

Efficiency opportunities through health and social care integration

**Delivering more sustainable
health and care**

Foreword

Citizens have a right to good health and to live independently for as long as they are able. Unfortunately, too often, the care that some of us receive is poorly joined up, frustrating and we have little say or control over it.

The Local Government Association (LGA) has long fought for transformation of the health and care system to one that is founded on the principles of keeping people healthy, independent and in control of their care. We want a system that is more personalised, more responsive – with the right decisions being made in collaboration with service users and carers – and seamless between the various organisations providing the care. We want the system to invest more money in preventing ill health and debilitating conditions, through services that are delivered at or nearer to home.

Councillors across the country are leading the debate with partner organisations to shape a future system of health and care based on shared local priorities to achieve the best outcomes for people with less money. The significant progress that local areas have made to date in developing integrated models of care has demonstrated that there is no universal solution to the challenge. However there are common elements that constitute good care, many of which are driven by strong personal relationships and a shared will to make a difference. We have an opportunity to share learning in the UK and further afield, to further develop our understanding of what a more sustainable system might look like in the future.

To help inform this debate the LGA has been working with Newton Europe and a number of councils and health partners to better understand how people are managed within the current system, in order to identify opportunities for delivering better outcomes at less cost. We published our interim findings from this work at the end of last year. We now share with you our final report, which sets out the evidence for improvement in providing more integrated care and critically, the key factors required in the approach to making that change successful locally.

We hope that you find the report useful.

Councillor David Simmonds

Chairman, LGA Improvement and Innovation Board

Contents

Headline messages	4
Introduction and approach	6
1.Improved outcomes and efficiency savings	9
2.Variation in front line decision-making	11
3. Avoidance of admissions to acute hospitals	14
4. Discharge planning to maximise independence	16
5.Deploying a better skill mix in teams	17
6. The approach taken to change	18
Conclusions	20
Appendices	21
Appendix 1 - Evidence of impact	22
a. Delivering a step change in residential placements in Kent, arising from the acute hospital	22
b. Reducing acute admissions through integrated front door processes in Pennine Lancashire	29
c. Reducing falls as a key preventative activity to reduce demand to both health and social care in Greenwich	32
d. Creating clarity of accountability for discharge in Swindon	35
e. Integrating the procurement of Continuing Health Care (CHC) and local authority beds in Sunderland	36
Appendix 2 - Further thoughts for leaders to progress change in their local areas	37

Headline messages

1. By focusing on the best care pathway for patients or service users¹, significant benefits can be realised in terms of improved outcomes, greater quality of services and financial savings. **Efficiency savings of 7 to 10 per cent**² of the budget areas assessed in this project could be realised through approaches to health and care that are better integrated. This equates to efficiency savings of over £1 billion nationally across the health and care system.
2. **Variation in front line decision-making** provides the greatest opportunities to improve efficiency. Health and social care practitioners reviewing 2,265 case notes through this study identified a significant lack of consistency in decision-making, and estimated that up to 45 per cent of pathway decisions could be improved. In almost every case there was evidence of over-provision care, potentially reducing the service user's independence. It was found that robust, multi-disciplinary reviews, at key decision points, can have a significant impact on consistency of decision-making, whilst requiring only a relatively small investment in terms of resource.
3. The largest single area in which resource can be saved is through **avoidance of admissions to acute hospitals**. In over a quarter (26 per cent) of the cases reviewed where people had been admitted to an acute hospital, there had been missed opportunities to make interventions that would have avoided the need for the admission.
4. **Discharge planning to maximise independence**³ would save money and improve outcomes. For nearly a quarter of people (24 per cent⁴) who were discharged from hospital with a care package, a preferable pathway was identifiable that could have delivered better outcomes at lower cost. Given that a significant subset of these pathways result in costly long-term residential placements this is of particular significance. Practitioners taking part in the study estimated that 59 per cent⁵ of long-term residential placements resulting from an acute hospital admission could be delayed or avoided.

The role of preventative services is key to any future model of health and care, leading to a reduced number of both acute and social care admissions. An estimated 25 per cent to 40 per cent of local authority service users would have benefited from preventative services, which they did not receive.

1 As defined by the multi-disciplinary review teams to be appropriate and most likely to result in independent outcomes

2 As defined in our approach, this work has not looked at all of health and social care spend. Reported savings of 7 to 10 per cent across the budgets looked at would translate to 1 to 1.25 per cent of total acute, community and social care spend. These figures are expressed in annualised savings terms and do not account for the fact that some savings will take longer to be realised than others.

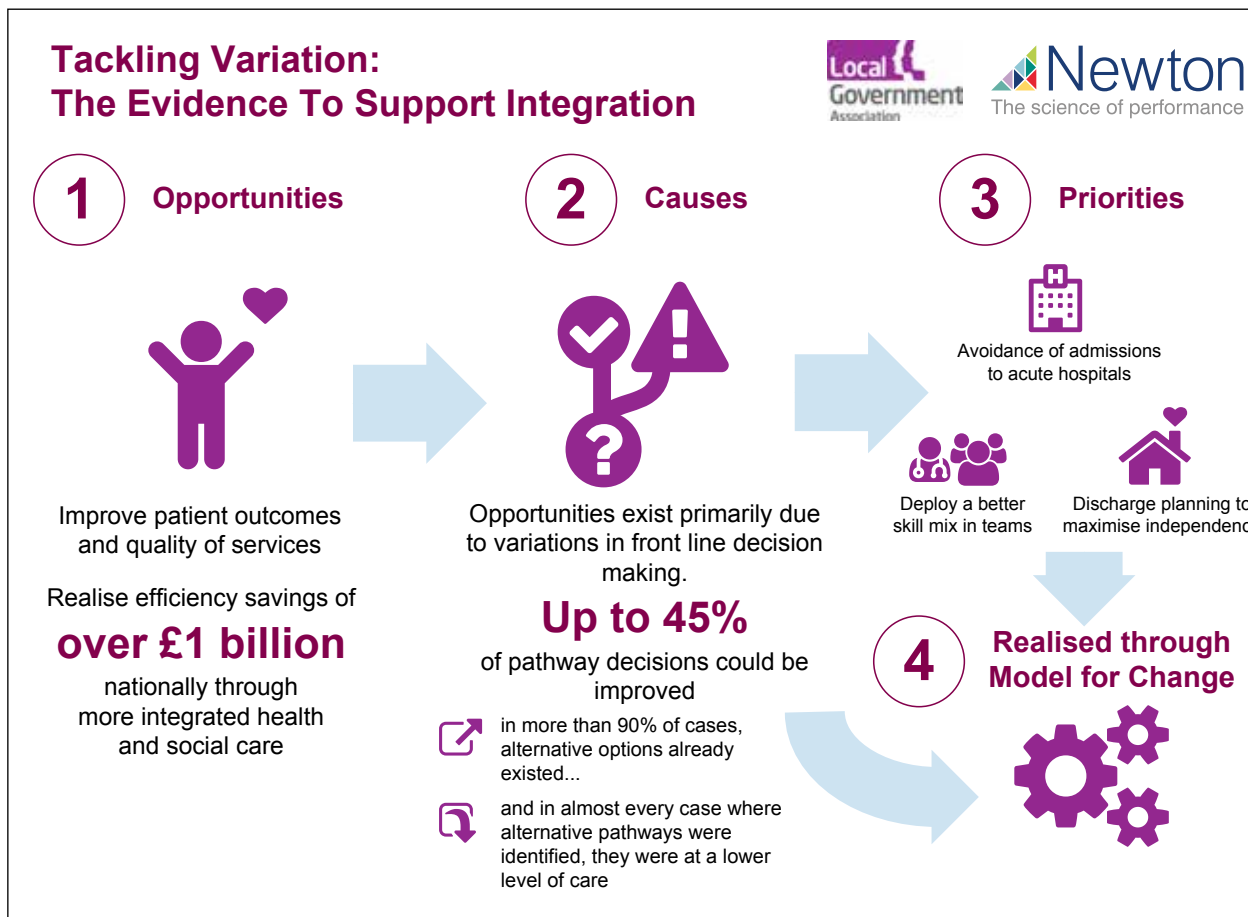
3 Defined as helping citizens regain or learn new skills to live their everyday lives and stay within their communities

4 24 per cent is defined as total opportunity identified. In the financial modelling it is assumed that half of this opportunity would be realisable through an improvement programme.

5 In the financial modelling one third of this figure is assumed as realisable

5. **Deploying a better skill mix in teams**, particularly within community services, would help to maximise resources. There is scope to develop a more effective mix of practitioners – clinicians and front line care workers – to free up community nurses, thereby making better use of the resources available.

6. It was found that the most important factor in realising these opportunities is not the design of the specific operational solutions. Rather, it is the **approach taken to change**, characterised by prioritised, evidence-based, locally developed solutions.



Introduction and approach

The case for change

In 2013, the LGA, as part of the Integrated Care and Support Collaborative commissioned National Voices⁶ to develop a definition of integrated care:

“My care is planned with people who work together to understand me and my carer(s), put me in control, and to coordinate and deliver services to achieve my best outcomes.”

It is recognised by key partners in health and social care that the current system does not do enough to meet these basic requirements. As well as offering poor user experience and outcomes, poor integration between health and social care is judged to result in services that are inefficient and offer poor value for money.

Care that is better integrated is a priority for most health and care partners, driven by increasing demand, greater complexity of needs and the drive to develop a more financially sustainable model for the future. Over the last few years there have been a range of government policies and national initiatives to promote integrated care. The most significant of these have been the Care Act, Integrated Care Pioneers, the Better Care Fund, the Five Year Forward View, devolution and Vanguard. Local areas have made progress in developing integrated models of care, frequently based on pooled budgets, multi-disciplinary teams, integrated commissioning or the development of new organisations providing integrated services.

A number of insights and lessons have emerged from these initiatives, the more recent reports coming from the Department of Health (DH) Integrated Care and Support Pioneers Programme⁷ and the LGA's 'The Journey to Integration'⁸. Whilst there is now evidence to show that greater integration and personalisation improves user experience and outcomes, there remains little evidence to demonstrate how financial savings will be delivered.

Our approach

In order to address this lack of evidence, the LGA has been working with Newton, councils and partners in five areas to undertake a robust assessment of the efficiency opportunities of integration across the health and social care system, to contribute to the developing understanding of what a truly sustainable model for health and care might look like and how this can be achieved.

Diagnostic assessment

The five geographical areas were identified to represent a mixture of size, location and urban/rural environments. They are Kent, Pennine Lancashire, Greenwich, Swindon and Sunderland. Good practice examples, addressing different opportunities, have been reflected from each of the areas studied. In four of the participating areas Newton undertook a short, intense diagnostic exercise. This involved working alongside acute

⁶ National Voices is a coalition of social care and health charities, to provide a voice for the voluntary sector at the national level

⁷ Early evaluation of the Integrated Care and Support Pioneers Programme – Policy Innovation Research Unit, 2016-17

⁸ The Journey to integration, learning from seven leading localities – Local Government Association, April 2016

hospitals, district nursing providers, adult social care services and clinical commissioning groups (CCGs), as well as consulting with primary care and the voluntary sector. The fifth area, Sunderland, was covered through an evidence review and workshop to share and understand similarities with the other four areas and to determine applicable best practice examples.

For the diagnostic exercise, a detailed analysis of the last two years' attendance and admission data was undertaken. In each area, between 700 and 750 anonymised sets of case notes were examined. Local workshop sessions were held with health and social care practitioners to determine if the best care pathway had been followed for the service user. If the pathway was not thought to result in the optimal outcome, an alternative, more appropriate approach was identified. The practitioners involved in the exercise comprised:

- general practitioners (GPs)
- district nurses
- social workers
- occupational therapists
- discharge coordinators
- acute nurses (A&E, medical and discharge)
- geriatricians
- A&E consultants
- integrated discharge personnel
- third sector representatives.

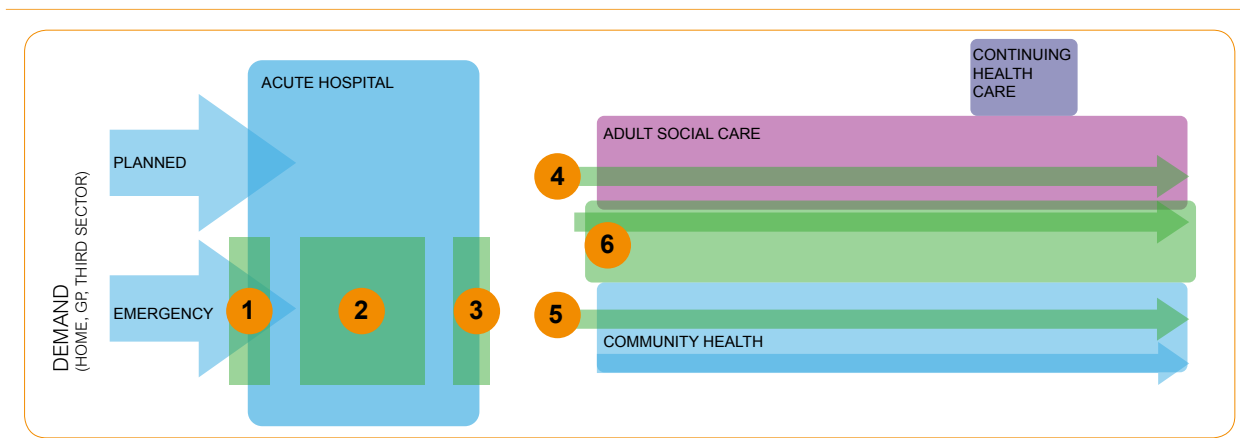
All judgements made on the selected care pathways and opportunities for improvement have been made by local practitioners rather than by either Newton or the LGA.

The work focused on the care pathway decisions made within the seven questions below:

1. Are those patients attending A&E doing so for appropriate conditions and are they being admitted to hospital beds from A&E appropriately? Could we have identified and prevented those needs earlier?
2. Could patients in non-elective hospital beds be treated outside of hospital?
3. At the point of non-elective hospital discharge, are we selecting the correct pathway for patients?
4. At the point of intake to the local authority, are we selecting the correct pathways for service users?
5. At the point of intake to community nursing, are we selecting the appropriate pathway for patients?
6. Is there an opportunity to better coordinate services for patients/service users receiving both community nursing and social care provision?
7. How does procurement by local authorities compare to that undertaken by CCGs?

These questions have been applied to the 18 and over age group and are represented in the diagram below.

Figure 1 - Model of the diagnostic exercise undertaken in each area



Throughout the work, local practitioners identified potential pathway improvements that should have been made, following the structure below:

- What was the level of need of the service user?
- What alternatives could ideally have been provided to service users?
- Why was this not provided?
- What are the financial and service user implications of the alternative approaches?
- How likely is it that this change could be achieved?

A flow model was then developed to summarise the findings, providing a prediction of the service user and cost flow changes in the system.

Scope of work

The efficiency of delivery of the individual services (improvement in unit cost that could be achieved by doing the same volume of work in a different manner) lies outside the scope of this work. Based on Newton's delivery experience outside of this project, this efficiency is typically worth 5 to 15 per cent of the direct budget studied, in addition to any other opportunities for efficiency improvement identified within this work.

This work did not look at the field of mental health specifically. Whilst a number of preventative opportunities were investigated, the work did not examine the full impact of public health and social determinants of health (such as being in work, loneliness in old age or obesity) on system demand. These areas offer further potential opportunities for efficiency improvement.

The budget areas assessed in this project covered the non-elective adult acute pathway⁹, which accounted for 11 to 19 per cent of the total health and social care budget for the participating areas.

⁹ Non-elective adults acute pathway spend reviewed: over 18's CCG, acute, community health and social care (but excluded mental health)

1. Improved outcomes and efficiency savings

A central aim of this work was to answer the question: “Can integration lead to savings, and if so where might these savings come from?”

Findings from this work confirm that by focusing on the best care pathway for patients/service users, significant benefits can be realised for both users and the system. Evidence suggests that savings of 7 to 10 per cent¹⁰ of the budget areas assessed in this project could be realised, equating to over £1 billion across the health and care system nationally. In the main, this would be achieved by shifting resources to support people living more independently than they do currently.

While significant, this figure should be considered within the context of the national trends in increasing complexity of need and rising demand. For the NHS alone, without efficiency improvements, the NHS Five Year Forward View forecasts a £30 billion cost pressure by 2020/21¹¹. In order to meet the challenge of increasing complexity of need, acute systems will need to provide more intensive support where needed and be released from those interventions which can be delivered more effectively elsewhere. Simultaneously however, councils have faced a 40 per cent reduction, in real terms, to their core government grant. In adult social care, funding reductions and demographic

pressures arising from an ageing population have resulted in a £5 billion funding gap¹².

Given this context, it is expected that the majority of efficiency opportunities will be used to absorb and manage demand growth.

In order to achieve many of the savings identified, it is necessary to invest funds elsewhere in the system and move resources between different parts of the system. The inability to move funding to the appropriate settings was a major obstacle to change observed during this project. The overall trend required to realise these opportunities is to move funds from acute to community and social settings. For illustrative purposes, a summary of these funding moves is shown in Figure 2 below.

These figures are presented for a health and social care system with a combined budget¹³ of £1 billion (the average size of the areas reviewed), with a reviewed non-elective adult acute pathway of £133 million. Whilst they are illustrative of the average cost movements across the areas, the specifics will vary for each locality.

This example shows opportunity for £12.5 million of net system savings; £11.9 million of these are derived from reducing demand on (and therefore costs for) the acute sector. The main areas for re-investment are:

10 As defined in ‘The Approach’, this work has not looked at all of health and social care spend. Reported savings of 7 to 10 per cent across the budgets identified would translate to 1 to 1.25 per cent of total acute, community and social care spend. These figures are expressed in terms of annualised savings and do not account for the fact that some economies will take longer to be realised than others

11 <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

12 LGA Adult social care, health and wellbeing: A shared commitment. 2015 Spending Review submission. www.local.gov.uk/publications

13 The figure of £1 billion is comprised of all health and social care spend from the CCG and the local authority. It does not include primary care spend, specialist commissioning or wider council services. The total UK spend in this category is ~£100 billion

- community health: £2.2 million
- integrated teams (a combination of GPs, community nurses, social workers and therapists): £500,000
- the local authority: £700,000, primarily through short term beds and reablement services, coupled with the integrated

therapeutic care above. Much of the community health investment would be offset by savings (£1.7 million), whilst the local authority investment would be more than offset by the savings in this area (£1.9 million).

Figure 2 - Summary of savings opportunities and average cost movements

Location	Gross Savings	Re-invest required	Net saving/ cost movement	Main driver of savings	Main driver(s) of investment
Acute	£11.9m	£0.0m	£11.9m	Acute admission reduction Alternative locations of care	N/A
CCG/Other	£0.8m	£0.2m	£0.6m	CHC commissioning	Rapid access units / urgent care centres
Community	£1.7m	£2.2m	-£0.5m	Nursing skill mix optimisation	Additional home based clinical services Step-down intermediate beds
GP	£0.0m	£0.3m	-£0.3m	N/A	Additional activity
Integrated teams	£0.0m	£0.5m	-£0.5m	N/A	Short term nursing / care / GP support
Local authority	£1.9m	£0.7m	£1.2m	Reduced residential spend	Short term beds Re-ablement
Total	£16.3m	£3.8m	£12.5m		

2. Variation in front line decision-making

Opportunities identified exist primarily due to variation in front line decision-making. A recent review by Lord Carter on unwarranted variation in English hospitals¹⁴ identified efficiency opportunities of £5 billion within acute hospitals. Whilst the LGA's work focuses on the decision points at the main interfaces between providers along the care pathway, many of the findings from the LGA project complement and support Lord Carter's work. Both Lord Carter's review and the LGA work highlight the opportunity and challenge in tackling unwarranted variation. The LGA work also highlights an important factor related to Lord Carter's findings on discharge, it is crucial that these be targeted in a manner that aims to maximise independence.

A key factor identified by practitioners reviewing case notes, within each of the participating areas in this study, was a significant lack of consistency in decision-making. They estimated that up to 45 per cent of pathway decisions could be improved. There are two major drivers contributing to this:

- How the system responds to risk. There are penalties and ramifications for missed diagnoses, but no penalties for widespread over-provision of care. Over-provision of care may lead to the person becoming overly dependent on the system, which in turn may damage the long term outcome and significantly increase the long-term costs.

'Which single point of access? We've got so many'

GP

"You are always worried about missing something and feel pressure to prevent under-provision of care. Going against this can feel like you are taking a risk on your own. We need a counterbalance to review and develop practitioners so that they are also driving maximum service user independence."

Social worker

- How decisions are made at the key decision points. There are many factors contributing to this, including:
 - professionals being unaware of the full range of services available to support patients
 - decisions not always being taken by the most appropriate practitioner
 - cultural differences between organisations, individuals and roles
 - undue influence on the part of the patient, family or carer such that the best pathway is not taken.

Furthermore, as new services or initiatives are added, many systems have built up an increasingly complex 'menu of services' that can be provided in the local area, making successful navigation even more challenging.

¹⁴ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

The case studies¹⁵ in this report show that effective, group based multi-disciplinary team decision-making can have a key role in mitigating these factors, leading to improved outcomes, with a relatively low resource requirement. A separate study has shown that the wider the range of skills of the multi-disciplinary team, the better the outcome is likely to be for the patient.¹⁶ This study suggested that the team is likely to perform at its best where each person's contribution is valued and an element of peer challenge is designed into the culture of the team. When leaders consider the multi-disciplinary skill sets of their teams it will be important to ensure the accountability of decision-making is not lost.

“Wouldn't it be beneficial to have a quality assurance type step, similar to the way we've been looking at these cases, in the discharge process? Someone to ensure that all possible options had been objectively considered?”

Consultant physician

Figure 3 on page 13 summarises the numbers of case notes reviewed and pathway decisions, which the local practitioners believed could have been improved. In almost every case where an alternative pathway was identified for a service user, this alternative would have been at a lower level of care. Furthermore, the alternative pathways identified were already in existence (to some extent) in more than 90 per cent of instances, although they were not always commissioned at the correct level. This indicates that in the short term there is less need to develop new services, but rather a need to make better use of existing services or agree a new level for a specific service.

This requires accurate measurement of and responses to flows and outcomes through the different stages of the system. For example, in one area, referral patterns to reablement¹⁷ were examined across two neighbouring localities. In one locality the team referred 10 per cent of individuals to reablement while in the other, 70 per cent were referred. When case notes were exchanged, each team continued to refer to reablement at the same levels. The decision to refer, rather than being based specifically on the individual's needs, appears to be driven by the culture, practices and habits of the team.

Reducing variability of decision-making encompasses more than simply implementing new protocols and standards. Creating the culture and mechanisms for practitioners to develop and challenge each other's decisions, through peer support, reflective practice and management reporting, for example, has been found to lead to more robust and less variable decision-making. These approaches can also support practitioners to move to a less risk-averse approach, ensuring that all options are considered to maximise the service user's independence. This is explored further in the report.

The issues described thus far in terms of decision-making refer primarily to clinicians and front line practitioners. There is also a need, however, to ensure that patients and carers are better informed about the options available to them, to understand and contribute more effectively to decisions about the best care pathway to address their needs. This is critically important in getting the decision right. For example, this study has revealed that **33 to 43 per cent of self-referred A&E attendances were inappropriate, and in 74 per cent of these attendances the service user had not considered other options available to them.** Case reviews at discharge, both from the acute hospitals and from community

15 See Appendix 1, case study a: Delivering a step change in residential placements in Kent arising from the acute hospital and b: Reducing acute admissions through integrated front door processes in Pennine Lancashire

16 Enhancing the efficiency and effectiveness of community based services for older people - Enderby; Ariss; Smith; Nancarrow; Bradburn; Harrop; et al NIHR report 2012

17 Reablement has been defined as 'services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living'

nursing also highlighted examples of setting incorrect expectations for patients early in their pathway, with this having a negative influence on the subsequent decision about

their care. Clear accountability and clarity of roles in Swindon shows how this effect can be tackled, reducing incorrect onward referrals at discharge by over 30 per cent.¹⁸

Figure 3 – Evidence arising from the review of case notes and pathway decisions

Area of focus	Case notes reviewed	Pathways which could be improved	% Pathways which could be improved	Top 2 other pathways proposed	Most prevalent reason for variance, other than practitioner variation	Of savings identified % attributable to this area	Savings for typical geography (£1bn H&SC spend)
Q1 - A&E attendances	563	195	35%	GP or Community nursing instead of attendance	Patient & family decision	3%	£0.4m
Q1 - A&E admissions	189	68	36%	Community health or GP instead of admission	Hours alternative services (such as RAU) commissioned. Different stakeholders being joined up in their approach	42%	£5.3m
Q2 - Acute settings of care	726	370	51%	Home with clinical or social support instead of hospital bed	Discharge process incomplete	21%	£2.7m
Q3 & 4 - Acute discharge and Local authority intake	500	219	44%	Domiciliary package instead of residential / nursing Falls service, voluntary sector support, equipment & telecare	Hospital pressure, Service user choice / family pressure & knowledge of services	17%	£2.2m
Q5 & 6 - Community nursing and overlap with social care/ability of service user and family to self care	287	162	56%	Move part of registered nurse workload to lower grade nurses, care workers, service users & families. Utilise registered nurses elsewhere in system	Independent planning between nursing and social care Establishment shape	12%	£1.5m
Q7 - CCG Commissioning					Supply of housing in market Impact of spot purchasing	4%	£0.5m
Total	2265	1014	45%			100%	£12.5m

Comments:

1. % pathways which could be improved are total opportunity identified. Realisable opportunity is predicted and modeled to be significantly less
2. % above refer to patient pathways chosen and should not be equated to budget savings. This is modeled separately
3. acute settings of care involve case note reviews at 2 points in time per patient - this is not equivalent to bed days and is modeled separately
4. local authority intake decisions include both incorrect initial pathway and missed opportunity for preventative services
5. community nursing decisions include inappropriate caseload, but mostly refer to a different skillset being able to perform the task
6. reasons quoted are from the multi-disciplinary group of practitioners based on information available in case notes

¹⁸ Appendix 1, case study d: Creating clarity of accountability for discharge in Swindon

3 Avoidance of admissions to acute hospitals

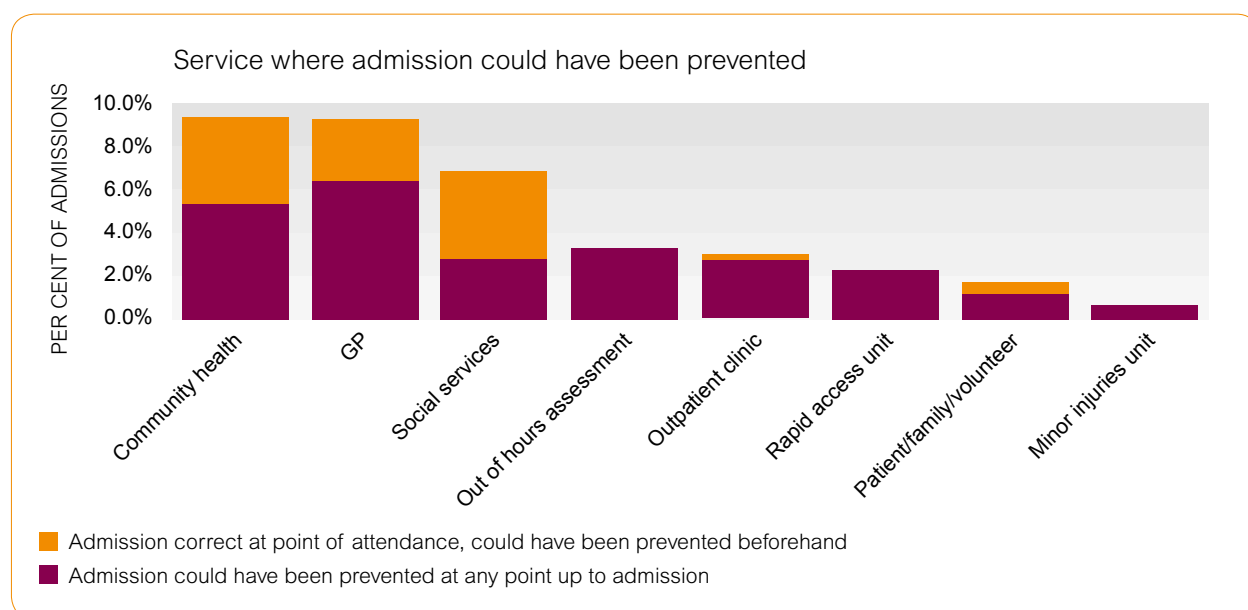
Whilst opportunities to increase independence and reduce cost were found across the health and care system, the greatest area of potential financial savings is the avoidance of A&E admissions. Many of the avoidable admissions related to individuals with numerous co-morbidities, and who typically experienced longer lengths of stay in the acute hospital than the average. This accounts for 42 per cent of the financial opportunity identified.

Case example: Mr J, age 82

Mr J was being cared for in an intermediate care centre, when he suffered a collapse. Discussion through the workshop concluded that the patient should have been kept in the intermediate care centre and managed there, but lack of a senior decision maker resulted in an attendance at A&E and then admission to hospital.

Nearly two thirds (64 per cent) of cases identified by the reviewing practitioners as avoidable admissions to hospital could have been avoided by means of interventions and decision-making on the day, at the point of attendance at hospital. The remaining third (36 per cent) would have required early identification and prevention prior to the point of attendance to avoid the hospital admission. The majority of the preventable A&E admissions would be diverted to other primary and community health services as shown in Figure 4, which indicates where resources might be better placed in order to reduce admissions to hospital. This is a key target for most CCGs and is within the scope of the Better Care Fund.

Figure 4 – Services where avoidable admissions might have been diverted



It is important to note that it is not simply a matter of the right resources being in the right place. In over 90 per cent of cases the required pathways were available, but the reviewers found that pathway decision-making at the critical points in the system varied widely. System efficiency demands ways of working that integrate fully into these decision points, to ensure that the full benefits are realised.

Access to integrated community teams at the 'front door' (the point of access – usually A&E – but there may be admissions also to coronary care or direct admission to a ward) of acute hospitals is shown in Pennine Lancashire as having a 5 per cent impact on admission rates.¹⁹ The greatest preventative impact can come through social care, supporting individuals prior to attendance at A&E. The greatest preventative opportunities were observed to be falls prevention and tackling loneliness – an area where the voluntary sector can also play an important role. An example of this can be seen in the work undertaken in Greenwich to reduce falls as a preventative activity, with its impact on demand for both health and social care.²⁰

Case example: Mrs P, age 80

Mrs P was diagnosed as having chronic obstructive pulmonary disease (COPD), was breathless and suffered from anxiety and loneliness. She was noted to have attended A&E 33 times over the last two years. Consensus from a workshop was that telecare and more accessible social support would have prevented her from relying on A&E and on the ambulance service for transport.

Case example: Mrs L, age 82

Mrs L was in a residential home run by social services. A falls risk was identified, but no falls prevention activity undertaken. Five months later, she fell, fractured the neck of her left femur, requiring a hip replacement. One month later, she sustained a fracture to her right femur. Mrs L is now in a nursing home with limited mobility.

¹⁹ Appendix 1, case study b: Reducing acute admissions through integrated front door processes in Pennine Lancashire

²⁰ Case study c: Reducing falls is a key preventative activity to reduce demand to both health and social care services in Greenwich

4 Discharge planning to maximise independence

Two elements were highlighted as important in effective discharge planning:

- Ensuring that patients are not held in hospital beds when alternative settings may be suitable. This work, using a Clinical Utilisation Review tool²¹ and cross-referencing with local practitioners has estimated that 10 per cent of the non-elective bed capacity could realistically be freed up by patients receiving the same clinical care in an alternative setting. The study indicated that the majority of the alternative settings are likely to be home-based, with either community or social care support.

Case example: Mrs V, age 88

Doctors had discharged Mrs V and she was ready to leave hospital after nine days. She was delayed for a further 28 days, however, whilst agreement was sought over the funding arrangements for her nursing home. She subsequently acquired pneumonia in hospital.

- Ensuring that when patients with complex needs are discharged, they are supported by the most appropriate pathways. **In almost every case where practitioners identified an alternative pathway for a service user, the alternative was at a lower level of care and would incur less cost to the system.** The alternative pathways might reasonably be expected to increase the independence of service users in the longer term with less reliance on both the care and health systems. **Accessing clear and joined-up information about a patient or service user at this critical stage of the pathway was highlighted as a particular challenge.**

²¹ <http://oakgroup.com/salford-royal-foundation-trust-clinical-utilisation-review-tool/>

“What strikes me through this exercise is the difficulty getting the information, even with time to sit and look through notes. How can we expect decisions to be optimal at the point of discharge?”

GP

Case example: Mr B, age 73

Mr B should have been discharged home after his short stay in hospital care. Instead he was discharged to a community bed, where he contracted an infection and remained in hospital for a prolonged period of time. His health has now significantly deteriorated.

Review practitioners also found that the expectations of patients and family were often felt to have been heavily influenced by professionals, early in the care pathway.

They observed that the professionals setting these expectations often do not have sight of the most appropriate discharge options (for example an acute consultant advising on social care packages) and no feedback loops exist to support their learning. This frequently appeared to lead to discharge assessments seeking additional services that were not necessary. These included ‘double-handed’ visits after discharge, admissions to short and long-term care and formal care packages, where none were needed.

5. Deploying a better skill mix in teams

The most valuable and expensive asset of the health and social care system is its workforce. Whilst reducing the number of highly skilled professionals in one part of the system may seem an attractive option to release savings quickly, this study has shown that sustainable efficiencies can be realised by taking a more sophisticated approach, and aligning skill sets across the whole system.

A number of the areas studied (A&E admissions and setting of care) highlighted the need for a greater number of registered community nurses. This diagnostic exercise sought to understand if registered nursing capacity could be increased.

When reviewing nursing case notes, the registered nurses identified repeated occasions on which they had been carrying out tasks that could have been delegated to healthcare assistants or, with training, to patients and carers. The majority of registered nurse time was found to be spent on low level wounds, diabetes and medication management. Whilst registered nurses should have intermittent oversight of these cases, they did not believe they should be doing the majority of the direct service provision.

“The specialist diabetes nurses used to train residential staff to deliver insulin – that doesn’t happen anymore and we do the work”

District nurse

District nursing teams were found to comprise of between 62 per cent and 90 per cent of registered nurses. **These nurses calculated that the workload only required their grade of input for 40 to 51 per cent of the time.** There is a missed opportunity on both a personal development level, as well as a system level. This capacity could be used to support other parts of the system such as admissions avoidance, which would provide both system efficiency as well as development for registered nurses.

By cross matching information on district nursing support and social care provision on a week by week basis, nurses further identified that 23 to 30 per cent of the activity they undertook could be done by either the service user, their family or care workers already visiting the service user. This would not only create greater registered nurse capacity, but also encourage service user independence.

Case example: Mr A, age 85

Mr A is a patient receiving four carer visits per day but he also had a nurse visiting every three days to replace a patch on his arm. The carers could have been trained to replace the patches for Mr A.

6. The approach taken to change

There are some consistent messages arising from this work that impact on an area's ability to realise the efficiency opportunities identified across the health and social care system. The case studies set out in Appendix 1 provide practical examples of what can be done to develop better integrated models of health and care and realise the opportunities identified through this work.

The most important factor evidenced in realising these opportunities is not the specific solution designed, but the approach taken to change. Innovation efforts typically focus on the solution, however too often they fail to achieve the desired objectives. Typically this stems from applying the 'solution' without a clear view of how it works in the local context, which elements of the application are critical and what the outcome-based measures of success are.

Successful health and social care partners use a change process based on the following principles:

1. **Focus efforts where the biggest difference can be made.** There are many potential opportunities for integrated health and social care. Health and care partners are each faced with an array of different and changing objectives and advice – and this bombardment of requests may often overshadow the focus required to make large-scale improvements. It is better to deliver fully on a smaller number of major opportunities, rather than make minimal impact across many. In order to do this, robust quantification and comparison of opportunities is needed, with active decisions about what not to do as well as agreement on priorities.

The system resilience group is frustrating, we all add actions onto the list, end up with well over 60 and then seem to go round in circles each week”

Acute CEO

2. **Put the right structure in place, with appropriate leadership, governance and resource.** Successful models observed through this work all featured the involvement of one or more strong leaders, who took ownership and accountability for the outcomes. Change takes time. It demands that people commit the necessary energy, time and determination to deliver the new approach from the very outset. The appropriate governance needs to be established, before, during and after the change programme.
3. **Align strategies.** In any programme of change it is essential to ensure that the work processes are aligned with each organisation's vision and incentives. The two systems of health and social care have significantly differing organisational strategies – in many situations they do not prioritise the same things. To create successful change, leaders must recognise that this will require each practitioner in each organisation to change their way of working on both cultural and operational levels. There will need to be a compelling communication process, which relates these changes to the overall 'direction of travel' of the organisation and the wider system in which it sits.

4. **Empower the front line.** Successfully implemented change management is characterised by a process in which solutions are co-designed with front line users. Any new design or approach that is needed should be created with the insight and help of the people who will be using it. A design stage provides a valuable opportunity to bring together staff from different organisations into teams, thereby building stronger perspectives and understanding of the roles taken by everyone involved.
5. **Rigorously measure performance.** It is always essential to ensure that partners will be able to recognise whether successful change has been achieved. Metrics to capture meaningful data on decision-making (and hence pathways), quality and cost are essential. Where possible these should be outcome based measures (such as independent outcomes post reablement). A baseline of historic performance can be calculated and used as a benchmark against which improvement can be measured.
6. **Live test and design solutions.** Any new design or approach should always be tested in a trial area of appropriate size – large enough to be statistically meaningful, yet small enough that all stakeholders can be involved, any damage or fall-out can be limited and external impacts on the programme can be fully understood. In Kent a 40 per cent reduction in residential placements was achieved within the pilot site before the project was rolled out more widely, sharing the learning by means of a ‘product manual’.²² Many organisations jump directly from “idea” to “implementation” – either with a shortcut design process or no design at all. A year later management’s expectation of the operation can be very different from what is happening in reality on the ground. Performance metrics should be monitored and considered in light of the baseline performance. It is unlikely that any new design will be perfect at first, and there should be the expectation of challenging and iterating the design to ensure that the required results are achieved.
7. **Standardise the new approach and then roll out at scale.** Once the points above have been achieved, the new design can be standardised and prepared for implementation across the remaining areas. The key principles above (albeit with less re-design) need to be applied in each case.
8. **Simplify the system.** Innovation typically takes place by adding another ‘patch’ to the system, without taking away the previous alternatives. Whilst this may seem easier in the short term, it fails to address root causes and increases complexity over the longer term. In order to ensure change is fully sustainable, older ways of working must always be removed. Crucially any existing pathway must be scaled back (and measured) to prove that the new design is not simply a new “bolt on” service. This ensures that the options available to front line decision makers are simplified, rather than becoming more complex.

The case study example from Kent illustrates these principles and how they were applied.

Four further examples, covering the range of opportunities highlighted through this study are described at Appendix 1.

²² Appendix 1, case study a: Delivering a step change in residential placements in Kent, arising from the acute hospital

Conclusions

This report has identified the possibility of finding efficiency savings for both partners (health and care) through better integration and working together.

The focus must be on key decision-making at critical parts of the care pathway.

The challenges for commissioners include the need to examine and rationalise the menu of services offered and to scrutinise the volumes of services provided, in order to maximise the opportunities for better outcomes.

There are challenges for clinicians and other practitioners to ensure that the best decisions are being made, consistently, to ensure that the best possible care pathway is provided for the patient, rather than being driven by the perceived needs or capabilities of the organisation.

There is a need for everyone to better understand the impact on patients and service users of the available options so that they understand why particular care pathways may be more effective and more appropriate for them.

Many of these changes can be made within relatively short timescales. The key to success will be the approach that is taken to the change.

In a context of increasing demand and reducing funding the challenge for national bodies is to rationalise the number of 'asks' made of health and care partners, drawing together initiatives to provide a greater clarity of focus and learning, enabling areas to focus on developing sustainable local solutions.

Appendices

Appendix 1 Evidence of impact

- a. Kent
- b. Pennine Lancashire
- c. Greenwich
- d. Swindon
- e. Sunderland

Appendix 2 Further thoughts for leaders to progress change in their local areas

- a. Developing risk-sharing to avoid disincentives
- b. Simplifying information governance and data-sharing agreements
- c. Aligning leaders

Appendix 1

Evidence of impact

a. Delivering a step change in residential placements in Kent, arising from the acute hospital

Background

Kent is one of the largest county councils in the UK, and a significant proportion of its budget is allocated to adult social care – £450 million in 2014/15. Within Kent there are seven acute hospitals, each with embedded social work teams, in common with most areas in the UK.

Of the adult social care budget, almost £70 million is allocated to nursing and residential care for older people and those with physical disabilities. Within this budget over half of service users in residential placements have come either directly from the acute hospital or from the acute hospital via a short-term placement.

To understand potential for improvement, an experienced multi-disciplinary group of practitioners (see 'Our Approach') reviewed the case notes of service users who had been placed in residential care after an acute stay. It was found that over 80 per cent of these people could have been given a different service, thus achieving a higher level of independence, without any compromise to their safety.

Alongside this, a sample of service users being considered for short or long-term placements were asked how they felt about their discharge destination. **Only 9 per cent of those asked expressed a clear**

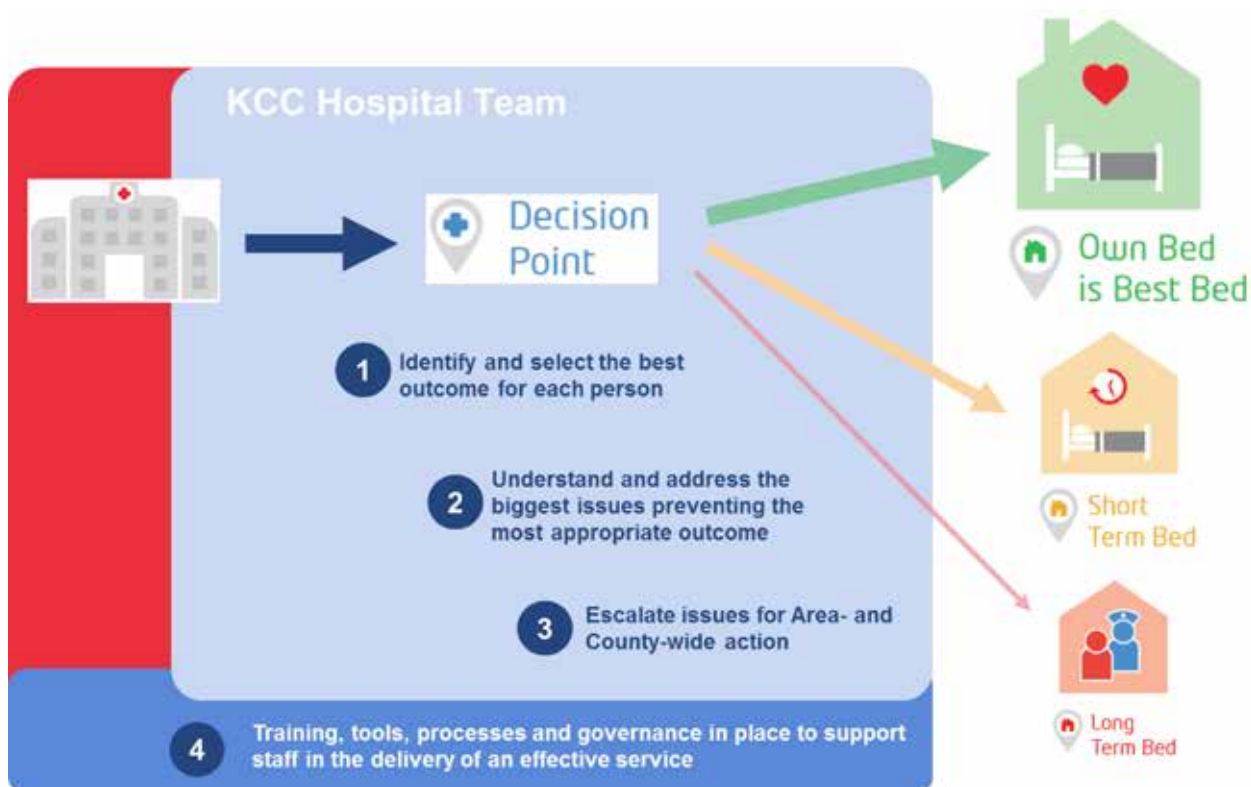
preference for going into a short or long-term residential placement, with 40 per cent preferring to go home. When the family and friends of the same sample of service users were asked what they would prefer, over 75 per cent selected a short or long-term residential placement, whilst only 2 per cent wanted the service user to return home. The workshop members' view was that in many cases the ward-based staff supported the family and friends and were encouraging short or long-term placements. On further enquiry of the ward-based staff, however, it was found that they were not familiar with the full range of enabling interventions on offer.

Designing the new service

From the analysis, it became clear that a focus on improving the culture and behaviours around practitioner decision-making is needed to improve the discharge process. Layering on additional pathways to an already complicated system was not going to provide the solution – a change in ways of working was necessary. One acute hospital was chosen as a pilot site.

The initial step was taken by a team of social workers and acute hospital staff, who following a round of further case reviews, challenged, agreed and then simplified their "vision" for delivery of their service, as shown below.

Figure 5 – Kent vision for the service



Supported group discussion

The team quickly recognised the value of constructively challenging cases as a hospital team and were keen to see this built into their new ways of working. The discussion focuses on each client’s individual needs and examines what combination of services (often a complex mix) could be put in place to allow the client to be discharged home safely.

Whilst the new ways of working were being established it was found that additional intensive support from social workers, prepared to challenge the status quo, was critical – alongside clear measures of success. In the initial weeks of the pilot phase, when this support was not present, the new ways of working quickly began to fall away.

It was found that the practitioner providing the intensive support does not necessarily need to be of a high level of seniority within the organisation but must be respected within the teams so that their input is acted upon. As the process became better embedded within the teams, the Social Care Discharge Coordinators (leaders within the hospital teams) took over the responsibility for providing the support and challenge on a daily basis, with the team manager attending the meeting to provide extra support once or twice a week.

The team undertook to examine every potential avenue before the client’s discharge path was agreed. Every case where a client could potentially go to a short or long-term placement was discussed in a dedicated daily meeting. This discussion offered the practitioner further support in identifying other potential options for the service user. Simple, often visual tools were used to help facilitate this process as shown in Figure 6.

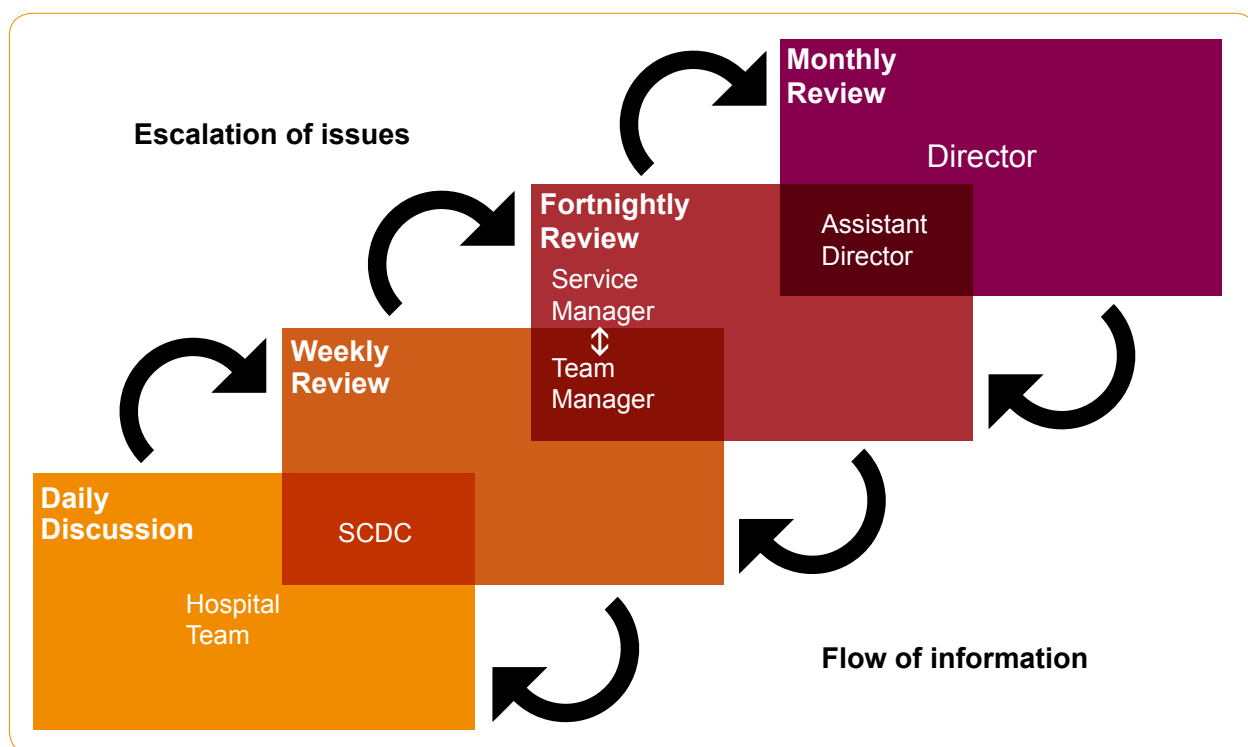
Figure 6 – Pathways to promoting independence



Clear escalation route

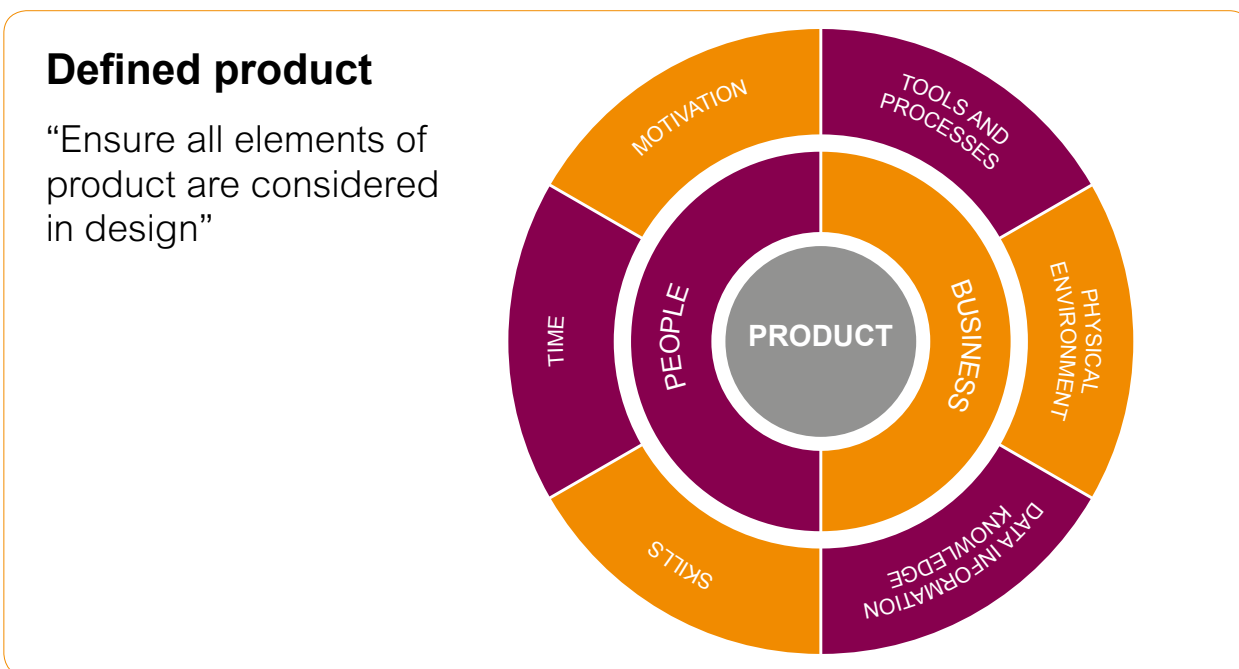
The team of practitioners designed a clear governance structure to resolve issues that could not be solved by the hospital team alone – see Figure 7. The unresolved blockers were regularly reviewed and overcome.

Figure 7 – Governance structure for responding to issues



(SCDC – Social Care Discharge Coordinators)

Figure 8 – Designing for sustainability



A 40 per cent reduction in long-term placements was achieved from working within the pilot site. Towards the end of the pilot phase the team identified and reflected on the key levers to enabling this change. These were then articulated in a ‘product manual’, to share their learning going forward with other sites. The ‘product manual’ described a set of key elements, as shown in Figure 8.

It is significant to note that the left hand side of the diagram, which describes the ‘people’, elements of the team and its culture, in terms of the skills, time invested and motivation were identified as the most critical to the success of the pilot to date.

A substantial change management initiative was undertaken to roll out the ‘product’ in a controlled manner across the entire authority. Reflecting on previous change initiatives, senior managers at the authority were all too aware of the risk of underestimating the effort, time and resource required for roll-out. A further advantage of articulating the ‘product’ clearly and concisely was that it enabled all stakeholders to recognise where the ways of working were not performing as intended.

Impacts of the work

Benefits to service users

Mrs W was admitted to the acute hospital feeling unwell, with severe confusion, having suffered a collapse. Before being admitted, Mrs W lived with her son and had a care package of two calls by carers per day, to help with personal care and meal preparation. Her mobility had deteriorated rapidly leading up to and during her stay in hospital, where she became bed-bound.

Initial assessment indicated reduced mental capacity, but the caseworker noted an improvement within a couple of days, and Mrs W expressed that she wanted to go home. At first, Mrs W’s son had indicated that he wanted his mother to be placed in residential care. The Kent Social Services caseworker arranged for a meeting with Mrs W and her son, along with her occupational therapist and nurses from the ward.

The meeting was used to discuss Mrs W's care needs and create a care plan for how these were best going to be met. It was agreed that she would be referred for an increase to her package of care, to support a return home. The meeting and discussions with various professionals convinced the son that this was the best outcome.

“Both the OT’s and social worker’s input convinced me to give home care a try”

Mrs W's son

Mrs W has now returned home with additional support and the community case manager has been in touch to take over management of her care going forward. When asked about how she felt about the outcome, the KCC hospital caseworker commented:

“We always try to get people back to their home in the first instance. It’s in her best interest, especially as she wants to go home.”

Kent CC hospital caseworker

Mrs H was admitted to hospital following a severe stroke. She had previously lived with her husband and had been entirely independent. When she was referred to social services, the referral had already been made for a short-term placement in a community hospital, requiring a peg feed. The social worker was aware that Mrs H was due to be reviewed by the short and long-term support team (SALT), so waited for the outcome of that review, upgrading Mrs H to a soft diet, before progressing with the SALT assessment.

The ward staff argued that Mrs H was cognitively impaired and going home with her husband, whose capacity they also questioned, would not be safe for her.

The social worker reviewed the mental capacities of both Mrs H and her husband and confirmed that both were capable of making the decision about Mrs H returning home.

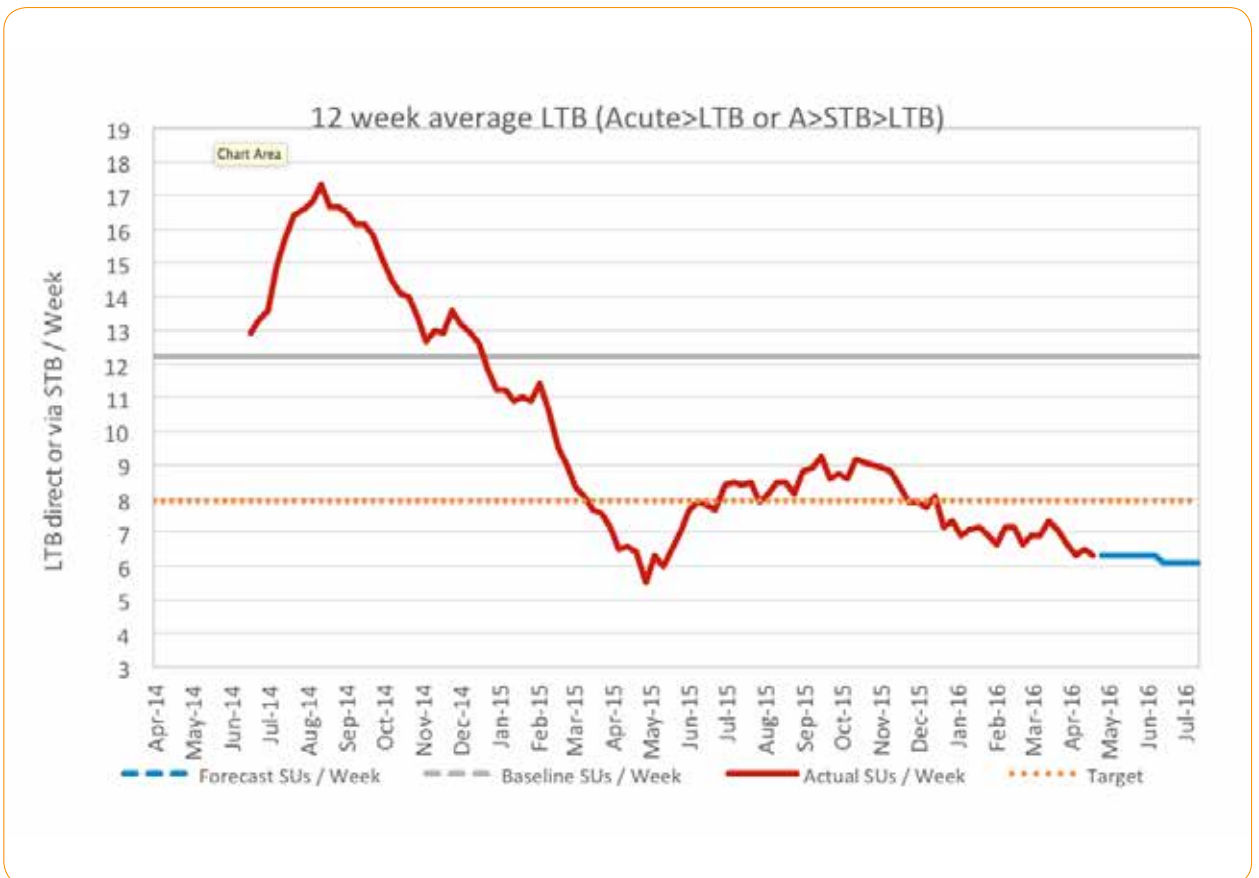
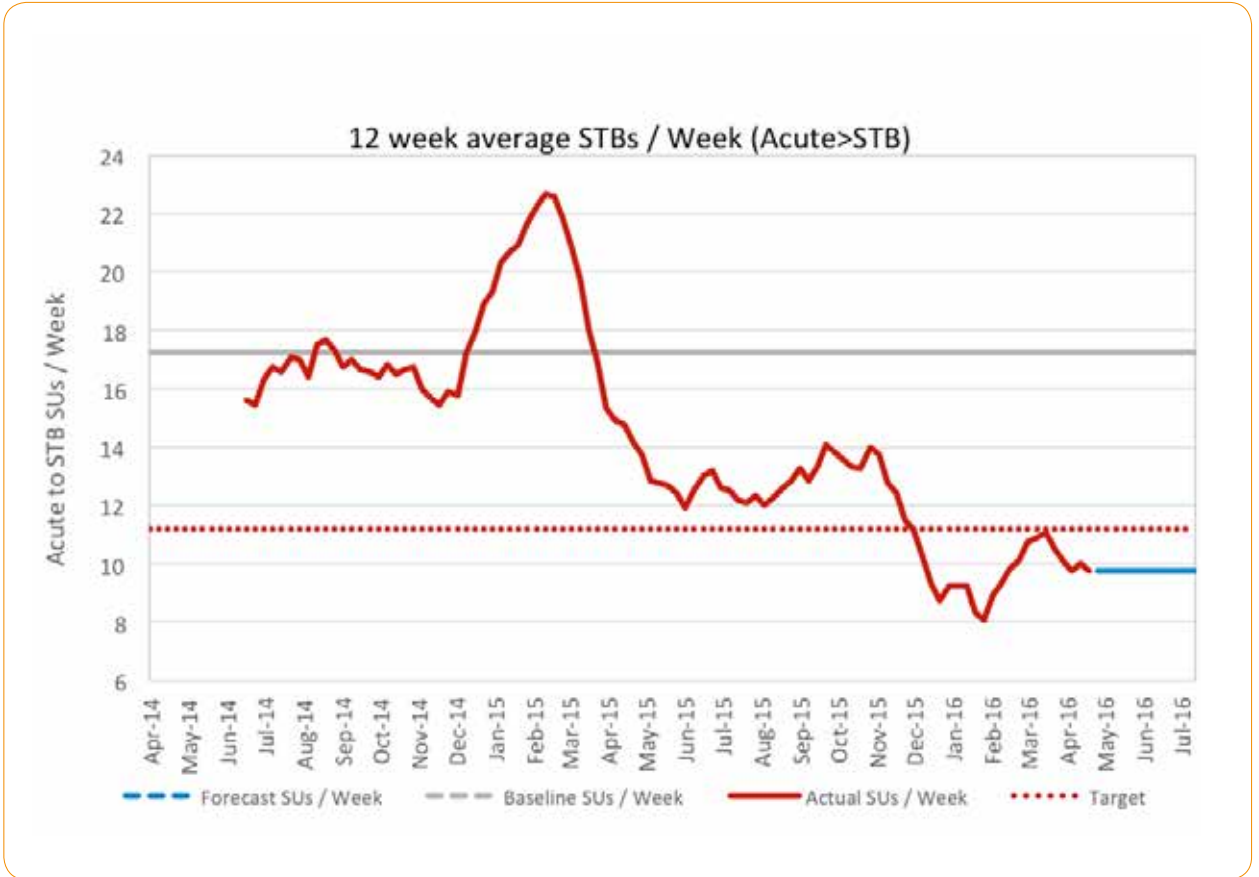
There was still disagreement from the ward staff and the rest of Mr and Mrs H's family. To try to allay the family's fears, the social worker asked the dietician to provide Mr H with a clear list of the foods that Mrs H would be capable of eating. As a result, the rest of the family were happy that Mr H would be able to manage his wife's diet at home. To offer further support, the social worker arranged for a meals service to provide Mrs H with hot meals for three weeks, which also gave Mr H ideas for what he could cook for his wife. In addition, the worker arranged for Kent Enablement at Home (KEaH) and telecare services to be put in place for Mrs H, to include a falls sensor and carer assist (a pager allowing her to contact her husband when he was working in his office). To provide additional security, 'Crossroads'²³ was also put in to give 24 hour care for the first three days after discharge. Supported by this package of interventions, Mrs H was able to return home safely with her husband.

Benefits to the local authority

It was important to ensure that clear performance metrics had been identified to enable monitoring of progress. Figure 9, below, demonstrates that significant improvements have been achieved, with a 36 per cent reduction in short-term bed placements and a 34 per cent reduction in long-term bed placements, across Kent County Council.

²³ Crossroads is a charity that can provide 24 hour care for short periods (typically 72 hours). The service is typically for dementia crisis but is also used in East Kent to make sure that someone can cope in their own home on discharge from hospital

Figure 9 – Reduction in the number of residential placements



Accounting for the alternative pathways these service users are now taking, annualised savings of £4.1 million have been delivered for the council.

Benefits to staff

The benefits to social services staff were clear. Feedback from staff at the acute hospital highlighted that after some initial apprehension of the new process, members of the team embraced the regular discussion and felt supported by their colleagues. There was also acknowledgement that the process made the decision-making more consistent across the team. Studies²⁴ have shown the benefits of group supervision in social care, many of which are also seen in the structured group discussion of cases, which is integral to this process.

“The daily wash-up process provides us with a mechanism to ensure we are applying an evidence-based method of approaching cases and achieve the best outcome for service users.”

Social worker

Everyone feels more supported in getting someone home.”

Acute discharge coordinator

Involving the wider Integrated Discharge Team in these discussions brought further benefits to staff, bringing knowledge from voluntary and community organisations as well as health and social care staff. This built greater awareness of the range of services available to people on discharge from hospital.

Similar impacts elsewhere

Sunderland local authority has made some similarly positive improvements in their referrals to residential nursing beds through their Vanguard programme ‘All Together Better’. The authority’s whole system strategy and particularly the set-up of a ‘Recovery at Home’ service (providing step-up and step-down care) have helped reduce its rate of admissions to residential nursing homes by 45 per cent to date.

²⁴ <http://www.scie.org.uk/publications/briefings/briefing43/>

b. Reducing acute admissions through integrated front door processes in Pennine Lancashire

Background

As highlighted in this report, managing admissions to the acute hospitals offers the greatest opportunity to support independent outcomes and make savings. The risk of spiralling medicalisation of patients once in the health and care system is widely acknowledged, yet few reports show firm evidence of a positive impact being made to reduce this. The Pennine Lancashire area has made some progress in this area.

Like many areas, Lancashire has a long and complex range of health and care services that have both evolved and have been added to, over the years, making care navigation a significant challenge. Some progress had been made, however, to provide improved access points to services, through Integrated Neighbourhood and Integrated Locality Teams.

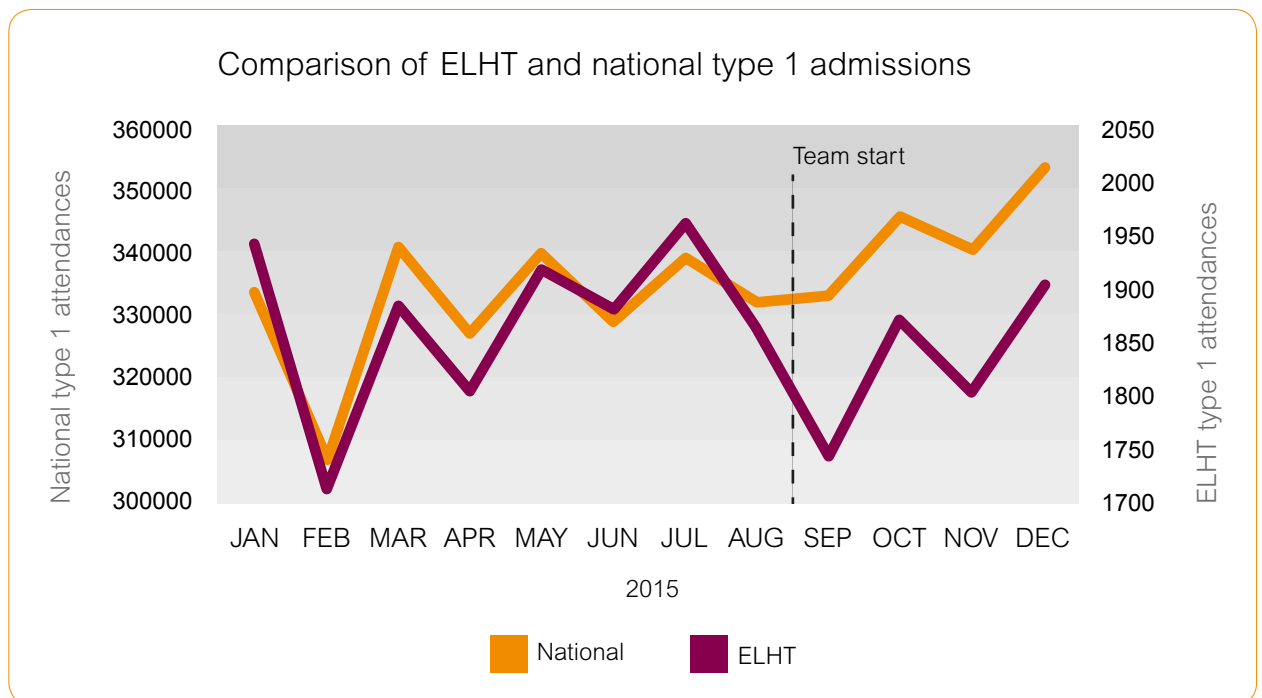
Facing rising pressure on both bed capacity in the acute hospitals and on front door

A&E services, Lancashire initiated a major programme of work to bring together the disparate array of supporting professionals located in A&E into one team including Intensive Home Support Services (IHSS), OT, physiotherapy and the voluntary sector. IHSS comprises both district nursing and social services staff, providing step-up and step-down services, aimed at treating patients in their own homes. IHSS has been a key referral pathway for the front door A&E 'deflections' for those people who following triage do not need A&E treatment but would be better treated at home with the appropriate interventions.

With the setup of a multi-professional front door team in A&E, the authority has reduced acute admissions at East Lancashire Hospitals NHS Trust (ELHT) by 5 per cent, against a national trend of rising demand (see Figure 10, below). This equates to about 100 to 120 avoided admissions per month. A similar number of patients are 'deflected' from the Acute Medical Unit (AMU) within 72 hours of admission, whilst ensuring these patients are placed on the most appropriate, independent pathway and do not get drawn further into the system inappropriately. Of the successfully deflected patients, it was found that 70 per cent require support for respiratory (COPD), falls, mobility or pain relief.

Figure 10 – ELHT admission rates compared to national trends

Source: ELHT A&E attendances and Spells data. HSCIC nationally reported A&E attendances and admissions



Case example: Mr C, age 94

Mr C was recently widowed and lived alone. He experienced considerable pain and his mobility was declining as he was awaiting a hip operation. Mr C had a fall, which he attributed partly to the side effects of his pain medication. Paramedics found no bone injuries, however Mr C was shaken by the event and the continued risk of falls. He was referred to the Integrated Community Assessment Team (ICAT) who put in place overnight crisis care for three nights, referred him on to Integrated Home Support Services (IHSS) for therapy and nursing assessments the next day. These visits detected a UTI, for which antibiotics were prescribed and also highlighted the need for walking frames and minor support equipment. A short-term one week care package was also commissioned.

Mr C and his family were delighted by the outcome, speed and responsiveness of the service. They felt much more confident and Mr C was ready to continue independently, post-implementation of the care package. In numerous other examples people in similar circumstances have remained in hospital for a protracted length of stay.

- Supported group discussions allow the best options to be appraised quickly and accurately with a multi-professional team.
- The solutions and ways of working were designed in a 'bottom-up' approach, by the team based in A&E.
- The team placed great emphasis on building relationships with the surrounding staff and partners – these working relationships are necessary to alter behaviours.
- The approach was consistent with and supported by the hospital's overall quality improvement plan, which had been articulated as 'Working together internally and throughout the health economy, to provide the right care, in the right place, at the right time.'
- Evidence of the impact was captured and analysed.

Further impacts of the work are seen in the four hour A&E targets and performance, in relation to delayed transfers of care (DToC). Whilst the four hour performance for type 1²⁵ A&E at ELHT is not yet at 95 per cent, since September 2015 it has improved relative to the nationally declining backdrop (December 2015 performance ELHT 91 per cent vs 87 per cent nationally). Similarly DToC occurrences have dropped relative to the national increasing backdrop. Both of these trends are shown in Figure 11 below.

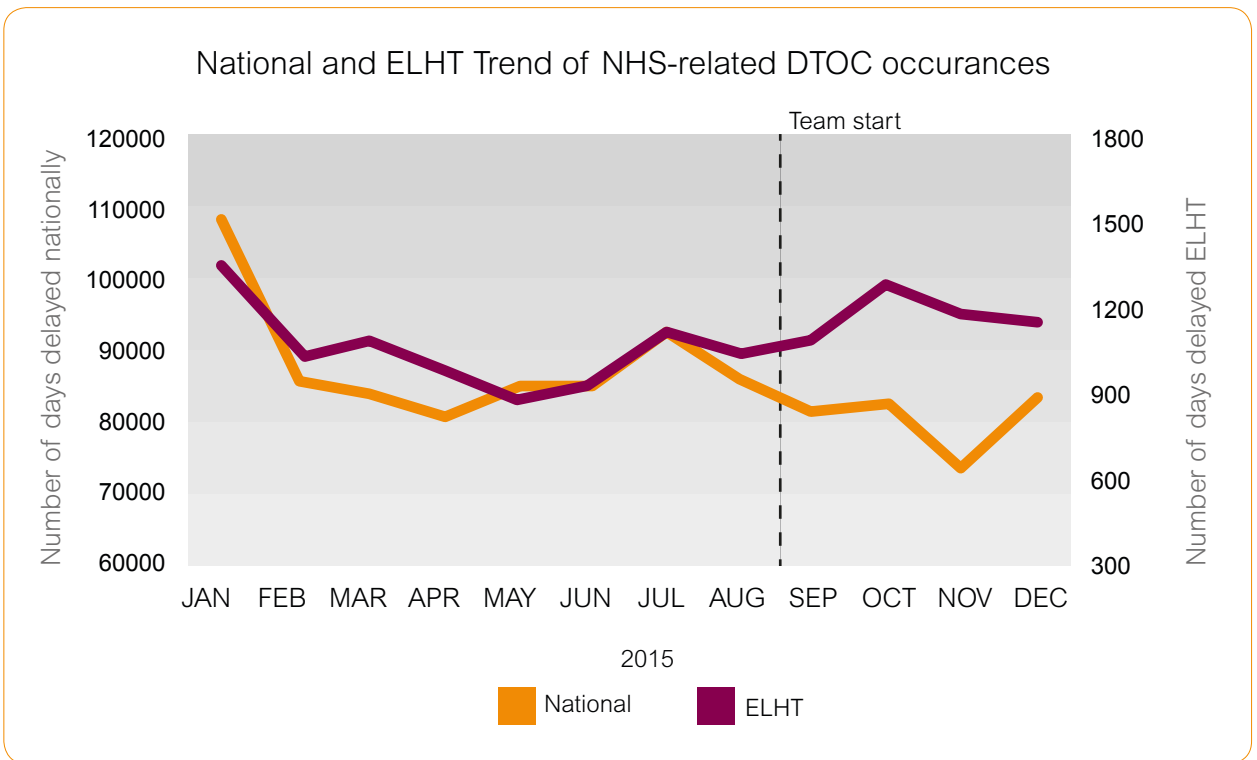
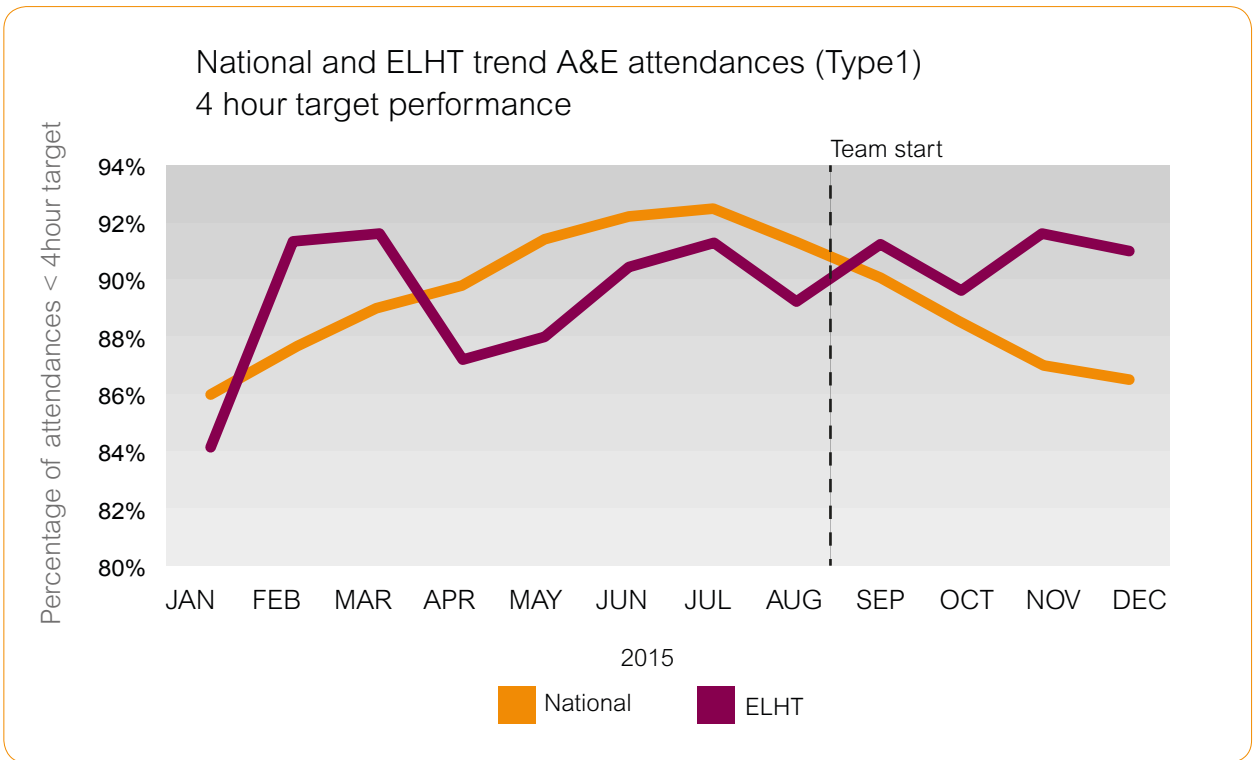
Why has this worked?

Practitioners working in East Lancashire suggest that there are a number of factors in the approach to change which have contributed to the success in reducing admissions:

- The intervention (integrated 'front door' team) is located at the point of decision (A&E) so that practitioners are able to offer community based options before patients get drawn further into the acute system.
- The focus has been placed on consolidation, making decisions and access to services simpler. Rather than adding on more resource, existing resources from multiple teams have been consolidated into one team.

25 Type 1 A&E department: a consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients

Figure 11 – ELHT 4 hour and DToC performance



Source: HSCIC nationally reported A&E attendances, admissions and DToC data

c. Reducing falls is a key preventative activity to reduce demand to both health and social care in Greenwich

Background

The role of preventative services is key to any future model of health and care in these and other areas. When analysing service users at the point of entry, or 'front door' of the local authority, it was found that 25 per cent to 40 per cent of users would have benefited from preventative services, which they did not receive. Furthermore, of the 21 per cent of cases classified as 'avoidable acute hospital admissions', approximately one third of them would have been due to early identification and prevention. The most common type of preventative service 'missed' in these cases was falls prevention.

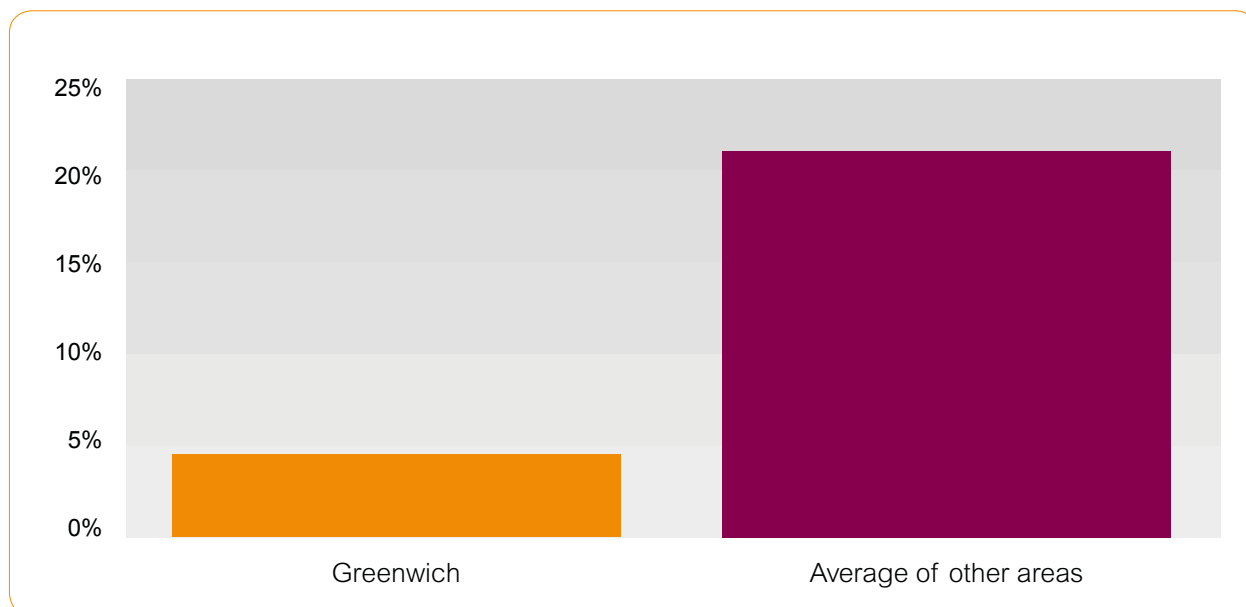
Of the areas studied as part of this work, Greenwich showed the most comprehensive use of falls prevention at the front door of the local authority, illustrated by the evidence from the case review workshops, as shown in Figure 12 below.

Within Greenwich a bespoke multidisciplinary falls team, managed by a dedicated falls coordinator, operating across health and social care was put in place, more than 10 years ago, to reduce the number of falls occurring. The initial focus had been on referrals to social care, with a more recent emphasis on those presenting at A&E.

'Making the correct choice the easy choice'

Considerable thought has been invested in ensuring that the correct decisions are made for the cohort of patients most likely to benefit from falls prevention. As part of the initial focus on referrals to social care, the falls prevention team have set up a mandatory assessment form, to ensure all referrals for social care and all service users undergoing a care package review are assessed for their falls risk (in line with NICE and 161 guidelines). This process has now been in place for 10 years, gradually gaining the support of GPs and other partners.

Figure 12 – Percentage of local authority service users receiving a package of care identified as who should have had falls prevention support, but did not



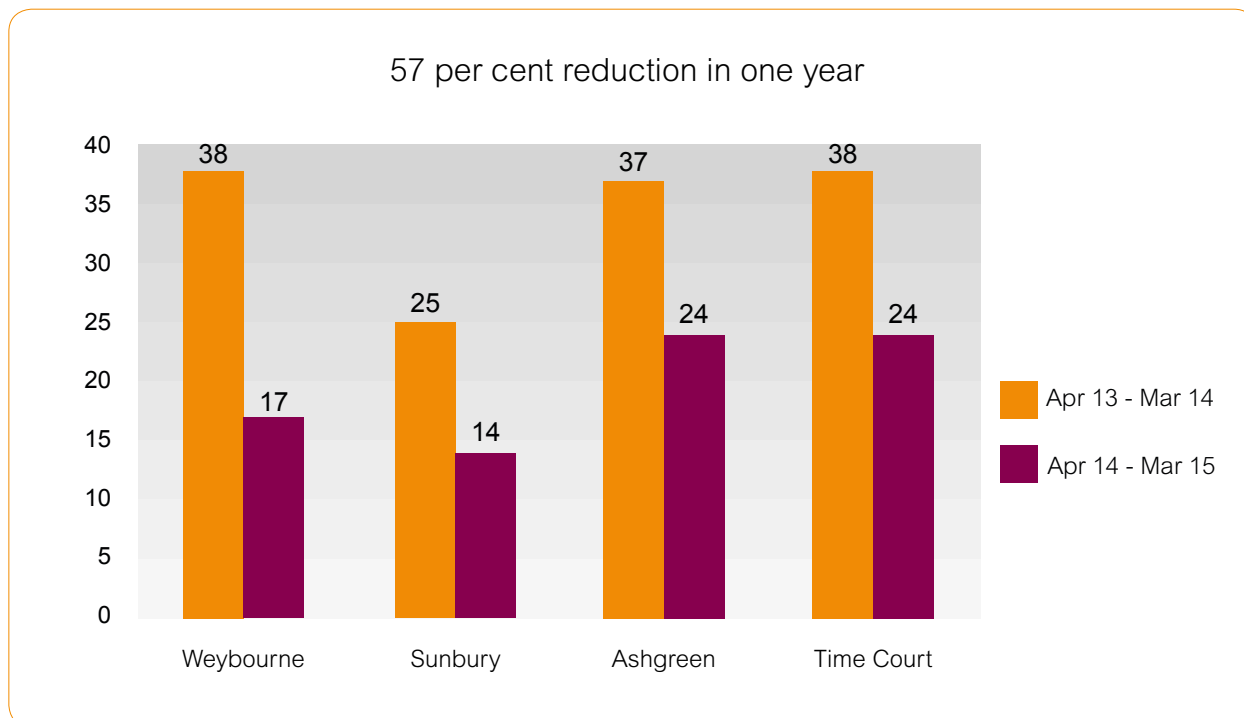
Source: Greenwich case review workshops

Figure 13 – Falls assessment in Greenwich

3. Supporting you in explaining your situation	Secti	Falls Screening		
4. Significant Relationships / Useful Contacts		This section of the form pre-populates to the CAR Health Referral.		
5. Therapy and Nursing Assessment		Is there a history of more than one fall in the last 12 months- including this current one?	<input type="text" value="-- Please select --"/>	
6. Financial Information - For Financial Assessment and Benefit Checks		Is the patient on four or more medications per day?	<input type="text" value="-- Please select --"/>	
7. Home Visit Information		Does the patient have a diagnosis of stroke or Parkinson's Disease?	<input type="text" value="-- Please select --"/>	
8. Would this person benefit from the Telecare Service?		Does the patient report any problems with their balance?	<input type="text" value="-- Please select --"/>	
9. Falls Screening		Is the patient unable to rise from a chair of knee height?	<input type="text" value="-- Please select --"/>	
10. Health conditions and disabilities that impact your well-being		If there are 3 or more 'Yes' answers to the above screening questions AND;		
11. Assessment of Care Needs		-The person is over 65 pass this referral to the Falls Prevention Team.		
12. Risks		- The person is under 65 and has a Neuro condition, pass to the Neuro Team.		
13. Emergency Evacuation		- The person is under 65 pass to the appropriate CAR Health Team.		
14. Support you currently receive from your		Additional Details <input type="text"/>		

The development of key performance indicators (KPIs) and the use of them to inform decisions has been key to improving outcomes. The analysis below shows a reduction in falls, achieved across a set of residential homes following a focused effort of reduction.

Figure 14 – local authority data for falls in Greenwich Care Homes 2013/14 to 2014/15



Further opportunities

The falls service in Greenwich undertakes a total of 365 contacts per week. The service is at full capacity with a waiting list of 12 to 15 weeks, which is currently increasing. This has had an impact on outcomes, with some users falling whilst awaiting intervention from the service.

Analysis of data from other areas in the study has indicated an urgent need for a capacity review of the various falls prevention offers. In some areas, such as Greenwich, the service is fully utilised, whilst in others capacity is available – although this is not being utilised by practitioners due to the nature of their decision-making processes.

Given that this study has highlighted falls prevention as a significant opportunity, it is important to consider the overall reduction of investment in falls services across the UK.

d. Creating clarity of accountability for discharge in Swindon

Background

There is a risk that integration is interpreted as simply the merging of organisations and blurring of boundaries between teams. The evidence from this part of the LGA project suggests that an approach that brings people together physically but does not address accountability and working practice can lead to poor decision-making.

In each area, Newton worked alongside practitioners to compare how patients were being discharged from hospital, by looking at the selected pathway and asking if a more appropriate option could have been put in place. In Swindon, the majority of patients with complex and multiple needs are discharged appropriately to the correct service type for their needs. Yet in another geography, one third of patients with complex needs were discharged to what local, reviewing practitioners regarded as the 'wrong' service.

It is worth noting that within Swindon, in keeping with other areas, although the service type was correct, significant opportunity existed to reduce the size of package within that service.

Good practice

Ward staff across both hospitals lacked knowledge of all the preventive and short-term intervention pathways available. However, the key difference between the hospitals in the two different geographies studied was the clarity of accountability of discharge coordinators. These individuals had the greatest oversight of all the options. Where the discharge coordinator had clear accountability for the discharge process, ward staff tended not to get involved in discussions with the patients about their longer-term options.

Pathways were more appropriate in this situation. Where ward staff or clinicians were influencing the discussions without comprehensive knowledge of the services available, the result was found to be considerably less satisfactory.

“The wards now describe the patients to us instead of prescribing care. How are they meant to know all of the options out there?”

Discharge assessment referral team member

The comparison of the behaviours and structures operating in the two geographies indicates that where practitioners have clarity over their roles and responsibilities, and coordinators are held accountable for pathway decisions, service users are more likely to be referred to the optimal pathway. The study found that the most common reason that service users were inappropriately occupying hospital beds was the delay in assessment and provision of ongoing packages of care. The optimal pathways were found to be at a lower level of care, suggesting that clear accountability and more effective decision-making is likely to result in an additional benefit of reduced discharge delays.

e. Integrating the procurement of Continuing Health Care (CHC) and local authority beds in Sunderland

Background

In previous projects Newton has observed several examples where a service user in a nursing home has had their funding source changed from Continuing Health Care (CHC) to the local authority, or vice versa, and the cost has changed without the actual care provision changing.

In this study, CHC nursing home rates across the participating areas were compared to internal benchmarks and national framework benchmarks for CHC nursing. This indicated an opportunity of 4 per cent rate reduction. There is the potential for further opportunities when the integration of the commissioning function is considered more broadly.

The progress of many projects to address issues of this nature is often hindered by the complexity and lack of flexibility in data sharing between key partner organisations. Integration cannot move forward at pace until this barrier is removed.

Good practice

Sunderland provided an exception to the norm in this regard. The local authority here has commissioned CHC and local authority beds, as one, for the past five years. This results in achieving the same rate for both types of bed. The authority also achieved one of the lowest costs per week of any of the geographies studied for both bed types.

Strong relationships between health and social care have been built over many years in Sunderland, and this has been a key enabler to the result.

Leadership commitment and drive has been essential in progressing an integrated model of care. Based on the discussions in Sunderland and supported by the findings in the other participating areas, a set of questions has been developed for leaders to consider to support progress – see Appendix 2.

Appendix 2

Further thoughts for leaders to progress change in their areas

In addition to the thoughts on leadership arising from the case study from Sunderland, see Appendix 1. Evidence from this work suggests that there are three other challenges which should be addressed in progressing integration efforts effectively:

- developing risk-sharing to avoid disincentives
- simplifying information governance and data-sharing agreements
- aligning leaders.

Whilst these factors are touched upon throughout the main report, they are expanded on here to support leaders in ensuring these critical areas are not missed.

2.1 Developing risk-sharing to avoid disincentives

Discussions with chief executives and directors of adult social care services highlighted how NHS and social care funding systems are poorly aligned. The financial and flow model built as part of this work shows how, if service users change pathway through the system, the tariff/funding changes will not change accordingly. This could lead to a situation where one partner benefits from integration, whilst the other pays.

There are examples of good practice in this regard; new initiatives such as Year of Care²⁶ and the devolution programme in Manchester (Devo Manc) may help to solve this financial risk sharing in the long term²⁷.

In the meantime, health and social care partners should develop risk-sharing strategies at a local level to avoid the pitfall of financial disincentives.

2.2 Simplifying information governance and data-sharing agreements

The progress of many projects of this nature is often hindered by complexity and lack of flexibility in terms of data sharing between key partner organisations. Integration cannot move forward at pace until this barrier is removed.

The ability to collate and analyse datasets meaningfully across organisations to allow strategic improvement work, is critical. The project team has needed to adopt differing approaches in each area and at times has faced challenges in obtaining consent to share anonymised data. This is indicative of a wider and more serious issue for effective integration.

As part of the fieldwork the project has brought together GPs and social workers to work side-by-side to review case notes. Many revealed that they had never had visibility of one another's care plans before, nor were they aware of the range of services available. They were therefore unable to integrate their approaches to an individual's care.

²⁶ www.yearofcare.co.uk

²⁷ www.greatermanchester-ca.gov.uk/homepage/59/devolution

To enable practical change to be planned and measured, data to be shared amongst partners must be operationally useful.

Addressing the challenge of information governance and sharing is both a system and a cultural issue – and requires leadership at both local and national levels. Leicestershire has made some notable initial progress in this area, bringing together health and social data to provide system-wide dashboards for interrogation²⁸. The next challenge for the authority will be rolling-out these tools at scale, to influence decision-makers. Sunderland has also made promising steps in this direction, with a clear case for change agreed by all parties and data-sharing agreements now in their final stages of development.

2.3 Aligning leaders

When identifying possible areas to involve in this project, the LGA and Newton spoke to leaders from 11 health and social care economies. In fewer than half of these was it possible to get all relevant leaders around the table to discuss the project. A number of leaders were unwilling to take a shared approach, or allow access to their data.

In some areas, integration appeared to be driven by one or two enthusiastic individuals. When considering the challenges of continual budget pressures and changes within each organisation, clearly a step-change will be required in the prioritisation of integration. This alignment of vision and direction is understandably a critical part of the successful change model.

Sunderland was ahead of most other areas when, in 2012, the local health and social care organisations agreed their intermediate care strategic direction. This strategy focused clearly on the need to target long-term independent outcomes and was signed up to by all parties. The vision articulated at the time was:

“To develop a locality focused collaborative model which maximises independence and quality of life for people of all ages, whilst ensuring cost-effective use of resources. We will ensure the individual and their carers/family are at the heart of their care and support, ensuring they have access to information, advice and support to promote real choice and control, increase self-care and self-management, and enable individuals and their carers to remain as independent as possible, for as long as possible.”

This alignment ensured that the authority in Sunderland was well placed to accelerate its changes as soon as the Better Care Fund was introduced. To date the authority has reduced admissions to residential nursing homes by 45 per cent through their whole systems interventions, particularly through the Recovery at Home service.

²⁸ www.lsr-online.org/launch-event---14-october-2015.html

2.4 Questions for leaders to consider in developing an integrated model of health and care

Based on the findings and priorities outlined in this paper, a set of questions has been developed for leaders to consider in developing an integrated model of health and care

Figure 15 – questions for leaders to consider in developing an integrated model of health and care

- Do we have an evidence base to show where the greatest opportunities exist in our system?
- Have we really prioritised where we are going to focus and have all parties signed up to this? What are we not going to do?
- Have we broken the programme down into phases to ensure sufficient focus and evidence of success can be maintained?
- Have we agreed simple, clear, yet specific system objectives and aligned each partner's strategy to support the achievement of them?
- Do we have a simple mechanism to allow re-deployment of resources to the places required to support change?
- Are we using rapid pilots, iterating and proving solutions before rolling them out?
- Is our change led by front line staff and are we maximising the power of multi-disciplinary team reviews to control accurate decision-making?
- How are we going to rationalise the menu of service post implementation to make decision-making simpler, rather than more complex?



Local Government Association

Local Government House
Smith Square
London SW1P 3HZ

Telephone 020 7664 3000
Fax 020 7664 3030
Email info@local.gov.uk
www.local.gov.uk

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