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EDGE WORK

Summary Report

What is driving poorer outcomes at the interface between Health and Social Care?

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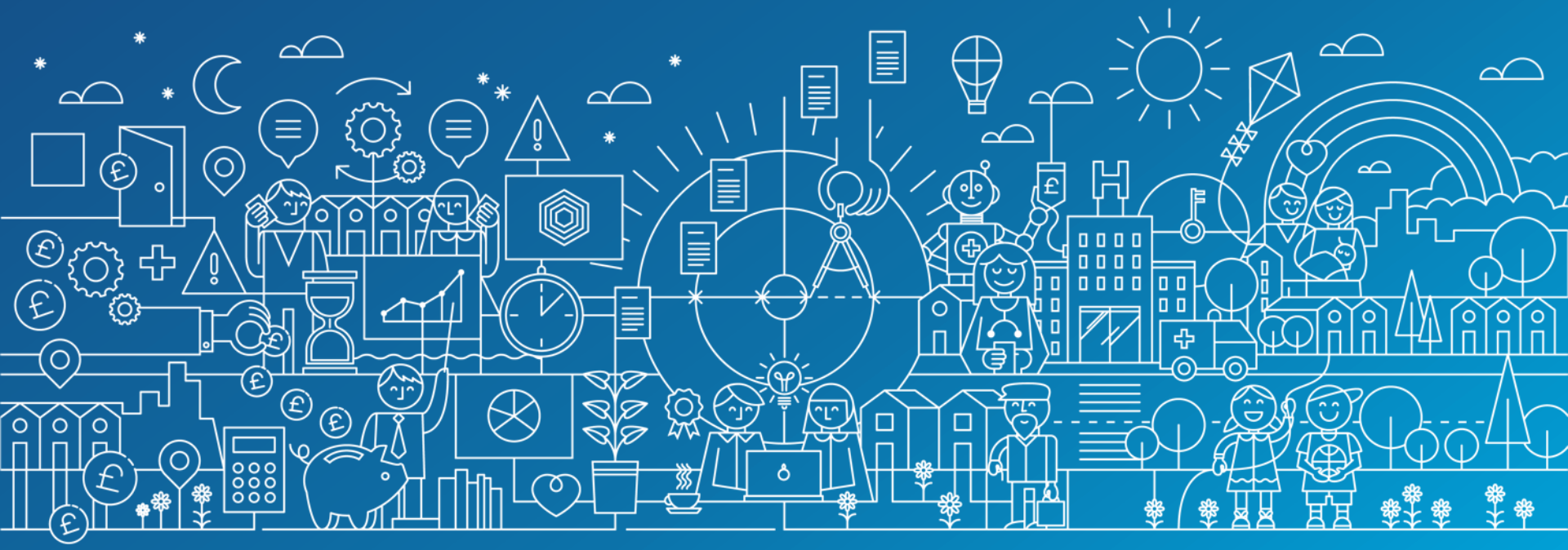
May 2019



Introduction

This report provides a summary of the findings from a recent survey conducted by IMPOWER, which looked at what is driving poorer outcomes for people at the interface between health and social care.

This primary research was presented at ADASS Spring Seminar 2019 and was used as the basis for a front page article in The MJ.

Due to the positive feedback and engagement received to date, IMPOWER are now looking to work with a range of local health and care partners, to build local evidence and ambition to resolve the issues that are outlined in this report.

What's really going on at the interface between Health & Social Care?

One of the most profound questions facing public services today, is what is driving poor outcomes at the interface between health and social care.

In the spring of 2019, IMPOWER decided to tackle this question head on by conducting primary research across health and social care professionals.

Our hypothesis was that the importance of relationships and behaviours have been undervalued.

This summary report presents the high level findings from the research, which were initially presented at the ADASS Spring Seminar 2019.

5
key questions

210
responses

Adult Social Care professionals

Hospital Staff

Community Nurses, GPs and others

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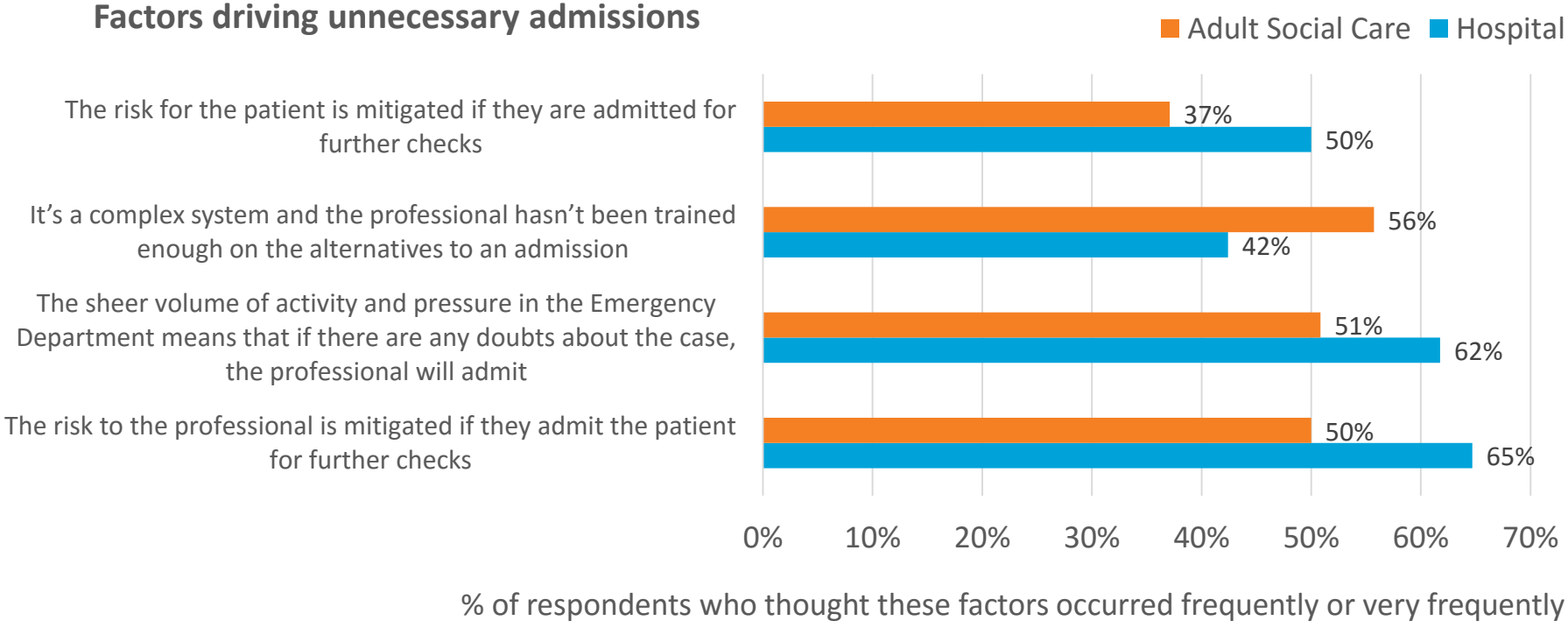
Finding 1: Behaviours and culture are causing unnecessary hospital admissions

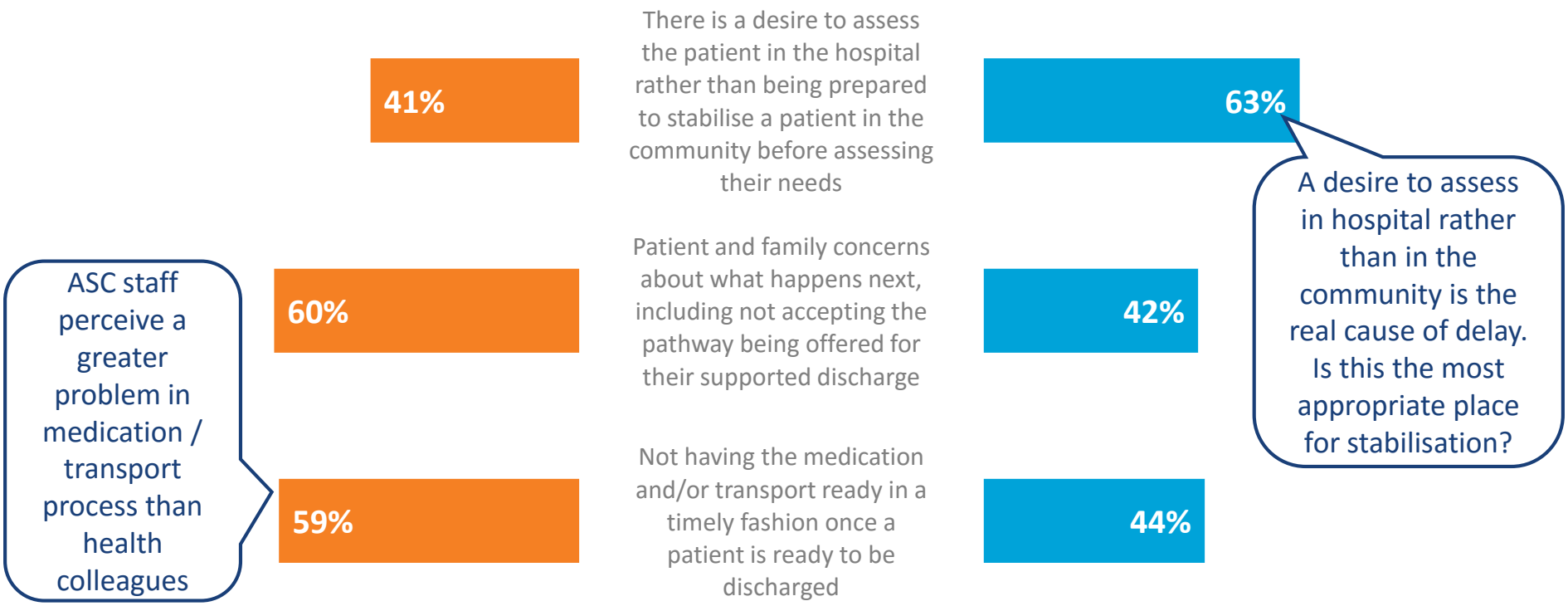
Hospital and Adult Social care staff experience factors differently, but overall the most common factors identified are all caused by behaviours and cultures rather than process. For example the highest score for hospital staff is driven by mitigating risk, and for adult social care staff it is around behaviours relating to understanding and considering the alternatives.

Factors driving unnecessary admissions



Finding 2: Discharges are delayed due to a potentially unhelpful desire to stabilise in hospital rather than in the community

There is a big discrepancy between how frequently staff from different settings believed that they influenced decisions that prevent a patient from being discharged from hospital when they could have gone home. For example, there appears to be a risk aversion in hospital settings that prevents people from being stabilised at home.



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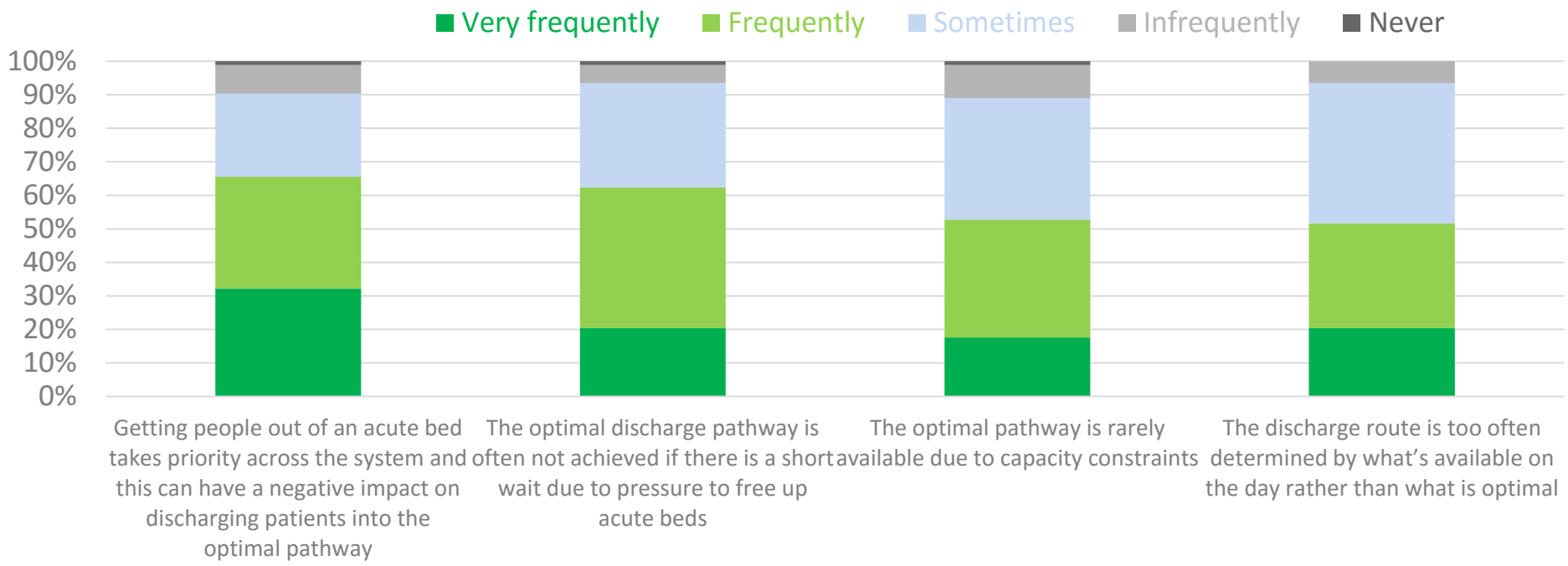
Finding 3: Sub-optimal discharges occur because of system pressure

There is a strong belief across the system that optimal discharge often comes second to the need to free up beds, and that decisions are made based on what is available, not on what is right for the patient. The following four statements were found to be most frequent.

How frequently do you believe the following influence decisions that cause a patient to be discharged from hospital through the wrong pathway?



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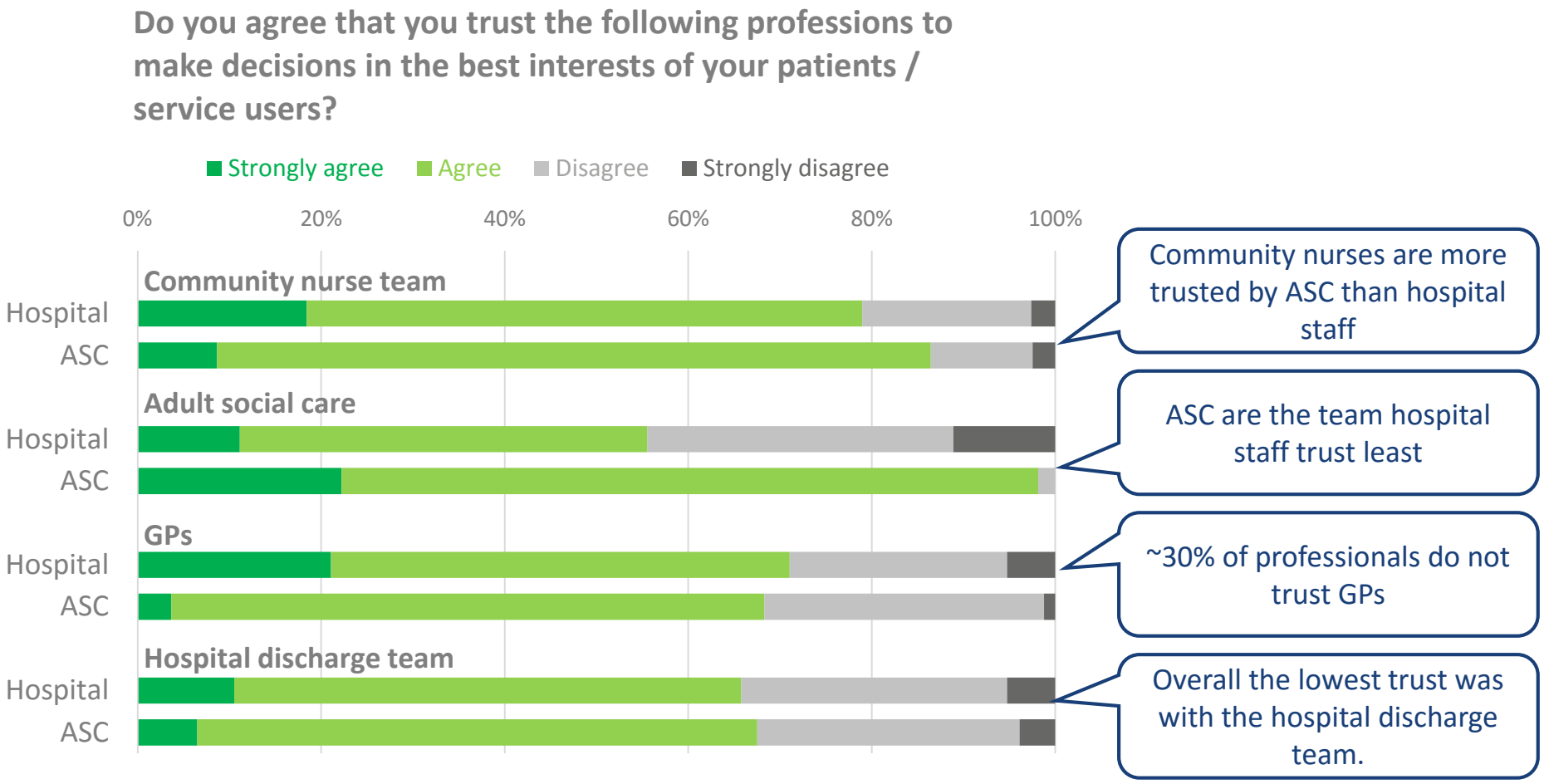
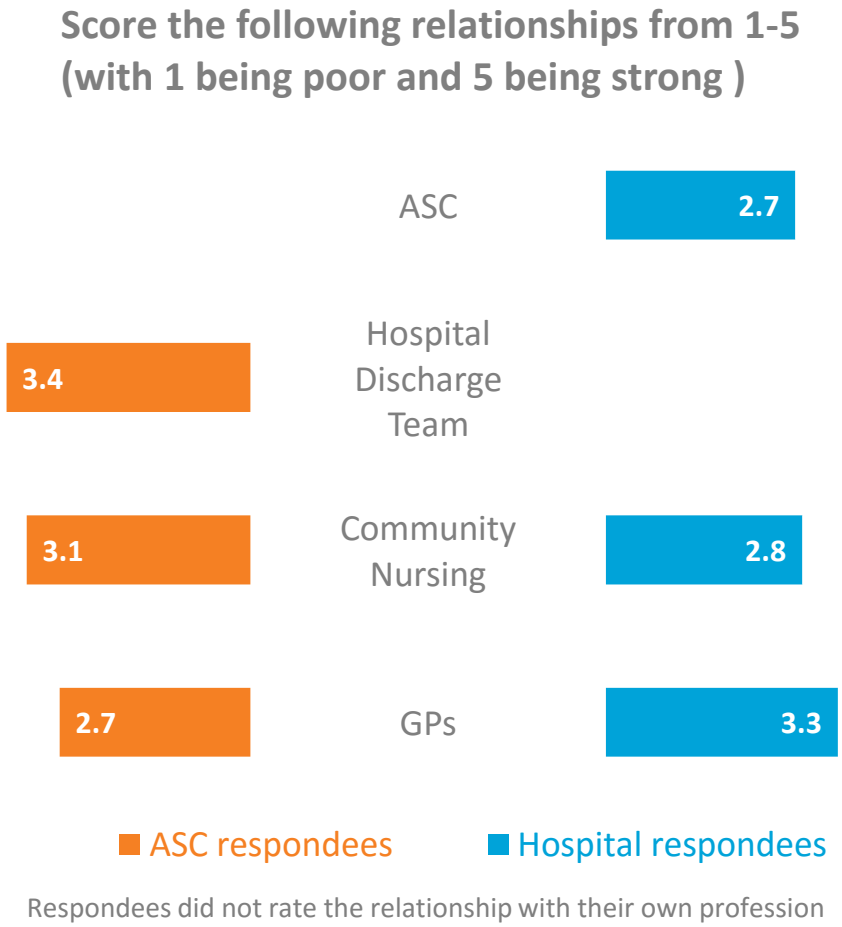
Finding 4: There is a significant trust gap between hospital and ASC staff despite years of effort to improve integration



Finding 5: Relationships are poor and uneven across the interface



Relationships were found to be poor across the sector and uneven between professional groups.

The lowest scoring relationships were between:

1) ASC and GPs, and
2) Hospital discharge staff and ASC. Conversely however, ASC's relationship with hospital discharge staff was rated the highest overall. This mirrors the trust findings on the previous slide and suggests that there is a disconnect in the relationships between health and care.

Research conclusions

Conclusions:

- This is a **significant** and **multi-factorial** complex issue
- Most interventions are **process/system** led
- **Behavioural factors** are driving unnecessary admissions and delayed and sub-optimal discharges – this is **adversely affecting outcomes** for patients / service users
- There needs to be a **greater focus on changing cultures and behaviours** as opposed to just processes and systems
- Relationships are **poor** and **uneven** across the interface between health and care
- There is a substantial **trust gap**
- Despite five years of increasing work together, trust has **not significantly improved** (and in some cases has declined)

Questions to consider:

- Is this insight surprising and does it **reflect your experience** locally?
- Can this insight help you **reframe the conversation** with partners?
- How much effort in your local system is **focused on improving culture and behaviours,** and is it working?
- Would having richer **local insights and evidence** help you reframe the conversation with partners?

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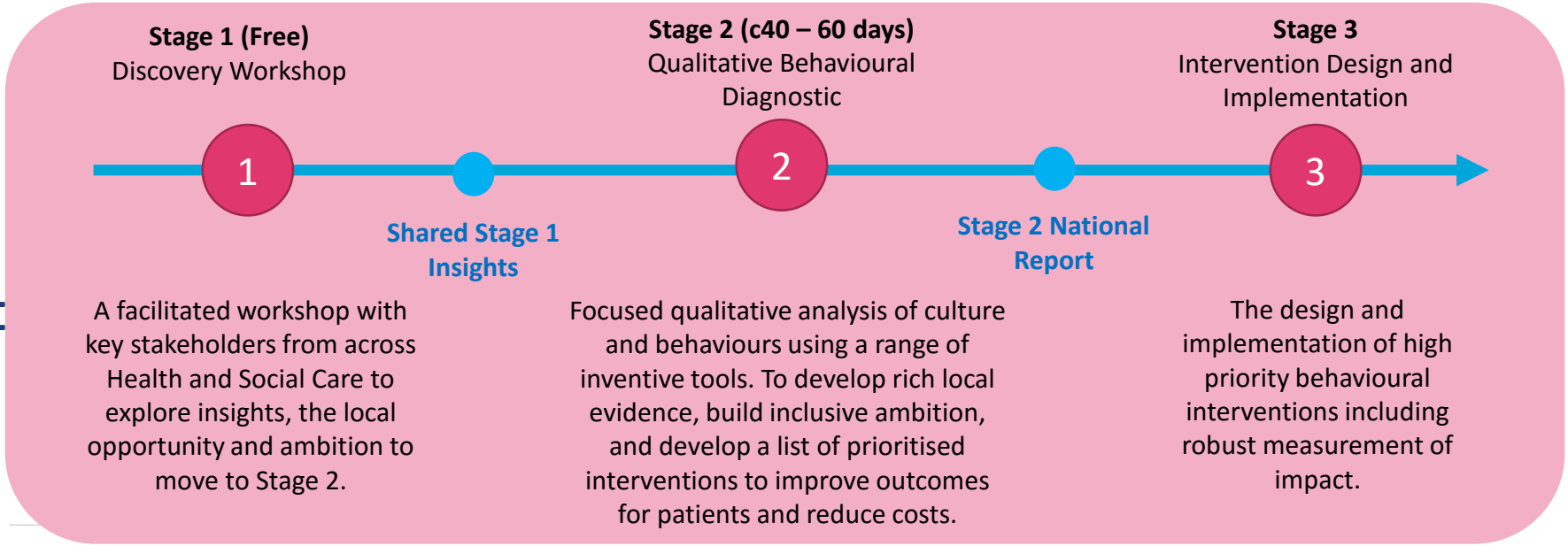
What happens next?
How can you get involved?

What next – how to get involved?

IMPOWER are now looking to work with a range of local health and care partners (starting in June and July), to build local evidence and ambition to resolve the issues that are outlined in this report. The programme will also focus on sharing learning and insights between different participating areas and developing a national report of findings.

Objective: Develop local evidence and ambition to address cultural and behavioural issues at the interface between health and social care. Share learning and insights across participating areas.

Approach



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Approach – Stage 1

Stage 1: Discovery Workshop (Free)

A facilitated workshop with key stakeholders from across Health and Social Care. To explore IMPOWER's primary research findings and complete a local gap analysis exercise, before determining the appetite, scope and decision to move to Stage 2 of the programme. The key insights from Stage 1 will be shared between participating areas.

Get in touch to book one of our first 10 workshops in June or July!

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Approach – Stage 2

Stage 2: Qualitative Behavioural Diagnostic (c40-60 days)

IMPOWER will work with local health and care partners to conduct a **focused qualitative analysis** of culture and behaviours **across 6 to 8 weeks**. This will provide rich local evidence and insights regarding the opportunities to improve outcomes for patients through a focus on culture and behaviours. Insights and learning will be **shared across participating areas**.

We anticipate the first part of this approach is to understand what the system's **desired behaviours** are, and to build some **hypotheses** on why the desired behaviours are not being exhibited. These potential barriers will then be tested through the qualitative analysis and either verified or disproved.

The process will help build inclusive ambition across partners. The output will be a **prioritised list** of possible cultural and behavioural **interventions** that will be shared as part of a **final workshop with local health partners.**

The outputs from Stage 2 will then be taken forward into Stage 3 of the programme. A **national repor**t will bring together insights and learning from all participating areas.

Note – the precise scope of Stage 2 is flexible and will be agreed with local partners during Stage 1. It could be wider or different in scope to that outlined above.

Approach – Stage 2 methodology

Desired behaviours	• Finalise list of desired behaviours • Identify key hypotheses / barriers for why these behaviours are not being exhibited
Data analysis	• Short piece of data analysis to evidence flow across the system, bottle necks etc. Reasons behind this to best tested through qualitative analysis
Structured interviews	• Structured interviews with senior stakeholders and frontline mangers / staff on culture and behaviours
Case reviews	• Multi-agency review of us up to 30 cases to test evidence of desired behaviours being put into practice / reasons why they were not
Surveys	• Two culture and behaviour surveys, targeted at senior stakeholders and frontline staff
Observations	• Observations of practice, testing messaging and broader behaviours. Engagement with service users • Observation of key meetings both at a strategic and practice level
Comms review	• Review of communications given to service users / their families and what is on display in the environment they are being seen in / passing through

Approach – Stage 3

Stage 3: Design and implementation

IMPOWER will work with local health and care partners to agree those priority interventions to be taken forward to design and implementation. The precise scope of work will be agreed during Stage 2.

Implementation will take the form of a ‘test and learn’ approach recognising that solutions need to be continuously refined and improved when being introduced to a complex system.

Specific metrics will be developed to track and measure the desired impact of each intervention.

IMPOWER will use a range of unique tools to help deliver sustainable change within a complex system (e.g. applied behavioural science).

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