Senedd Cymru's Health and Social Care Committee:
Inquiry into Hospital Discharge and its impact on patient flow through hospital

Joint Written Response from the WLGA and ADSS Cymru

Background of the organisations

The Welsh Local Government Association (WLGA) represents the 22 local authorities in Wales, and the three national park authorities and the three fire and rescue authorities are associate members.

The WLGA is a politically led cross-party organisation, with the leaders from all local authorities determining policy through the Executive Board and the wider WLGA Council. The WLGA also appoints senior members as Spokespersons and Deputy Spokespersons to provide a national lead on policy matters on behalf of local government.

The WLGA works closely with and is often advised by professional advisors and professional associations from local government, however, the WLGA is the representative body for local government and provides the collective, political voice of local government in Wales.

The Association of Directors of Social Services (ADSS) Cymru is the professional and strategic leadership organisation for social services in Wales and is composed of statutory directors of social services, the heads of service and tier three managers who support them in delivering statutory responsibilities: a group which consists of over 300 social services leaders across the 22 local authorities in Wales.

The role of ADSS Cymru is to represent the collective, authoritative voice of senior social care leaders who support vulnerable adults and children, their families, and communities, on a range of national and regional issues in relation to social care policy, practice, and resourcing. It is the only national body that articulates the view of those professionals who lead our social care services.

As a member-led organisation, ADSS Cymru is committed to using the wealth of its members' experience and expertise. We work in partnership with a wide range of partners and stakeholders to influence the important strategic decisions around the development of health, social care, and public service delivery. Ultimately our aim is to benefit the people our services support and the people who work within those services.

Introduction

Delays in hospital discharge and timely transfer of care to other secondary providers, primary care, and community care, have a significant impact on people in receipt of care their families and carers, as well as having an impact on those people requiring admission into hospital. Therefore, discharge and transfer of care planning and its effective implementation is everyone's business, with the Multi-Disciplinary Team (MDT) at both ends of the system being critical to its successful delivery.

Delayed Transfers of Care (DToC) are seen as one of the main reporting mechanisms for the sector and are a benchmark used by Welsh Government to determine how well a health board and local authority are performing. The measurement of DToC has been described by the Wales Audit Office as the only national measure of discharge.[i] Over the past few years, there has been a great deal of work to both understand the issues and causes of DToC and poor patient flows, along with tools and resources to address these. A DToC is a symptom of a poorly aligned journey for people. Therefore, we must consider the wider challenges in the integration of health and social care support for our people. As such, a DToC cannot be considered in isolation. We must consider other factors and variables, including workforce supply indicators for the system.

The varying complexity of DToCs require effective partnership working by health and social care organisations, as well as third sector and commissioned providers. Moreover, in line with the Social Services and Well-being (Wales) Act 2014 and the Principles of Prudent Healthcare, joint working should be driven by the voice of individuals and carers and what matter to them, not just professionals. It is pivotal that the principles of co-production are at the centre of arranging and providing care because supporting people to safely transfer from one setting to the next, needs a person-centred, whole systems approach, with agreed joint protocols, effective communication, and flexible practices to achieve the best outcomes.

Therefore, a DToC can be an indication of both service pressures and ineffective collaboration, in terms of planning, commissioning and delivery, contributing to systemic failure, rather than the actions of individual parties, whether in social care or the NHS. Given that a DToC is such a complex issue, we strongly believe that in pursuing a whole systems approach in the planning, commissioning and delivery of health and care services, to fixate on this one area in isolation would be to miss the point. Fundamentally, we need to ensure we are shifting our focus from secondary hospital-based care to supporting independence, wellbeing and preventative care in the community, as articulated in *A Healthier Wales*. Historically, the majority of DToCs can be attributed to delays within the NHS itself. However, in the period just prior to the COVID-19 pandemic and despite much work being undertaken, there was evidence of an increase, in certain parts of Wales, in the proportion attributable to social care. This is an unfortunate reflection of the pressures faced by local councils, where the capacity of the workforce is a major contributory factor and so too, is the stability of the social care sector, particularly for domiciliary care and care homes.

The COVID-19 pandemic has underlined the essential value of social care in helping people to live the lives they want to lead, demonstrating just how critical social care is. However, it has also brought into sharp focus the full range of challenges facing social care. Many of the pre-existing issues facing social care, including increasing demand, funding pressures and workforce challenges have been exacerbated and add to the significant pressures being experienced across the health and social care system, including in relation to DToC. We therefore welcome the Committee's inquiry looking at how flow through hospitals can be improved, but as cited earlier, feel this cannot be considered in isolation to factors across the whole system, including focussing on preventing hospital admissions. It will be important for the Committee to consider both the pre-existing challenges facing the system, as well as the significant immediate pressures being experienced as a direct result of the pandemic.

As part of the Committee's considerations, it will also be important to reflect on some of the work and research that has already been undertaken in this area over several years with the aim of improving flow. Some of the key areas of research are highlighted in Appendix 1, which should be supplemented with examples of best practice, as highlighted by Welsh Government in its May 2021 publication, *Delivering Home First*.[ii]

The Approach of Local Authorities

Councils across Wales have been doing all they can to reduce delays in getting patients out of hospital and back into the community, where the most efficacious level of rehabilitation and reablement can take place. However, social care is about far more than alleviating pressure on the health service; it is a vital and essential service in its own right, which provides care and support to maintain independence and improve well-being.

The focus of current policy is to shift demand from expensive services such as acute hospitals and nursing homes to managing conditions in a community setting. We believe that is the right approach and that policy aim must be continued, particularly considering the COVID-19 pandemic. There needs to be a shift in focus across the health and social care system as a whole, from health systems centred around hospitals, to health and social care systems focused on communities and community services as defined in their broadest sense. Making community-based and preventative care the central focus of the system requires a whole-systems approach to change, spanning hospital services, community services, primary care, and social care, as well as housing and other community resources.

The winter periods preceding the COVID pandemic, saw greater collaboration across services and organisations in support of improved flow of individuals using care and support through the hospital system and transferring to care in the community. For example, most

local authorities have integrated nursing or intermediate care teams working in the community to 'pull' patients out of hospital back to their home or community, furnished with appropriate level of support they need to be re-abled and live as independently as possible. We believe the value demonstrated by these integrated teams who possess the skill, additional capacity, and critical local knowledge, lends itself to ensuring that the discharge policy function should primarily reside with the community and not with the hospital.

As collaborative partnerships continue to mature, so relationships between partners have continued to improve. Particularly as the work of the Regional Partnership Boards takes further root; partners now jointly own DToCs and collective action has been taken to try to tackle the issue.

Whilst progress continues across the regions in Wales, there have been a number of trends consistently reported by local authorities in relation to unscheduled pressures in previous years; many of which have been exacerbated by the demands placed on the health and social care system of trying to manage and suppress the pandemic. These include:

- **The fragility in domiciliary care and reablement services, exacerbated by market capacity, volatility in demand and short-term problems, associated with sickness or leave at times of public holiday.**
- **Responsiveness and complexity of service required are significant issues, with workforce recruitment and retention providing significant challenges.**
- **Capacity in traditional residential care had been relatively resilient, but many areas have reported a scarcity of specialist Elderly Mentally Infirm (EMI) and nursing care capacity (in part as a result of workforce issues and with a particular challenge with recruitment of nurses).**
- **Pressures on the hospital system, in particular increased admissions and people presenting with higher levels of acuity, coupled with the reduction of hospital beds.**
- **Patient/Family/Carer choice and expectations not being properly considered and managed.**

Impact of the Pandemic

While in recent months much of society had been looking towards the easing of restrictions and recovery, the health and social care sector has remained under considerable and increasing pressure. Social care has seen an unprecedented increase in demand for services. Some of this was latent demand while services were not operating at full capacity or specific

services were not available (such as day centres) and some is new demand for care and support services, as a result of the indirect harm from delays in health care and treatment and family / carer breakdown. In addition, Long Covid has increased requests for support from social care services and the mental health and well-being impacts of the pandemic are well documented. There is a clear message being received from across the social care sector that they are still in response mode.

Both WLGA and ADSS Cymru continue to seek regular feedback from local authorities on the issues and concerns they are facing at the local level in delivering social care services. While the level to which specific issues are impacting locally can vary, all have highlighted concerns and challenges which reflect common pressures being experienced across both adult and children's services. These include:

Workforce - There are now significant challenges in relation to recruitment and retention both for in-house (including assessment and provision) and commissioned services across both adult and children's services. This issue has been exacerbated by number of issues including:

- Competition both from the health service and other sectors who can offer better terms and conditions. This has been further exacerbated because of a reduction in immigration since the UK left the EU, which has increased the need for the hospitality industry to recruit locally, effectively competing for the same pool of staff as social care.
- A reduction in staff prepared to continue to work in the sector, with some making lifestyle choices to reduce working hours and many leaving the sector because they are exhausted.
- Some have felt let down by the lack of recognition given to social care workers, with NHS workers seemingly more valued and so some are walking away.
- Increasing demand and pressure being placed on an under-valued and over-stretched workforce (with some employers unable to honour leave requests and employees exercising their zero hours contract rights).
- Difficulties in filling staff voids due to a large number of staff having to self-isolate.

Care at Home – Both in-house and commissioned services are under significant pressure, with demand for services increasing. Local authorities are experiencing domiciliary care packages being handed back which has a wider impact on reablement provision, hospital discharges, prevention of admissions and responding to urgent need.

Waiting lists – Waiting lists are increasing, people waiting for packages of care and for people awaiting assessment and/or equipment and support from occupational therapists.

This also impacts on unpaid carers well-being as there are delays to provision of equipment and training/support to meet their cared for's needs

Unpaid Carers – There are increasing concerns for unpaid carers who have continued under severe pressure throughout the pandemic. While carer's services have continued to support people, there has been an increase in demand, with concerns that if unpaid carers are unable to continue to care effectively, then there will be increased demand for support placed on already overstretched services.

The unprecedented demand has led to several health boards, local authorities, and the Welsh Ambulance Trust to issue joint statements in recent weeks outlining the deeply concerning situation to the public. For example, the Cardiff and Vale region has seen a 30% increase in people needing care at home compared with pre-pandemic numbers. This huge increase in demand – alongside a UK-wide shortage of care workers and health care staff – is leading to delays in care provision and preventing the timely discharge of patients from hospital settings.

The statements have warned that across the health and social care system there is not the staff to cope with the sheer volume of people needing to be discharged from hospital with care packages or who need care in their own homes and communities. The significant delays in these services have led to a shortage of NHS beds, backlogs in areas like A&E, and the Welsh Ambulance Service looking after patients in their vehicles outside hospitals. As a result, partners have had to urge people to take on responsibility for looking after their loved ones – when they are medically fit to be discharged – to try and free up hospital beds. They have also called on people to return to the care sector if they have left or join a fast-track programme to become a qualified carer.

In responding to these challenges, councils and health boards are meeting regularly to review cases and address barriers on a person-centered level. Each council is aware of the cases within its own boundary and working with the health board to maintain an overview. A range of positive interventions have been put in place to improve flow through the system, both by councils, health boards and by working together. This includes new ways of working and further investment in capacity and continued efforts to recruit more staff. Further preventative work and focus to stop people entering hospital in the first place is also required.

It is also important to note that social care continues to support a significant number of people in the community, which prevent hospital admission in the first place. This far outweighs the number of delays in hospital discharges, which reflects that prevention and

early intervention services play a critical role in reducing pressures in secondary care services.

As a result, there is a good knowledge and understanding of what is stopping medically fit people being discharged from hospital. There are a variety of reasons for the current delays in discharge, with the numbers and reasons for DToC changing on a day-to-day basis. Currently, there are two clear 'top' reasons as to why there are delayed transfers of care from hospital:

- Individuals are awaiting packages of domiciliary care (with a lack of capacity to provide new packages and also due to packages being handed back to councils); or
- Individuals are awaiting a place in residential care or nursing homes (including awaiting assessment by care home managers but also noting that COVID is still in circulation and impacting, for example patients waiting for COVID test results or care homes being classed as 'red').

In addition, there are a range of other issues which are having a significant impact, including:

- Awaiting social worker assessment.
- Awaiting reablement (including step down beds in some instances and therapy).
- Awaiting Occupational Therapist assessment.
- Awaiting NHS Continuing Healthcare or a number of health assessments (e.g., mental health or nursing assessments).
- Risk averse approach which over prescribes support arrangements and reduces supply of support services available and is based on deficit not peoples' assets.

Getting through the winter period is fast becoming the key priority for a number of councils, with the fragile situation in social care (Adults and Children's services) the key risk area. With the role social care plays in maintaining an appropriate flow through the health and social care system, along with other key partners such as housing, significant concerns remain about the ability of social care to maintain services to all those who currently receive care and support over the coming months, let alone meeting the continuing and ongoing increase in demand for services.

Discussions continue at the local, regional, and national levels to consider what support is available and what further actions can be taken to best support councils and health boards at the present time.

The workforce is the most significant area of concern for councils at the moment. Workforce capacity and the significant challenges in recruitment and retention are issues that cut across all of the issues highlighted, and are the main reasons for the lack of capacity to provide packages of care needed to undertake assessments or provide reablement support; with the loss of existing staff and challenges in recruitment as significant concerns. While local authorities, private and third sector partners are all utilising the social care *WeCare.Wales* campaign and coordinating efforts to support improvements in awareness of the opportunities in social care, addressing the current pressures needs a multi-pronged approach.

We believe that there is a need for a clear and sustainable offer to stabilise the domiciliary care and care home workforce and to provide proper and fair renumeration for the workforce. Councils are fully supportive of the Welsh Government's intention to increase pay for social care workers to the Real Living Wage (RLW). However, it is becoming increasingly clear that our ambition must go beyond this if we really want to be able to offer 'fair pay' for those who are undertaking some of the most important roles in society. There is also a need to take immediate action – the workforce challenges are already with us, and so there is a need to do all we can to increase social care workers pay now, there is simply no room to delay.

Some proposed ways to support and grow the social care workforce put forward include:

- Incentives and Rewards for new and existing carers.
- Further extend *WeCare.Wales* publicity campaign to encourage new carers and the development and roll out of introduction to social care training programmes.
- Support Social Work and Occupational Therapist posts to improve recruitment and retention.
- The provision of ongoing support for existing workforce wellbeing.
- Increasing capacity in social work by removing administrative and liaison tasks.
- Increasing capacity in social work by employing managed agency staff.
- Ensuring that registration requirements of staff by Social Care Wales is proportionate and is sufficiently flexible to respond to changing contexts, i.e., flexibilities in workforce registration, including reducing barriers for new entrants.

Other steps that could be taken to support include:

- Work with UK bodies to reduce turnaround times for DBS applications - delays are preventing new staff taking up vacant posts in a timely way.
- Earlier referrals to social services for assessment, ideally when a patient enters the hospital system.

- Consider the learning from the pilot in Gwent to support strengths-based approaches in hospital discharge supporting both the cultural and systems changes required to focus on what matters to individuals.
- Improved communication with the wards - often information is not passed between hospital staff and can result in mixed messages or conflicting information.
- Focus on better screening and decision making at the front doors of acute hospitals and within care homes, so that a positive risk approach is taken, to minimise the need for hospital admission, working to a 'home first' / D2RA model of community support, when planning for a discharge from hospital.

These steps are ones which can be taken in the short-term, but the current pressures have yet again laid bare the fragility of social care services and the need for long-term sustainable funding. This includes the need for continued investment in the immediacy to address unmet and under-met need, tackle rising pressures, retain hard working social care staff, and invest more in prevention. Local government has long been calling for a shift in focus across the health and social care system as a whole, from health systems centred around hospitals to ones where health and social care systems focus on place-based communities; primary and community services and wellbeing, addressing people's physical health, mental health and social needs together. Taking this approach and shifting resources into the community will support us in the longer term to take a far more preventative approach, focussing on preventing admissions to hospitals in the first place and preventing escalation of issues and the need for crisis responses. Such an approach will lead to better outcomes and experiences for families and less pressure on the health and social care system as a whole.

Key Actions

The previous section considered some of the immediate pressures and actions that need to be taken in order to manage the current unprecedented demand but looking to the longer term and given the profound impact that COVID has had, we need a longer-term vision which shapes a new patient pathway into and out of acute care. We believe that as part of the COVID recovery process, regional and national partners across health and social care need to reconsider the expanded research evidence that has been published over the past decade and in doing so, address the challenges set out within the seven key themes below:

PRE – ADMISSION

- ***Prohibitive pathways*** - we believe that the Wales Ambulance Service Trust must examine its pre-admission pathways to ensure that they are not prohibitive or focussed on presentation rather than on the individual.

- ***Personal choice and positive risk*** – the person, their family, community networks etc. are all critical variables that must be considered from the beginning of the assessment process.
- ***Options to refer to other agencies*** – there are pockets of good practice across Wales with strong case examples to demonstrate this, but it needs to be spread wider.
- ***Community alternatives for GP's*** – General Practitioners are an essential core partner not just for the NHS as a provision of strategic advice but also in delivering community services, like operationally supporting reablement and other community-provided care. GP Cluster developments are enabling this consideration.

ADMISSION

- ***Only admit if there is no other choice*** – people are still admitted prematurely without other choices or options properly examined and risk assessed.
- ***Focus must be on the person*** – evidence suggests that people with co-morbidities will deteriorate in hospital, as will the strengths they have to draw on, both personally and from their families, communities, and other sources of support.
- ***More resources to turn around and support in community*** – not just services but also support for carers and investment in community infrastructure.

DISCHARGE

- ***Develop a systems-wide approach to hospital discharge*** - the inter-relationship between primary, secondary and community care needs to be understood and the discharge process looked at within the wider system and beyond this to families, carers, community support (addressing both formal and informal care networks).
- ***Planning needs to start at point of admission*** – it must be based on the person's choices and what is in their best interests from a holistic perspective, involving the individual, their families and carers and should be led by the Community Reablement Teams in the community.
- ***Optimal discharge practice must be followed and adhered to*** – Government guidance on discharging patients safely from hospital to other care settings has changed in light of the pandemic, with the requirement of a negative COVID test to negate virus transmission. To ensure there is safety parity in the system between health and social care services, good practice guidance must be properly followed by all partners to reduce the risk of community transmission.
- ***Development of more appropriate step-down accommodation –*** as more Discharge to Recover to Assess pathways are designated, then there is a need to identify and

resource more step-down bedded facilities, which could mean the restoration or re-purposing of NHS and council facilities.

COMPLEXITY

- ***There is a significant increase in complexity*** – those with complex needs are the ones that are stranded in the system and the longer they stay, the more moves between sites, the further complexity, leading to increases in DToC.
- ***Risk adversity increases with complexity in secondary care and leads to an over-prescription of care*** – this is dis-empowering and leads to deterioration, dependence and increases delays.
- ***Communities manage huge complexity*** – but need resources to expand and family/carer support.
- ***The lack of community-based support leads to increased complexity*** – during the COVID pandemic in particular, people are increasingly resisting access to services to minimise face-to-face contact and reduce the risk of transmission but then they reach a point where they find it difficult to cope (and is equally applicable for carers/families).

CULTURE

- ***Need to move from an illness/deficit model to a strengths-based model*** - *focused on the individual and what matters to them*
- ***Conversations need to happen from the outset*** – real co-produced health care involving the person, their families and carers based on 'What Matters' and 'Last 1000 Days'.
- ***Culture needs to revert back to that of 'person centred' care and away from commodity-based care*** – so more focus on what the support the person really needs rather than on patient flow and bed numbers.
- ***Give clinical staff on wards the autonomy to support their own patients*** – this should be done in an integrated way rather than managing beds and bed occupancy.
- ***Implement existing guidance*** – leaders within the system need to ensure the guidance that exists on minimising delayed discharge is fully implemented and that all staff in the process are properly trained.

COMMUNICATION

- ***Ensure there is an effective flow of information*** - this includes IT systems, accurate and timely data entry and sharing of information across sectors, organisations and agencies.
- ***Robust communication to ensure that all involved are aware and informed of planning and progress*** - again co-produced with the person, their families/carers.

WORKFORCE

- ***There must be a fully integrated workforce based in the community***.
- ***Social care workforce must be properly remunerated and valued as a worthwhile profession*** – this includes parity of esteem with the health work force in terms and conditions, careers development and training.
- ***National government and statutory agencies with the mandate for workforce development need to expedite progress*** – there is a need to mobilise and invest in the ambition of the health and social care workforce strategy

Conclusions:
The pressures on acute hospitals come from many sources and are a symptom of wider issues in the local health and social care system, suggesting that a more sustainable response will be developed by looking at the whole system. Even before the COVID-19 pandemic, health and social care practitioners were finding that problems that were usually confined to the winter months were now increasingly being experienced at other times of the year as well. Yet dealing with an unprecedented public health emergency has placed a new set of pressures on the system which need to be managed. The need to invest more in preventative services to keep people health and safe in their communities is now paramount.

A significant amount of learning has been undertaken over the past 5 years and there are certainly lots of excellent examples of good practice to highlight, like:

- A single point of access.
- The establishment of Intermediate Care Teams (ensuring the provision of co-ordinated services across health and social care).
- The establishment of Rapid Response Teams.
- Social care and third sector staff working alongside health staff in hospital to prevent delayed discharges; and

- Extending the range of rehabilitation/reablement services (including the use of intermediate care flats as part of a wider health, social care and community complex).

Yet, despite the examples of good practice, the real difficulties in addressing the challenges presented by unscheduled care is the capacity of the organisations and resources available. Given the ever-growing pressure on services and the impact of cuts seen in previous years, particularly to local authority budgets, this will continue to be an issue. Whilst we understand that using Regional Partnership Boards is one mechanism to try to address this, enabling more joint decision-making across health and social care, there is also the need to fully acknowledge the significant pressures being faced by local authorities and ensure they are funded appropriately to meet these pressures; this is no more acutely felt than in the time of a national crisis.

People want to live in their own homes for as long as they can, including people with complex health and social care needs[iii]. Improved health care and a policy focus on choice and control means that both children and adults can expect to live in their own homes, with more complex health needs and enjoy longer lives. However, this in turn leads to a greater demand for care and support at home, as well as changing people's expectations regarding the management of need complexity if an acute episode of ill health emerges. People only ever want to go into hospital if there is no other choice and when they do, they want to be assured that they are there for a minimal amount of time and that there is a clear plan to return them to their residence of choice as quickly as possible, so they can be supported to continue to live their lives.

We believe the best way of achieving optimal person-centred choice and improved health and well-being outcomes is to ensure there is increased investment in early intervention and preventative services in the community, which will minimise acute health episodes and reduce the need for unscheduled admission for treatment and care. However, when unscheduled admission is required, then a clear plan to discharge which is person-centred and holistic it vital.

REFERENCES

[i] Wales Audit Office, What's the hold up? Discharging Patients in Wales, 2019.
[ii] Welsh Government, Delivering Home First – Hospital to Home Community of Practice: key learning and practice examples, May 2021.
[iii] Care and support at home in Wales Five-year strategic plan 2017-2022.

APPENDIX 1:

Previous Research

In 2013, the Community Hospital Interface Group published its report on DToC and stated that if improving flow is to be assured on a sustainable basis, a three-stranded approach is needed:

1. **A preventative approach which identifies those at risk of being admitted to hospital and seeks to intervene to avoid this where it is appropriate to do so.**
2. **A proactive approach which identifies and manages those at risk of becoming delayed when in hospital.**
3. **Effective systems and processes to identify and manage those who experience a delay in their discharge or transfer to a more appropriate setting.**

Following on from that research, the Social Services Improvement Agency also published a report entitled, *Delayed Transfers of Care: Informal Review to Identify Good Practice* (2016), which focused on operational practice, systems and processes within local authority and health board partnerships under the four themes of – Capacity, Consistency, Communication and Culture.

The research found there has been a conscious move towards rebalancing provision towards primary and community-led healthcare services. The move towards a more community driven NHS response had led to significant investments in community services, including the establishment of Community Resource Teams (CRTs). Local authorities in partnership with Health Boards have developed the CRTs and have also provided a shared approach to reablement, in addition to the longer-term domiciliary care provision. This reinforces the need for all responses to take a whole systems approach.

Several actions have been identified to improve performance in relation to DToC, these included:

- Implementation of existing guidance - such as *'Passing the Baton'* and the Ten High Impact Changes for Complex Care.
- Avoiding unnecessary hospital admissions – working with GPs to identify key people at risk to target early intervention, use of specialist staff at the "front door", providing support and advice to care homes, use of third sector organisations in the provision of preventative services and support.

- Choice – ensure implementation of existing guidance, ensure staff are "on message" i.e., hospital is not accommodation; the need for early discussions to plan discharge; and improving the utility of intermediate care beds, step down beds, interim placements etc.

Research undertaken by the Institute for Public Care (IPC) at Oxford-Brookes University has continued to build on this work both in Wales and across the UK. In its report, *Reducing delays in hospital transfers of care for older people: Key messages in planning and commissioning* (2018), the principle author, Prof John Bolton, sets out a number of key steps health and social care providers can take to reduce DToCs. These include:

- Less focus on assessment (for longer term care) at the point of discharge and more focus on support for recovery, recuperation and rehabilitation with assessments taking place after this help has been offered – 'discharge to support recovery – then to assess.'
- Develop a set of specifically commissioned services to help people recover post hospital.
- Commissioners to understand the volumes of care that are likely to be required in the short-term - there is a regular flow of people through the out of hospital care system with most not requiring longer term support (the system should not get "clogged up").
- Those not requiring care should be let through the system quickly – with providers empowered to make the decision to end care where that is appropriate.
- Therapists and others in the MDTs to write recovery plans for people at point of discharge (everyone should have a fully drafted discharge plan).
- A greater focus on how to assist people to manage their long-term condition(s).

In his follow-up discussion paper, *Commissioning Out of Hospital Care Service to Reduce Delays* (2020), Prof Bolton sets out for health and social care organisations, a rationale for developing integrated strategies that can guide effective performance management, commissioning and day-to-day service delivery. At its core is the underlying principle that by focusing on achieving the right outcomes for people, tangible improvements in the effective use of resources should be seen. The paper, offers the following:

1. Considerations for health and social care partnerships on the behaviours that underpin integrated strategic demand management thinking.
2. Considerations for data collection to better understand supply, demand, and outcome focused performance of current and future service models.

3. A 'model' for describing the service elements that make up intermediate care services.
4. Considering what a 'good' intermediate care system should achieve.