into and out of hospital¹¹.

That said, the environment in which these improvements must be made is challenging with:

- growing demand from an ageing population
- increasing financial constraints
- pressure of a strong, top-down, command and control management culture in health
- incentives and drivers in each of the organisations involved, steering behaviours very much towards working separately – rather than collaboratively.

In early 2017, health and care leaders in the North of England decided to use their regional Better Care Fund support monies to tackle DToC in local health and social care systems. Across the region it was agreed that the aim was “to embed changes within local systems, through a holistic approach, that would maintain performance improvements sustainably over the annual cycle and beyond.” By working in detail with a small number of sites, it was envisaged that the learning could then be shared for the benefit of the region and wider.

Whilst the spotlight, quite rightly, is on the issue of people being unnecessarily in a hospital bed when they could be better and more safely cared for elsewhere, it is critically important to understand that:

DToC is not a cause in itself; it is a symptom of things going wrong in the wider health and social care system flow, the end result of which is a delay to the process of transfer. The result of this delay is a person, who could often be better placed at home, being stuck in a hospital bed.

There is evidence that if the wider system flow opportunities are addressed, the impact on delays would be significant. In the recent report by the LGA¹², some of these were quantified:

- **26%** of acute admissions could be avoided
- **20%** of acute bed days could be provided in a different, lower acuity setting.

To understand the picture fully, it is helpful to appreciate how DToC is reported in England. We provide a summary of this in **Appendix 1**.

It is also important to understand that the national picture masks significant underlying variation between different areas. Across England and similarly in the North, some providers regularly report **under 1%** DToC while others report well **over 20%**. Some areas and systems have addressed the underlying factors more effectively than others, providing opportunities for learning and improvement across the country.

¹⁰ <http://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7415#fullreport>

¹¹ <https://www.gov.uk/government/publications/local-area-performance-metrics-and-ambitions>

¹² <https://www.local.gov.uk/sites/default/files/documents/lga-efficiency-opportunit-b9c.pdf>

WHAT DID THE TEAM DO?

1. Identified sites for study

Newton worked with system leaders in the region to identify three areas. Sheffield, Fylde Coast and North Cumbria were selected to give a wide range of size, demography, urban/rural environments and system dynamics (see Appendix 2). They all showed high numbers of patients delayed in hospital beds, awaiting transfer to more appropriate settings. The view was that if a significant impact could be made on these diverse areas, then it would be reasonable to assume that the approach could be rolled out across the region.

As noted above, the **art of measuring DToC is complex** (see Appendix 1). Given this, the leaders of all three systems asked the team to extend the scope of the work beyond the reportable DToC measurement to look at all delays to patients declared medically optimised by a consultant – as it is delays of any sort that matters to patients.

In considering this report, it is important to note that throughout, unless stated otherwise, all 'delays' will refer to medically optimised patients rather than only those reportable as DToC.

2. Scrutinised the data

Newton's approach to intense diagnostics is to gather every piece of relevant data available – from every possible source. The team do not accept the data as it has been collected thus far, but goes through a rigorous process of triangulation to establish exactly what is happening to patients as they move through the system.

In each area the team worked and consulted with:

- acute hospitals
- community providers
- mental health providers
- adult social care services
- clinical commissioning groups (CCGs)
- primary care
- the voluntary sector.

3. Listened to people in the system

Establishing the reality of patients' journeys through the system by gathering rich, detailed information and intelligence, was continued into the next phase of the project by a process of listening carefully to people who work at the frontline of the system. This was an important principle, set right from day one. All judgments on the selected care pathways, as well as the opportunities for improvements, would be identified and made by the local practitioners themselves because they are closest to the frontline working reality.

A series of practitioner-led case reviews were set up with mixed frontline teams of acute and community nurses, consultants, care workers, therapists and GPs. A total of 132 cases were examined, each through the eyes of all the different care professionals around the table, to assess whether or not the best pathway decisions had been made for each case, at the appropriate time.

The intensive diagnostic exercise in each area concluded with a local **'summit'**, chaired and led by executives from each of the system partners. Each summit brought together over 40 senior managers and directors from across the CCG, hospital trusts, council, and the voluntary sector.

After establishing a common understanding of the findings, groups were set the tasks of drawing up:

- short-term plans to prepare for this coming winter
- longer-term plans to reduce DToC more permanently.

Overall, the team:

- reviewed the journeys of some 2,800 patients through the system, including 501 delays
- analysed 12 months of historical data in order to identify trends, opportunities and strengths and to highlight aspects worthy of more detailed investigation
- interviewed over 80 staff members, across all partners and levels of seniority, to explore mindsets and behaviours – both current and desired
- ran practitioner-led case reviews of 132 cases to understand whether the best pathway decisions had been made for each patient.



WHAT DID THE TEAM FIND?

A number of the findings were surprising – and some traditionally held assumptions were challenged.

Importantly, it became clear (and was evidenced) that the key underlying factors of delays to patient transfers cross over organisational and service boundaries.

Here are some of the key discoveries:

1. Things are not always as they seem to be, it all depends on exactly what is measured

Definitions of DToC turn out to be complex (see Appendix 1). As a result they may be interpreted very differently, even in neighbouring areas.

The credibility and usefulness of comparisons – and of course targets derived from the national DToC statistics – are considerably undermined by this factor. This is why the team, in response to local leaders, extended the scope of study to include ‘**all delays to patients who had been declared as medically optimised by a consultant**’ as a robust, easily defined and comparable measure.



During this study, DToC reported as a percentage of total medically optimised delays varied significantly, with one system reporting 23% of medically optimised patients as DToC and another 69%¹³.



NHS England defines DToC as follows:

A delayed transfer of care from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed. A patient is ready for transfer when:

- a) A clinical decision has been made that the patient is ready for transfer and
- b) A multi-disciplinary team decision has been made that the patient is ready for transfer and
- c) The patient is safe to discharge/transfer.

¹³ See Appendix 1.2

2. Where there's a will, but...

At every level, of every part of the system, in each of the three areas, the team came across people who were passionate about improving outcomes for patients.

During the practitioner-led case review workshops, clinicians and social care professionals were asked to describe an ideal system for patients – one which would ensure that delayed transfers of care did not happen. There was a high level of consistency in their responses.

The most commonly agreed words used by practitioners to describe an ideal system:



Figure 1: The ideal system for patients, from the staff's perspective

Change the language... no more talk of 'failed discharges', use 'outcome' plan, not 'discharge' plan (discharge focuses on the step, rather than the outcome). Rather than 'have we got delayed discharges?', it should be 'have we got the right outcome processes in place?'

Despite consistently positive aspirations, there is a large gap between these and the descriptors for the attitudes and behaviours staff identified as the reality of "how it actually is".

Here is the gap – as described by staff at the frontline of health and social care, consistently and irrespective of what they do or where they work:



Figure 2: Today vs. ideal mindsets and behaviours as seen by staff

3. Why is it the way it is?

People working at the clinical and social care frontline know how their working life should be – and how it should be for patients when they come into, and get out of, hospital.

They know that the way things run today is just not right. Staff do their very best for patients **despite** the constraints of the system, knowing that they are not always able to offer the care they want to provide, or would want a member of their own family to receive.

To address the gulf between how things work now and how everyone agrees the system should be, it is critical to understand why things are the way they are. This work provided clear and consistent insight into this – despite differing geographies and demographics.

Here are the underlying themes to be tackled:

1. Both health and social care teams influence the issue. Delays are a symptom of systems that do not work in a joined-up way. The key to addressing these symptoms is a shared understanding of the problem and collaborative working to address it.
2. Delays are underpinned by lack of clarity and ownership of the progress the patient makes through the system. Alongside this, frontline staff describe a failure to grasp the opportunity to improve the decisions made about the pathway for individual patients – defaulting to the habitual and easiest solution, rather than working out the optimal pathway for each individual.
3. Leadership sits at the core of tackling delays. In complex systems, strong relationships and mutual understanding are crucial to enable people to work together, to make change happen and to make it stick. To tackle the challenge of delays for patients, leaders must set the example and shape how the system behaves. This is not a simple ask. With systems under considerable pressure – perhaps with limited experience of implementing and sustaining complex change, or without sight of a clear evidence base showing where to prioritise and focus.

This work describes leaders driving change, and succeeding, often despite the prevalent climate and leadership models nationally, which tend to drive behaviours to more compartmentalised thinking and working. Given this, how can leaders be equipped with the tools they need?

The three systems in the study approached the issue of shifting behaviours in three ways:

- using the right level of detailed evidence to support consistent prioritisation across system partners
- following the first stages of a structured process proven to embed sustainable change (see Figure 4, page 39)
- taking time to reflect and break away from the fire-fighting mindset.

One of the three areas, once aligned behind the priorities of the respective Chief Officers of the three partner organisations, empowered one of the group to act as the voice of the total system. This cascaded down, with the respective COO / DASSs empowered to 'own' system-wide improvements, crossing each other's traditional boundaries. This has provided a powerful foundation for change.



Looking at the data and intelligence from frontline staff more closely, the team identified a set of underlying organisational issues.

Summary of the underlying factors:

- Lack of trust, feelings of fear
- Transactional thinking
- Complexity
- Lack of credible, granular evidence
- Trying to do too much
- Lack of appreciation of different cultures
- Habits

Underlying factors

- **Trust issues and feelings of fear** – At every level, both within and across organisations, staff expressed fear of the consequences of changing the way things are done or of driving the decision-making process. From physiotherapists expressing fear of litigation, to senior leader debates over how BCF funds would be used, trust was notably absent.

Trust is crucial. In an environment of fear and suspicion, staff are:

- more likely to default to the 'safe', habitual solution, with avoiding risk taking a higher priority than outcomes
- less likely to try new ideas or adopt new approaches
- less likely to maintain and use a consistent set of information.

Use of information and clarity of communication frequently compounds a lack of trust. When different individuals or groups look at snapshots of the data, but at differing points in the process, and therefore from different perspectives – friction arises. This is why, whenever possible, real time information – or as near to real time as is feasible – is a critical step in creating a culture of trust.



Hospital-based clinicians hear a great deal about the few 'failed discharges', but they will rarely hear the successes. This is a powerful driver of risk averse behaviour, which in itself can be contagious.



In one system a heated Friday email debate was observed following one organisation getting sight of a detailed list of delays. Unfortunately, the list was from the Monday and by the time it was being brought to light, many of the delay reasons had changed.

Establish 'one list' of delays that all partners can access and work to

- **Transactional, rather than whole system thinking** – In many instances staff described how a small part of the process had been improved in the system, without any understanding of the impact on the process as a whole.

Focusing on the delay without monitoring the outcomes at the same time places the sustainability of solutions at risk.

The new NHS social care interface dashboard¹⁴ provides a positive step in the direction towards a more balanced set of metrics. It also highlights examples of systems where reablement is happening in name, but not to the optimum level of effectiveness that is possible.

In one system, 'improvements' to the reablement service had decreased the time to reable, thus increasing capacity of the service and reducing delays for patients waiting at this step of the discharge process. However, this had not been done with an accompanying improvement in practice, thus the number of patients leaving the service having met their goals reduced from 30% to 20% (best in class systems can achieve 50+%). This change left service users with less independent outcomes, and increased demand on an already pressured domiciliary market.

- **Complexity of pathways** – Decision-makers at the frontline often have a vast number of different, complex pathway and service options to consider. This makes consistent decision-making slower and more difficult. Staff members in one area studied by the team were navigating more than 10 differently defined discharge pathways. Complexity was also sometimes seen as a barrier to the understanding and appreciation of the system as a whole, meaning that it is difficult to be able to make the most effective decisions about what support to provide. As a result, many staff, particularly when stretched and stressed, tended to '**stick to the bit they know**'.

Complexity may also be an indicator of the system not working as it should. New services and functions may be added, but people in organisations may be reluctant to stop doing the things they have always done (possibly a further manifestation of risk-averse behaviour). As new services or functions are added over the years, there is a build-up of incremental changes, adding still further to the system's complexity.

- **Lack of credible, granular information to support improvement** – The right level of evidence to support individual decision-making, consensus and wider system prioritisation of actions is critical in any complex environment. Much of the data available in the areas that were studied took the form of a '**snapshot**' of the overall position in terms of delays. Clear, accessible live data on outcomes and effectiveness of services was rarely available.

Credible, accurate and timely information, providing an appropriate evidence base is the essential foundation for driving improvement. Without access to a single, shared agreed understanding of the issues, based on sound evidence, as outlined in this report, it is extremely difficult to progress effective change.

¹⁴ <https://www.gov.uk/government/publications/local-area-performance-metrics-and-ambitions>

- **Trying to do too much** – In all the areas studied there were lengthy action plans in place, with numerous improvement schemes underway. These lacked clear prioritisation and alignment across the system, limiting their impact. In some instances, teams were making changes within their own organisations without considering the impact they would have on other parts of the system. The end result was a fix for one issue – but meanwhile a new issue was inadvertently created elsewhere.

It was also commonly observed that teams were jumping to potential solutions, without fully understanding the underlying factors and opportunities for improvement. There are often pressures on organisations from national bodies, requiring that copious volumes of best practice guidelines are followed and that plans are submitted. Streamlining these processes would relieve some of this pressure to allow teams to focus on local priorities.

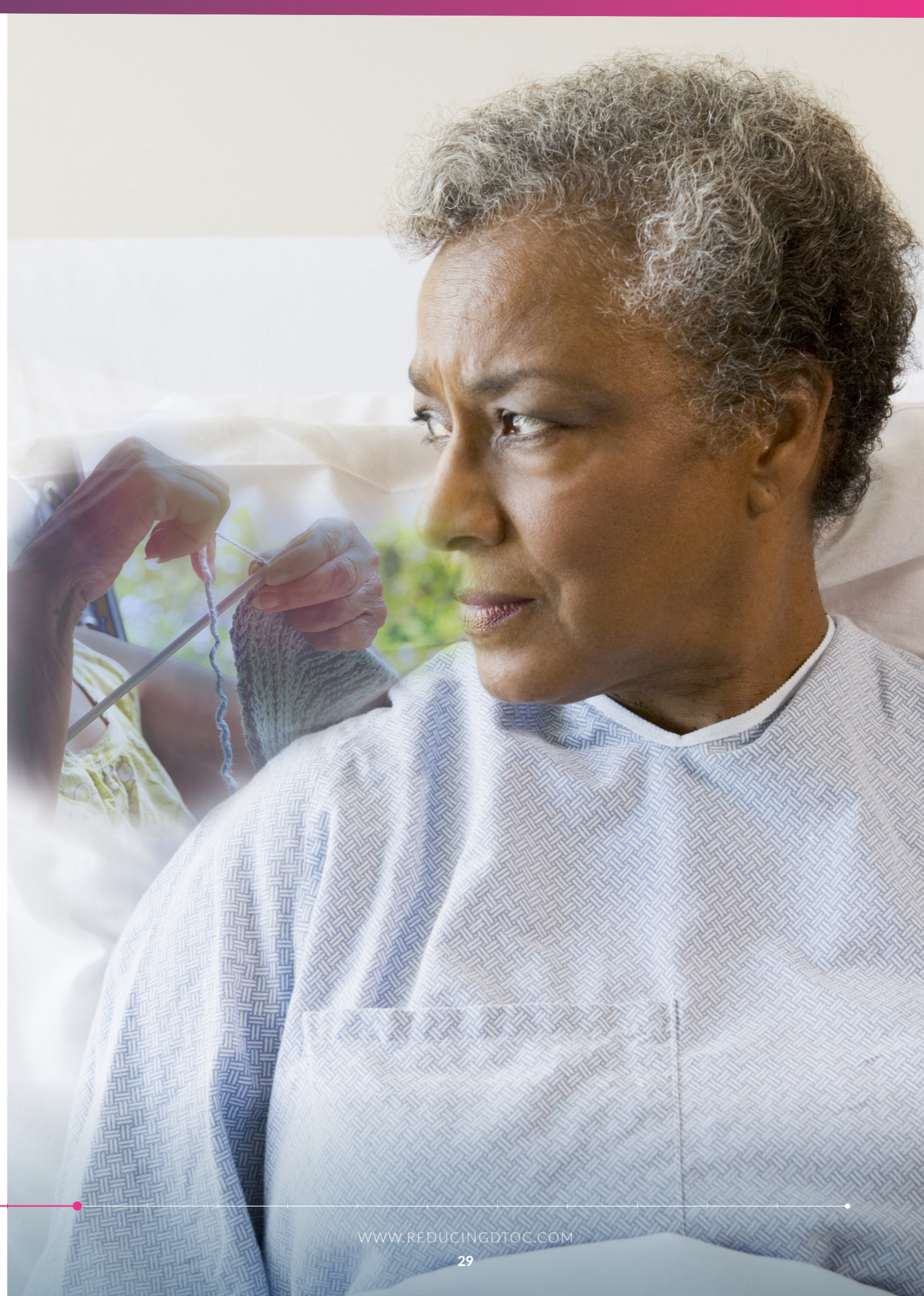
It may be that national bodies could support change by filtering and rationalising the guidance, acknowledging that different systems will require different support.

- **Lack of appreciation of different cultures** – Health and social care are very different organisations. Each has its own culture, strengths and challenges. Many of the leaders interviewed in this study had limited appreciation of the reality of the culture and pressures in parts of the system other than their own.

This often led to poor communication or misunderstandings that held back progress. Differing approaches taken to change, for example command and control as opposed to local sector-led improvement, compounds this factor further.

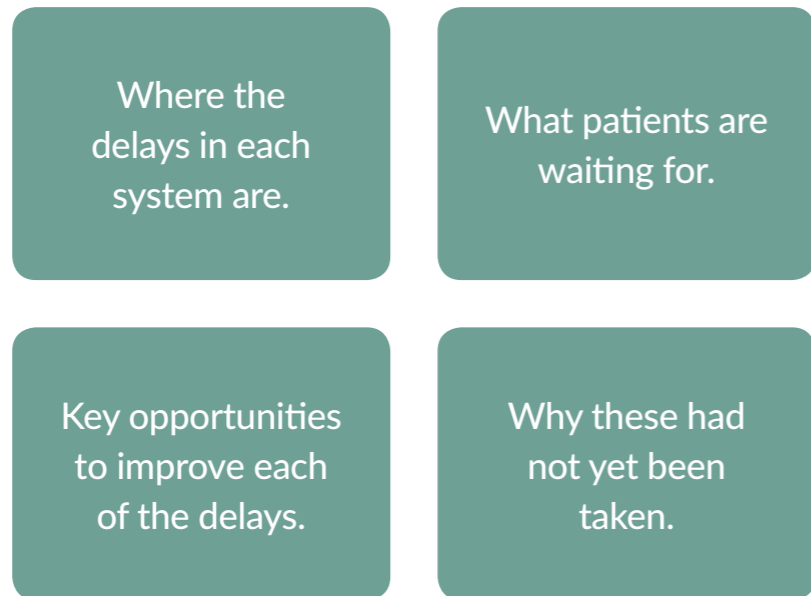
- **The way things have always been done** – The ‘way things are and always have been’ shapes deep-seated habits, which are difficult to change. Also, people tend to revert to the ‘norm’ when under pressure. These factors are rarely considered fully in change programmes, yet they may have a major impact on the speed and effectiveness of improvement. The local start point is critical and needs to be fully considered in any change effort.

Consultants who had worked in a certain way for 20+ years, therapists based for many years in an acute setting, rather than the community, the configuration and number of community hospital beds in the system all behaved in this way – “this is just the way we do things here”.



4. Waiting, waiting, waiting...

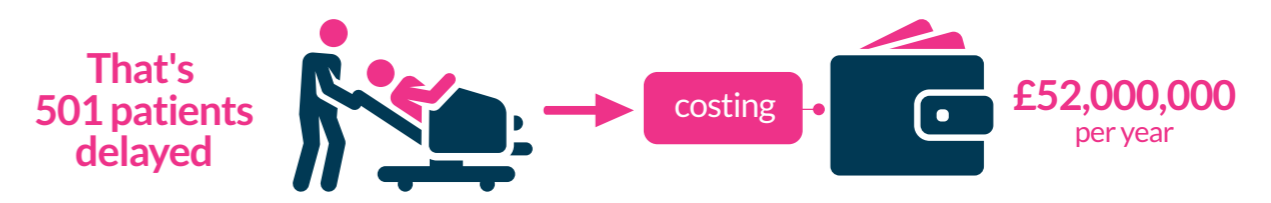
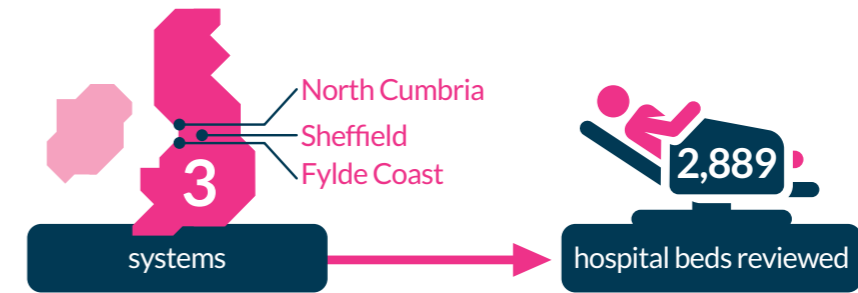
In each area, the team identified:



The findings are shown in detail in **Appendix 2**, providing a summary of the three systems studied. Consistent themes and issues emerged across all three areas, most of which will not be unique to these systems. The team also observed key local differences, highlighting the importance of designing changes that embrace local environments and challenges, if they are to be successful and sustained.

Delays fell into three categories:

- waiting for a decision on the pathway to be made
- waiting to go to either an intermediate, nursing or residential care bed
- waiting to go home with some extra support.



TOP 3 REASONS

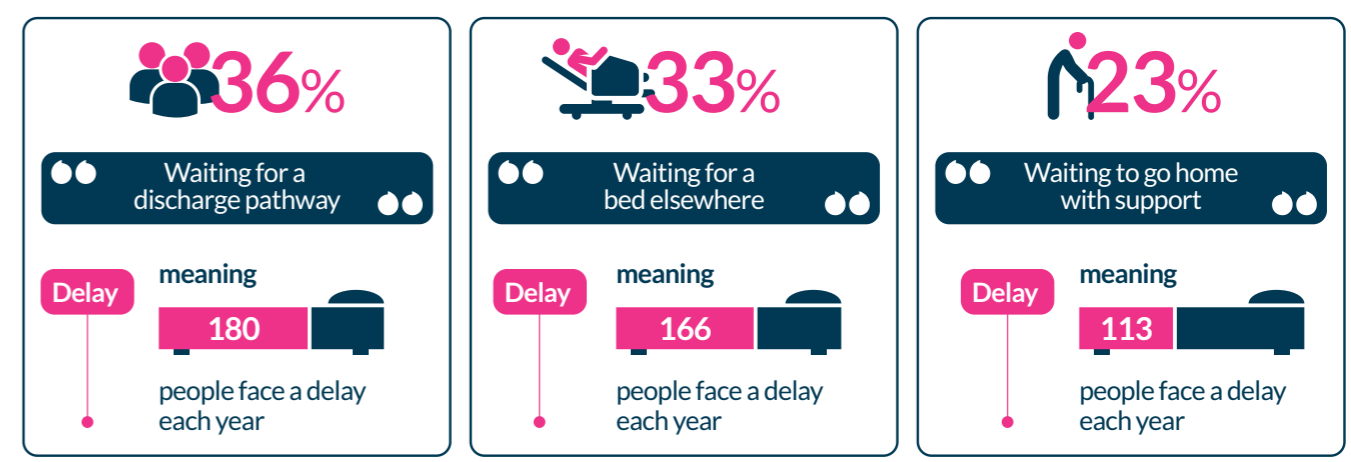


Figure 3: Causes of delay

Waiting for a decision on the pathway to be made

36% of delayed patients were waiting for a discharge pathway to be allocated, the main waits being for assessments and therapy.

- Across all three systems a consistent theme emerged – of poor communication of the patient’s status and their next steps. This, coupled with a lack of clear ownership for progressing each patient along the chosen pathway, was seen to lead to unnecessary delays. By default, ownership sits with the service undertaking each step.
- This results in each step being undertaken in series, one after the other, rather than in parallel. Running all the steps in parallel would not only dramatically reduce the overall time taken, but would also result in a better-informed process of decision-making. Each of the services involved with the patient would be learning from the findings and progress of the others, and everybody would be working at the same time towards the end point of the best possible outcome.
- However, there is more to be considered than simply reducing the number and extent of the delays. Should the assessment and/or therapy be taking place in an acute setting at all?

A review in one of the areas showed...

60% of assessments and/or therapy could have taken place out of hospital; the remaining **40%** could have been completed in parallel with other steps.

In one system, according to the hospital, eight patients were waiting for a social care assessment. When reconciling the list with the social work team, only one of the eight patients matched their list. This means that the team were either not aware what the patient required next or the referral had not been made, both of which cause unnecessary delay to patient discharge.



I have no idea who is meant to be progressing this patient and not sure who to ask to check.



-- Ward Nurse

Waiting to go to either an intermediate, nursing or residential care bed

33% of patients were on a pathway to an intermediate, nursing or residential care bed, the main waits being for nursing beds, funding agreement/CHC and residential beds.

- Unless there are exceptional circumstances, the decisions about patients’ care for the long-term, for the rest of their lives, should not be made in an acute setting. People are more confused and appear to be more vulnerable in an unfamiliar acute environment; they are likely to be more stressed, fearful and short of sleep than they are in their familiar home environment.
- In this study, decisions were being made in an acute setting. Teams of multi-disciplinary practitioners identified that **42%** of the patients in this cohort could have benefited from a different pathway decision.

In the main, the preferred pathways identified were to get the patient to their own home, with a period of reablement. The principal reasons for the decision not to discharge the patient to their own home with reablement were:

- reluctance from the frontline decision maker to take a perceived risk
- expectation setting with family/patient earlier in the pathway
- capacity of the reablement service.

Don't make long-term decisions for patients whilst they are in hospital

Waiting to go home with some extra support

23% of patients were waiting to go home with some extra support, the main waits being for domiciliary care and reablement.

- The greatest variation between the three areas was seen in this category of delay. North Cumbria, where the system has restricted capacity in the providers of care at home, given the remote geography and also competition for staff from the tourist industry, had the highest level, at **38%**.
- In all the areas studied, there were opportunities to discharge more patients to their own homes with reablement services. Alongside this, opportunities to improve service effectiveness were identified which would reduce patients’ long-term care needs and demand on the domiciliary market.

In all three areas, analysis of the data and subsequent scrutiny by frontline staff revealed that if the reablement service was supporting the appropriate volumes of people and working effectively, it would lower demand for domiciliary care to below current levels of capacity, thereby reducing delays. It is important to understand how many people will require what service each week and to ensure that there is the right supply to meet that need, with a focus on the outcomes delivered in a timely fashion.

- As seen in the other two delay categories, poor communication slowed progress for many of these patients, leading to additional deconditioning and greater care needs.

Appendix 2 gives a summary of practitioner-led case review findings, highlighting where multi-disciplinary teams felt better discharge pathway decisions could have been made and the main reasons for these not being taken.

5. Counting the cost

The cost of delays is rather more complex than simply the cost of the beds people are waiting in.

In the simplest sense, costs are considered here in two areas:

- a. Cost of non-ideal outcomes (split of council and NHS cost)
- b. Cost of acute and community beds occupied by delayed patients (NHS cost)

Cost of non-ideal outcomes:

The cost of non-ideal outcomes considered in **Table 1** are measured by considering the downstream cost of care provision for patients leaving hospital, where different pathway decisions could have been made. The practitioner-led case reviews in this study showed that **39%** of pathway decisions in hospital could be improved¹⁵. In over **90%** of these cases, the preferred approach would be to support patients on more independent, and less expensive, pathways, which also have the added benefit of reducing down-stream pressure on capacity. The table splits these into 4 categories of decision point.

Cost of acute and community beds occupied by delayed patients:

The costs outlined consider the variable costs for the 501 occupied delayed beds observed during this study¹⁶.

Based on the initial progress made in systems, the cost of remaining occupied delayed beds, not addressed by improved decision making, has been split into 2 lines:

- the cost of delays which is accessible through short-term activities designed to gain agreement on exactly what is happening (what in Sheffield went on to become known as the 'Get Control' phase)
- the cost of delays which will likely require medium or longer-term solutions.

| What is the cost of delays and decisions? | | | |
|--|--------------------|--------------------|--------------------|
| | In hospital | Out of hospital | Total |
| Decision point 1: Domiciliary to reablement | £920,000 | £5,890,000 | £6,810,000 |
| Decision point 2: Residential to reablement/domiciliary | £280,000 | £5,760,000 | £6,040,000 |
| Decision point 3: Nursing / EMI to residential/community/reablement | £480,000 | £2,880,000 | £3,360,000 |
| Decision point 4: Community hospital to reablement/domiciliary | £280,000 | £2,650,000 | £2,370,000 |
| Cost of remaining occupied delayed beds - requiring medium / long term solutions | £23,980,000 | £- | £23,980,000 |
| Cost of remaining occupied delayed beds - accessible through short term 'Getting control' activities | £10,280,000 | £- | £10,280,000 |
| ALL AREAS | £35,660,000 | £17,180,000 | £52,840,000 |

Table 1: Cost of delays and decisions

Downstream costs of delays and decision-making totalled **£17.2m (35%** of the total cost of delays) across these three systems, highlighting the importance and impact of system partners working effectively together for the overall benefit of patients and the system. This counters another of the traditionally-held beliefs that '**Local Authorities drag their heels**' when progressing patients as they are reluctant to take on the costs.

¹⁵ Appendix 2, Table 2.4

¹⁶ £196 per night - Based on figures provided by the finance teams in the systems reviewed



FIXING DELAYS

So far, this report has explored the behaviours, findings and key causes identified by detailed study and analysis of three areas across the North of England. So, how might others use this experience to tackle delays in their own systems of health and social care?

Firstly – how might systems go about reducing DToC (mindset and approach) and secondly, more specifically, what could be implemented and when.

1. The how... tackling mindsets and approach

The mindset required to tackle delays and work effectively as one system demands that leaders model the right behaviours.

Throughout this report the need for strong, effective and empathetic leadership to support a clear and positive approach is evident. Top-down, command and control approaches will not support the degree or the nature of change needed. Strong, effective, cross-system cooperative leadership is needed – rather than ‘siloed’ systems of leadership within individual organisations.

In the end, however, a plan can be the best-designed ever – but it will fail to achieve change if the specific behaviours needed are not modelled by system leaders.

Themes emerging from the three geographies covered by this study suggest that the system must have a single objective – to support the best possible outcome for the patient, and not simply to release the bed quickly. It has also become clear from this work that five practical behaviours are needed to drive improvement.

These are:

- Gaining buy-in to the cross-system mindset (one voice...)
- Being open and raising issues when behaviours slip, especially when the system is stressed (use the data...)
- Creating a safe environment in which concerns may be shared
- Protecting time to plan (summits and forums...)
- Holding each other to account (honesty and fairness...)



The way you have challenged and galvanised us as execs across the system has been invaluable, and has been a big part of the difference of this approach, alongside the rigour and depth of diagnostic.



-- CCG Director of Strategy

Three DToC summits have been held in Sheffield, bringing together colleagues from across all parts of the system. A key feature of these summits has been a 'leave your badge at the door' mindset. This tactic has been very effective – to the extent that it has been difficult to work out who works for which organisation on the day. Through these events a culture of shared accountability is emerging. This 'one-system' mindset with a focus on defining and taking practical action to reduce the number of people waiting for transfer, is providing a much-needed understanding of the avoidable delays in Sheffield.

A regular process of reviewing delays is now in place, creating a shared focus on resolving both here and now reasons for delay and making changes to prevent themes from re-emerging. This frontline focus is underpinned by a clear and rapid escalation route to the highest leadership levels in the system.

Supporting both of these areas is a shared data set that each part of the system trusts. This data is used to work through delays by priority, using delay reasons as the main driver, and provides the starting point for all actions to prevent delays.

Sustaining large-scale change

Previous work on integration of health and social care systems has highlighted the importance of a structured approach or 'model for change', to ensure that the changes put in place withstand pressures and are sustainable over the long term¹⁷ (a summary of this is given below in figure 4).

The model for change approach was adopted in this work by drawing together evidence of the local start point to support prioritisation. Frontline teams were heavily engaged in this, not only to gain consensus but also to align efforts across the system.

The approach also highlighted some key differences from previously held assumptions, particularly on where the major opportunities for improvement might lie in each of the systems reviewed.

Sustainable improvement was a key objective for this work. Focusing purely on the delay, without measuring or monitoring the impact or outcomes for patients, places the sustainability of the solutions at risk.

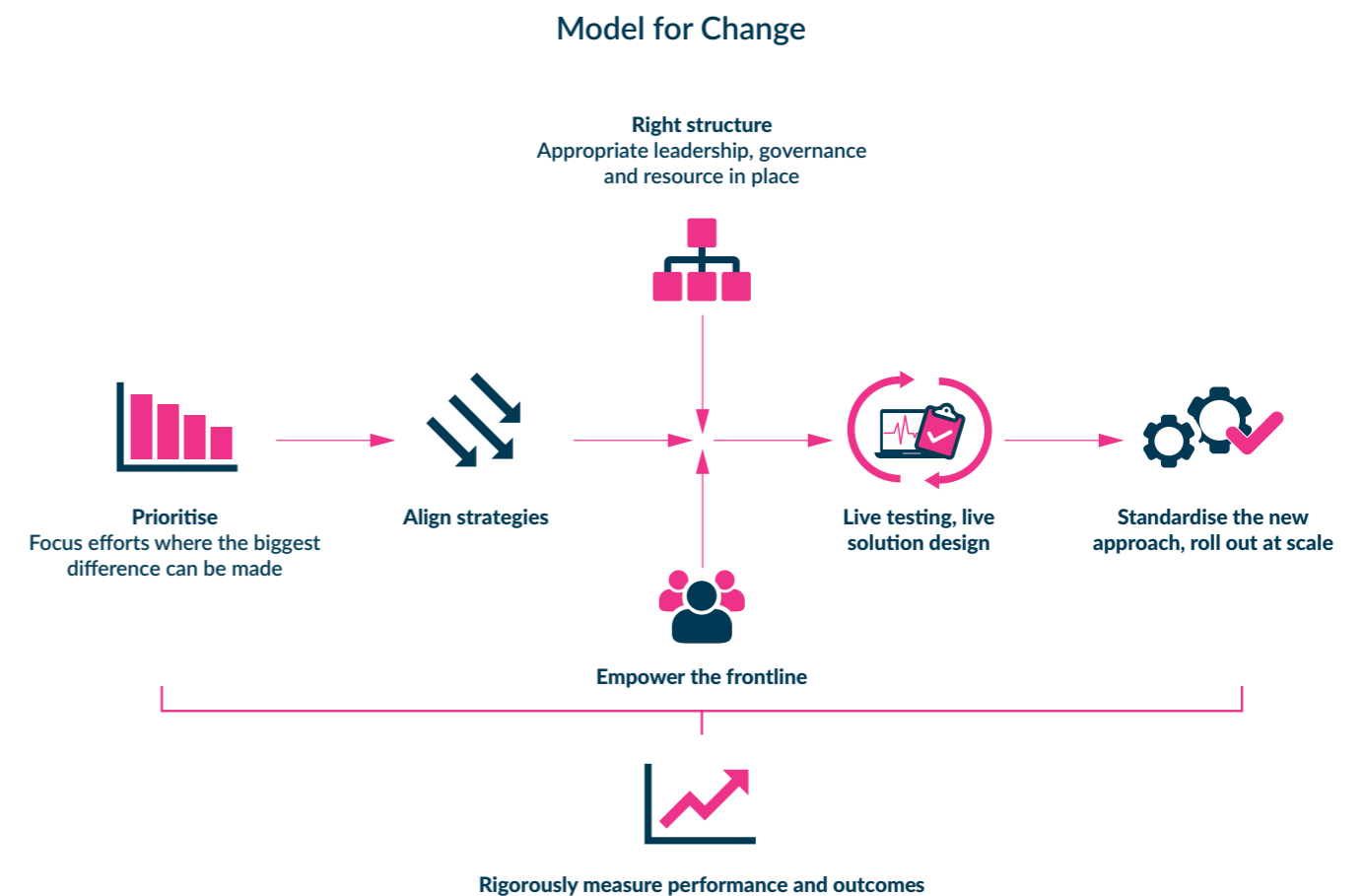


Figure 4: Model for change

¹⁷ <https://www.local.gov.uk/sites/default/files/documents/lga-efficiency-opportunit-b9c.pdf>

One of the areas studied felt that their delays were mainly caused by external factors. The data revealed that although the majority of improvements to be made originated within the hospital, to make and sustain these improvements would require all the various parts of the system to work together.

In another example, an area had adopted some of the best practice interventions from the '8 High Impact' change model, including 'systems to monitor patient flow'. Detailed review of the data showed that despite the strong technical solution in place, less than 50% of the staff on the wards were using the system as intended, limiting the impact and output.

Whenever possible, pathways should be simplified. For example, Sheffield have established 'three routes out of hospital'

2. The what and when: a phased approach

It has to be said that reaching the point where delays in the transfer of patients from hospital beds is a thing of the past, could take some time – and is unlikely to be straightforward. In taking this work forward from the assessment, system leaders, supported by the project team, have broken down their approach into three main phases.

Sheffield used the following terminology and structure for the phases:

- **Get Control** – 4–6 months
- **Right Practice** – next 12 months
- **New Solutions** – looking to the future

Get Control – first 4–6 months

'Getting control' means the partners in the different parts of the system sharing an on-going clear understanding of what is causing delays. It means putting the right people around the table to make decisions. Critically this means people who work at the frontline of health and social care.

In order to manage flows in the systems, the volumes required for each service (of the right pathways) must be understood. The system studied here did not yet have a clear picture of this.

Sheffield used the following approach to 'get control' of its patient delays:

- a. Having one clear view of current patients delayed that is used across the entire system
- b. Prioritising the actions that were taken based on understanding the areas where the biggest impact could be had
- c. Building an enhanced escalation structure to let the right people know what needs to be done, at the right time.

Sheffield put three meetings in place to tackle the points above, referred to locally as: Task, Flow and Escalation.

- **Task** takes one delayed patient list for the hospital and prioritises patients by the length of time they have been waiting. This single, prioritised list is then used, with a focus on the top few patients, to take action supporting them, and a follow up the next day.
- **Flow** looks at trends in delays for individual services, rather than individual patients, and health and social care managers get together to take actions to address themes and causes of these delays.
- The **Escalation** group comprises senior health and social care managers, and takes problems escalated from the **Flow** meeting, to resolve them. These could be:
 - practices on certain wards
 - capacity in the home care market
 - lack of residential home vacancies across the city
 - issues requiring long term solutions.

At the time of writing, Sheffield's 'Get Control' phase is already delivering results, and has given everyone in the system a much clearer picture of what is going on.

By working together in this way, teams have managed to reduce the number of DToC patients waiting in hospital beds by 35% in 12 weeks.

This improvement has required additional interim improvement resources and capacity to achieve; further work is required to sustain and build on the initial change. Given current workforce pressures in many systems, it is important to consider and resource the requirements accurately, to undertake and embed this scale of change.

The practical joint working, and the positive culture that achieving this success together brings, is supporting the system more widely in taking steps towards accountable care.

In the 2 weeks following their second round of summits, staff at Fylde Coast prioritised what they were working on and put in place an escalation structure to drive delays daily.

Alongside plans already in practice, this resulted in:

- A&E performance going from under 80% to high 90s%
- no people waiting on trolleys to be admitted, in the emergency room
- outliers reduced from 70 to 14.



Your work helped us focus. The most positive thing is the way all the people from all the organisations have worked together as one.



-- Comments from members of staff during the assessments



Right Practice – next 12 months

There are many valuable resources available across health and social care sharing elements of best practice. These include the 8 High Impact Change model¹⁸ and the NHS Quick Guides¹⁹.

Once systems have a good understanding of their processes, they will have a clearer view of the elements of best practice most relevant to them.

It is important to note that what works in one area may not be relevant in another. However, the following principles are likely to be helpful in most areas:

- focusing on priorities
- considering the local context
- adopting a realistic approach to implementation
- reviewing regularly.

Taking this approach should allow systems to prioritise the implementation of the areas of best practice which will make the most difference for them.

New Solutions – the future

At this point, systems have a good grip on patient delays, and have drawn on best practice.

Only now is it time to start considering new solutions...

Bear in mind:

- Three systems in the North of England have begun their journey to tackle delays and have made a strong start. However, strong effective leadership, consistent with the behaviours highlighted earlier, at every level, will be needed to sustain the change.
- The purpose in managing the discharge process for patients is to ensure that each person has an outcome plan focusing on their opportunity to recover from the hospital intervention.
- The discharge process should focus on the right setting for the assessment to determine the long-term outcome for the patient and the support delivered by the out of hospital care system – rather than whether or not the patient's discharge is delayed.
- A properly commissioned set of services is needed, that support patients at the point of discharge on the basis of what is best for the patient, rather than what is convenient for the organisations. These might include:
 - nurse care
 - therapeutic support
 - reablement-based care for a person in their own home
 - bed based facilities (which will have therapeutic and nurse support as well as good quality care).

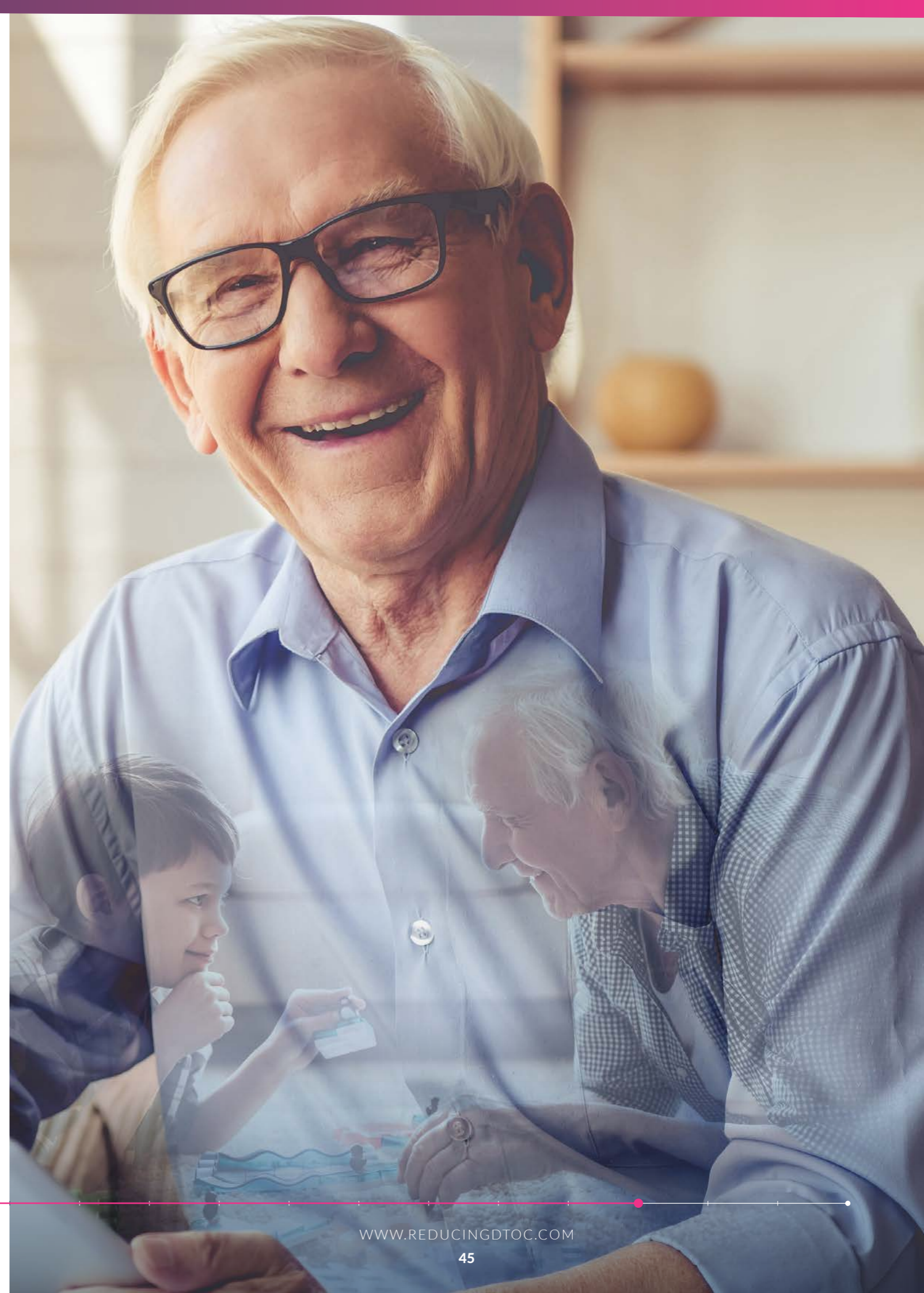
For some older people a simple volunteer service helping the person with practical tasks to re-establish themselves back at home is sufficient.

¹⁸ [https://www.local.gov.uk/sites/default/files/documents/Impact change model managing transfers of care \(1\).pdf](https://www.local.gov.uk/sites/default/files/documents/Impact%20change%20model%20managing%20transfers%20of%20care%20(1).pdf)

¹⁹ The Quick Guides can be found at www.nhs.uk/quickguides

Collectively these services might be thought of as **'Intermediate Care Services'**.

- Health and Care Commissioners need to understand the weekly demands that these services are likely to experience and to commission the right services in the right volumes to meet needs. Big question... are the right services being commissioned to achieve the right outcomes?
- Commissioners should hold the providers of these services to account for the outcomes delivered. Where all these elements are in place, it is possible to manage the flow of patients through the hospital, subsequent community services and back home with minimal delays.
- Where Intermediate Care Services, comprising both health and social care, are collectively supporting people's recovery, there is less chance that the system will be dealing with people whose needs they are unable to meet.
- If the right care pathway becomes the easiest care pathway to follow it is likely that fewer people will find themselves with the wrong forms of care and support.



IN CONCLUSION

1. Delays in the transfer of patients from hospital settings have been thought to be a problem of lack of capacity in social care. This work shows that the issues generally start in the hospital setting. That said, the evidence shows that each partner has had as much influence on both the delays and their solutions as the other. DToC is a system problem, and solving it needs effort from all parties.
2. A single set of evidence is needed, showing where people are waiting and a shared understanding of the underlying causes, based on robust, detailed evidence.
3. A shared set of priorities must be established.
4. Getting the right people together on a regular basis to take action, with a well-defined escalation structure is a must. It is also crucial that frontline teams are involved in these meetings.
5. Strong and appropriate leadership behaviours are needed to support this.
6. The right pathway should be the easiest pathway. And this should be a matter of course.

Thank you to all the people in North Cumbria, Fylde Coast and Sheffield who participated in this study and were so generous with their time - without you, this work would simply not have been possible.

APPENDICES 1 AND 2

Appendix 1 – Measuring Delayed Transfers of Care (DToC)

1.1 The current definitions for DToC²⁰ are complex and were observed to be subject to different local interpretations and practices. NHS England defines DToC as follows:

A delayed transfer of care from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed. A patient is ready for transfer when:

- A clinical decision has been made that patient is ready for transfer and
- A multi-disciplinary team decision has been made that patient is ready for transfer and
- The patient is safe to discharge/transfer.

1.2 If, for example, a system is setting Expected Date of Discharge (EDD) inconsistently or differently from the way other systems measure it, this has a significant impact on the reportable DToC figure. Some systems only include as DToC after the EDD has passed. Other systems do not focus on this in the same way. Technically, this date should be passed before a DToC is registered, as this is the date that the onward services should have been notified as the target discharge date.

In this study, major variation was seen in how the EDDs were set between systems and individuals within them, with some setting as the expected medically optimised date (correct), while others were building in to the date the expected delay for certain pathways (e.g. they know home care takes a week to put in place), thereby masking the true situation. Overall EDD accuracy was low and inconsistent across the systems observed.

1.3 DToC statistics are reported to NHS England by NHS trusts each month and compiled into the 'Monthly Situation Report'²¹. The primary measure is the 'total delayed days per month'. A 'delayed day' is where a patient remains in a hospital bed for a day and has been classified as a DToC according to the NHS definition²². It can be more useful to think of it in terms of 'delayed beds', whereby a bed is 'blocked' permanently, or 365 days a year (1 delayed bed = 365 delayed days). DToC can also be quoted as a percentage, which allows comparison between systems with different numbers of beds. The DToC 'rate' (%) is the DToC bed figure (average daily number as a percentage by the number of 'occupied overnight beds'²³. This can only be used nationally or at Trust level. Per 100,000 adult population is used as an alternative nationally and as the comparable rate at local authority geography.

It is also crucial to understand what DToC refers to specifically: '4.9% DToC,' for example refers to 'the percentage of occupied overnight beds' as recorded by the NHSE national dashboard June 2017.

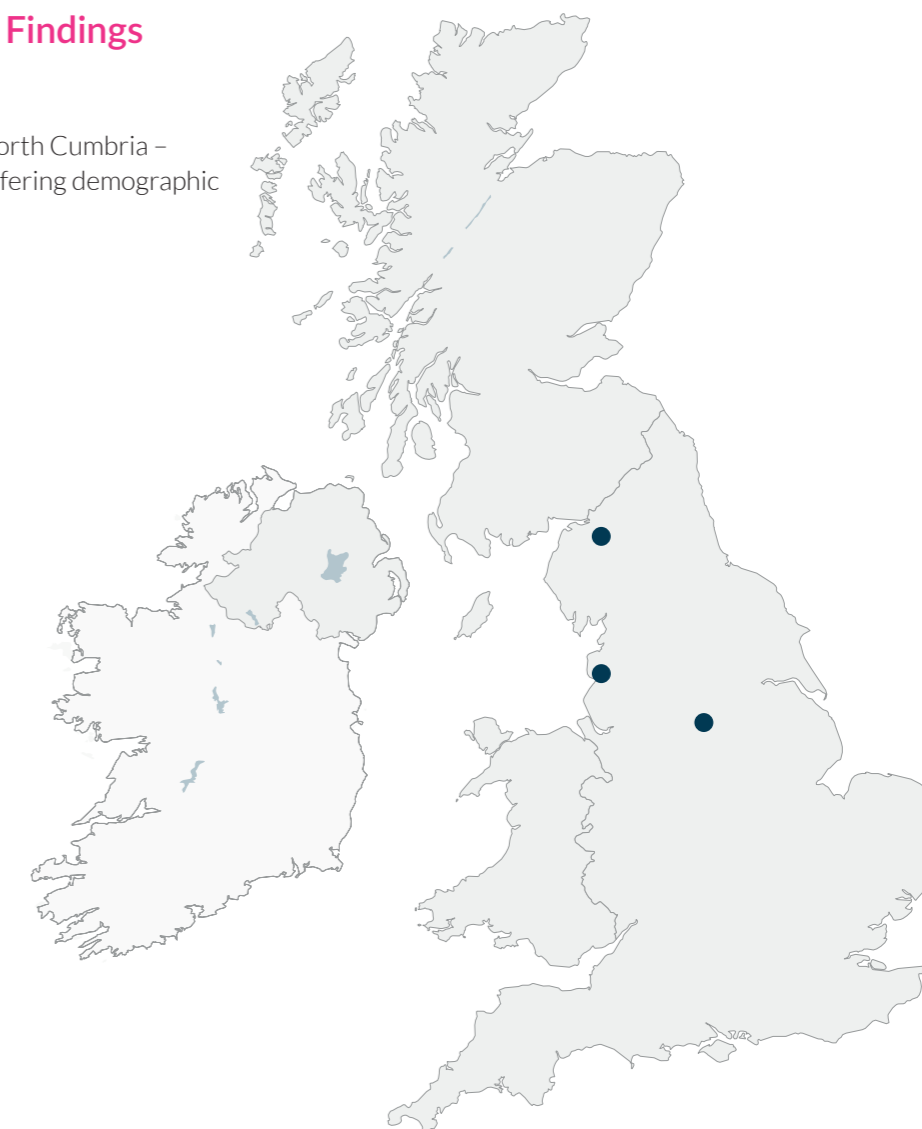
1.4 The overall picture of DToC across England showed an increasing trend from 15/16 to 16/17, although over recent months a slight reduction has been recorded.

1.5 In this report, all delays that took place after the patient had been declared 'medically optimised' by a consultant are considered. When only the delays which are classified as 'reportable DToC' are considered, however, the proportion of delays by each category changes dramatically. For example, when looking at all delays, 'Waiting for a decision on the patient outcome to be made' is the largest at 36% of all delays. However, when we consider only reportable DToC, 'Waiting to go to either intermediate bed, nursing or residential care' becomes the largest category. This can be attributed largely to the fact that systems often do not record patients in the 'Waiting for a decision on the patient outcome to be made' as reportable DToC.

Appendix 2 – Detail of Findings

2.1 The sites

Sheffield, Fylde Coast and North Cumbria – differing geographies and differing demographic



Summary of Findings

| | |
|--|-----------|
| Number of beds reviewed across three areas | 2889 |
| Number of patients delayed (% of all beds) | 501 (17%) |
| Number of patients that were reportable DToC (% of all beds) | 281 (10%) |
| Proportion of patients delayed that were reportable DToC | 56% |
| Number of detailed case reviews | 132 |
| Number of interviews | Over 80 |

Table 2.2: Overall summary of findings

²⁰ <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2015/10/mnth-Sitreps-def-dtoc-v1.09.pdf>

²¹ <https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/>

²² <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2015/10/mnth-Sitreps-def-dtoc-v1.09.pdf>

²³ <https://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/>

| Why are patients waiting? Snapshots taken during the assessment of the three systems | | | | | | |
|--|--|--|------------------------------------|--|--|--|
| Area of delay | Number of patients delayed (% of all delays) | Number of patients that were reportable DToC (% of all delays) | What are the patients waiting for? | Number of patients delayed (% of all delays) | Top opportunities to improve | Top reasons why these aren't happening |
| Waiting for a decision on their outcome to be made | 180 (36%) | 43 (9%) | Assessment | 80 (16%) | Improve communication and rate of progress Undertake in different setting Undertake pre-medically optimised and/or in parallel | Lack of clear communication and ownership for patient progress System primarily built around an acute-based assessments and therapy service |
| | | | Therapy | 68 (14%) | | |
| | | | Patient/Family Decisions | 16 (3%) | | |
| | | | Best Interest | 16 (3%) | | |
| Waiting to go to either an intermediate, nursing or residential care bed | 166 (33%) | 125 (25%) | Nursing/EMI | 53 (11%) | Undertake assessments out of hospital after a period of Reablement Improve communication and rate of progress | Reluctance from the frontline decision maker to take a perceived risk Expectation setting earlier in the pathway System primarily built around making long term decisions in the acute setting |
| | | | CHC | 37 (7%) | | |
| | | | Residential | 27 (5%) | | |
| | | | Intermediate or community bed | 24 (5%) | | |
| | | | Assessment | 14 (3%) | | |
| | | | Other ²³ | 11 (2%) | | |
| Waiting to go home with some extra support | 113 (23%) | 88 (18%) | Domiciliary | 53 (11%) | Increase flow to and capacity of Reablement | Lack of consistent understanding of the importance of Reablement |
| | | | Reablement | 47 (9%) | Improve effectiveness of Reablement | Reablement services not optimised |
| | | | Equipment | 13 (3%) | | |
| Other | 42 (8%) | 25 (5%) | Other ²⁴ | 42 (8%) | | |
| TOTAL | 501 (100%) | 281 (56%) | - | 501 (100%) | | |

Table 2.3: A closer look at why patients are waiting, from snapshots taken during each assessment

²³ These delays are mainly to do with repatriation, waiting for mental health beds and family decisions regarding placements.

²⁴ These delays are attributed largely to Stroke Rehab and Repatriation (to other hospitals).

| Are patients on the right pathway? | | | | | |
|--|----------------|---|--|---|---|
| Top level area of improvement | Cases reviewed | Number of cases where pathway could be improved | % of cases where pathway could be improved | Top opportunities to improve | Top reasons why these aren't happening |
| Waiting for a decision on their outcome to be made | 11 | 7 | 64% | Assessments taken place outside hospital | Lack of clear communication and ownership for patient progress |
| Waiting to go to either an intermediate, nursing or residential care bed | 85 | 36 | 42% | Most patients could have gone on to home care instead of resi/nursing | Reluctance from the frontline decision maker to take a perceived risk Family disagreements/ expectation setting Capacity of home care |
| Waiting to go home with some extra support | 36 | 9 | 25% | Discharge via Reablement | Capacity of reablement services |
| TOTAL | 132 | 52 | 39% | - | - |

Table 2.4: A summary of practitioner led case review findings, highlighting where multi-disciplinary teams felt better discharge pathway decisions could have been made and the main reasons these were not taken

If you work in the health and social care sector
and would like to discuss the topics raised in this
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