PROVIDERS DELIVER

Trusts IN SYSTEMS

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NHS Providers

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Contents

Foreword

Welcome to *Providers Deliver: Trusts in systems*. This is the seventh report in the publication series where we celebrate and promote the work of NHS trusts and foundation trusts, who are constantly seeking to improve care for patients and service users.

In previous editions of Providers Deliver we have explored the role of trusts in prevention, their resilience and resourcefulness during the pandemic response, and their innovative work to address staff shortages. In the most recent edition, which was published as a podcast series, we explored how hospital, mental health, community and ambulance trusts are responding with commitment and ingenuity to address backlogs of care while working to tackle health and race inequalities.

This time we are showcasing some of the important work being undertaken by trusts to support system working, and the central role they are playing in delivering on the priorities of integrated care systems (ICSs).

This report is timely. ICSs are a matter of months into their statutory existence, and there is a clear opportunity for trusts to be both system players and system leaders, driving the vision of better population health outcomes and greater value for money. However, it is also important to recognise that trusts are working within a very difficult operational landscape, and this shift presents new challenges and questions that will need to be ironed out as ICSs develop and mature.

The case studies in this report show how trusts are collaborating and innovating to support system working, and they deal with the increasingly testing operational challenges facing the health and care system. This includes working in partnerships to deliver care close to home, address health inequalities, and reduce unwarranted variation in service delivery.

We are pleased to share this report with you. This selection of positive and inspiring case studies is just the tip of the iceberg, and we hope that this report will serve to highlight the impressive work of trusts during these testing times.

Saffron Cordery
Interim Chief Executive
NHS Providers

Introduction

Context and operational pressures

In the past year, the NHS has made important progress in a challenging operational landscape. It has virtually eliminated 104-week waits and is exceeding pre-pandemic levels of activity in crucial areas such as two-week referrals for suspected cancer pathways.

However, the operational pressures, particularly around care backlogs, patient flow, and demand for urgent care, have been huge. And as we now enter winter, economic pressures, the increased cost of living, and activity driven by Covid-19 and flu cases, are likely to exacerbate these challenges and impact on both staff and service delivery.

These pressures are being felt across the NHS, in acute, mental health, community, and ambulance services, and are made more difficult by staff shortages in the NHS, which, at the time of writing, stand at 132,000.

Trust leaders see system working as part of the solution. No single organisation can effectively address longstanding challenges like staff shortages, health and race inequalities, and growing demand for services, alone.

Trust leaders have therefore made it a priority to support the setting up of ICSs, and to drive forward improvement through partnership working. They understand that collaboration between system partners can help address immediate pressures and deliver longer term improvements to quality of care and service delivery.

The trust contribution to system working

In July 2022, the Health and Care Act came into law providing a legal basis for collaboration between NHS bodies and to facilitate integration. This cemented a wider shift towards collaboration and integration, and was the logical next step as most trusts have been moving in this direction for some time.

ICSs are being established through statutory integrated care boards (ICBs) and integrated care partnerships (ICPs), and much of their business will be conducted through place-based partnerships and provider collaboratives. Trusts will be key players in this new context at the sharp end of delivering care, reducing care backlogs and driving transformation in a new system context through new collaborations. Trusts legal underpinning is unchanged by the recent Act, they will deliver many local services for patients, and remain the main employer of NHS staff.

As such, trusts will be a key player in delivering the four key priorities of ICSs: improving outcomes in population health and healthcare; tackling inequalities in outcomes, experience and access to healthcare; boosting productivity and value for money; and supporting broader economic and social development in local communities.

Alongside these opportunities, there will be a need for system partners to manage new risks. For instance, oversight from ICBs must add value, and avoid creating extra complexity or burden for trusts. Conflicts of interest will emerge and will need to be managed. And, in the face of different delivery structures, there must be clear lines of accountability for operational and financial performance, and quality of care.

Local response to a national shift

One size does not fit all. The opportunities for, and approaches to, collaboration look different depending on local circumstances.

This is evident from the case studies of good practice highlighted in this report. It demonstrates that there is impressive and varied work taking place to drive forward improvements in care for the benefit of patients and service users in different ways within a system context.

Working across sectors to address health inequalities

The North West Ambulance Service NHS Trust have been using the hypertension data collected by ambulance teams to support interventions targeted at reducing health inequalities and preventing ill-health. To do this, they worked closely with local primary care partners to share relevant data for high-risk groups.

Convening a range of partners to support cancer care and mental health services

The Clatterbridge Cancer Centre NHS Foundation Trust have been working alongside urgent care and cancer care partners as part of the Cheshire and Merseyside urgent cancer care board. The group brings together these partners, and other key stakeholders, to support appropriate and timely urgent care close to home with the goal of improving quality of care and patient experience.

Avon and Wiltshire Mental Health Partnership NHS Foundation Trust have been running a system-wide mental health finance oversight group covering in both ICSs in which they operate. This forum brings together a range of key partners from across the NHS, local authorities and the third sector to explore how they are spending mental health money as a system, and where there is potential for improved efficiency, additional investment, and reduced variation in service delivery.

Collaborating across systems to support admission avoidance and timely discharge

Central London Community Healthcare NHS Trust have been collaborating across systems to deliver two different models of virtual wards that support admission avoidance and timely hospital discharges. At the centre of both models is a focus on tackling health inequalities and digital exclusion.

Supporting staff and the wider system to address elective backlogs

Maidstone and Tunbridge Wells NHS Trust have eliminated 52-week waits for elective care, enabling them to support neighbouring trusts to address backlogs. A focus on staff wellbeing and a clinically led model of delivery, which affords frontline staff greater control over strategic decisions, has been central to the effective recovery efforts at the trust.

A continuing journey

We are at an early stage in the journey of ICSs, and it will take time for them to be fully embedded and demonstrate added value.

But trusts are already driving new opportunities as system partners to change how they work with each other and wider partners. At the heart of this, there is a commitment to improving care for patients and service users.

Trust leaders are keenly aware of the opportunities of system working, as demonstrated by the case studies in this report. With the right support and resource, trusts will continue to play a critical role in unlocking the benefits of this new landscape.

The view from Sir David Sloman

Chief Operating Officer, NHS England

Over the last two and a half years (and counting), in the face of extraordinary pressures, the NHS has continued to consistently deliver for millions of patients and service users. We have flexed services at unprecedented speed, developed new forms of care, like virtual wards and Long Covid services, administered millions of Covid-19 vaccines and supported new ways of working.

No service has remained untouched by the pandemic, and staff are now working hard to address worsened backlogs in elective care, mental health and community services, while also tackling major issues around timely access to urgent and emergency care, primary care and hospital discharges. While there is still some way to go, progress is being made in challenging circumstances, and we have virtually eliminated waiting lists of two years or more for elective care.

The wider NHS reform agenda will play a key role in supporting recovery. The partnership working that is rapidly breaking new ground across the country builds on progress and relationships developed over many years, and has been strengthened by the way health and care services have responded to the pandemic. The creation of integrated care systems (ICSs) as statutory bodies in July 2022 is a key next step. ICSs sit at the heart of our NHS reform agenda, and their success will need to be driven by ever-deeper collaboration between system partners.

As we look to the future, ICSs will be the key to planning better health and care services for every community, and delivering on national NHS priorities around service recovery, and improving outcomes for patients across all services. Effective partnerships will improve the access to and quality of care, and create more efficient and joined-up services. Alongside local government, the third sector and other partners, the NHS will need to play an increasing role in prevention, and managing people's health in their communities.

While ICSs are the overarching structures supporting collaboration, many of these ambitions will be achieved through a range of different partnerships, including provider collaboratives. As this report illustrates, NHS providers are absolutely central to this vision for the future.

Trust leaders had been embracing collaboration to deliver new and innovative services and ways of working for the benefit of patients and service users for many years well before the pandemic began.

As we move through the first years of ICSs as statutory bodies, we need to keep a focus on the role of providers in enabling greater collaboration within and across organisations, and continue to build on this progress.

Thank you to those who have contributed to this journey so far. Your work has been – and will continue to be – essential in progressing partnerships and collaboration for the benefit of patients and service users.

CASE STUDY 1

Maidstone and Tunbridge Wells NHS Trust

Themes >

- Addressing the elective backlog
- A focus on staff wellbeing
- Collaboration across systems to tackle health inequalities

Background

Maidstone and Tunbridge Wells NHS Trust (MTW) is a large acute hospital trust in South East England. It is part of the Kent and Medway integrated care system (ICS), which serves 1.9 million people. MTW serves around 760,000 people living in West Kent and the north of East Sussex, and employs around 7,000 staff.

Elective recovery since Covid-19

In February 2022, MTW eliminated its backlogs of 52-week waiters, making it the first major acute trust to meet this target. MTW is aiming to achieve a maximum wait of 40 weeks by March 2023.

MTW is now collaborating across the Kent and Medway system to support recovery, for instance by treating long waiters from neighbouring trusts. The team is also reviewing trust-level data to better understand elective waits in the context of health inequalities.

A clinically led model before the pandemic

MTW's effectiveness in addressing elective backlogs has been part of a longer journey for the trust.

In the years before the pandemic, MTW made significant progress in meeting key national performance targets around A&E, cancer, and electives, meaning the trust went into the pandemic in a strong position.

Miles Scott, who was appointed chief executive of MTW in 2017, oversaw the implementation of a clinically led model of service delivery before the pandemic. This was key in driving forward improvement.

There are now five clinical divisions at the trust, including the surgical division, leading on elective recovery. Sean Briggs, chief operating officer, says: "The impact of the clinically led structure can't be underestimated," because, although it was a significant shift for MTW, it has given clinical staff more autonomy. Sean says: "We've now got brilliant clinical people being supported and enabled by strategic managers."

A focus on staff wellbeing during recovery

The MTW surgical division place a real focus on staff wellbeing. Dr Greg Lawton, surgery division chief, says: "We made a deliberate decision to restart slowly [after the peak of the Covid-19 pandemic]. We allowed staff time to recover and then build back up again." This was important because, as Greg explains: "We were all a bit rusty; we had been working in a different way for 18 months." Sean adds: "It gave staff the confidence that we weren't trying to break them, that we were listening, and taking it step-by-step."

The surgical division has rolled out several different initiatives for staff, ranging from stand-up information sessions to newsletters and tea rounds. This sits alongside trust wide support for staff, which includes free parking and meals. Rantimi Ayodele, consultant trauma and orthopaedic surgeon, says: "Division leadership has been focused on staff wellbeing. This allows staff to concentrate on doing what they want to do – look after patients well and prioritise them.

An impact on recruitment and retention

Delivering clinically led services and prioritising the wellbeing of staff has had a positive impact on recruitment and retention at the trust.

Clinical staff have a say over what recovery looks like and play a key role in strategic decision making. For instance, Greg oversees a budget of £115 million and 1,400 staff in the surgical division. He reflects: "While recruitment has been tough in the last few years, in the surgical division we've done really well." The clinically led model is viewed as central to this. Greg says: "The reputation of the trust has changed. People want to come and work with us."

Significant operational pressures

Despite making progress on elective recovery, MTW is facing some significant operational pressures, particularly in emergency care. Sean says: "Going into Covid-19 we would see around 450 patients a day in A&E, and now this is closer to 600." This has a knock-on effect on capacity in the surgical division as the same teams do elective and emergency work.

Despite taking more patients from the 'front door' of the hospital, MTW is, like many others, finding it difficult to discharge patients in a timely way. The team estimate that, before Covid-19, there were 60 to 70 medically fit patients awaiting discharge residing in hospital beds, but this is now closer to 150. As Sean says: "This is two to three wards of patients that we didn't have before. That puts a lot of pressure on elective and emergency pathways." To support these challenges, MTW have implemented a digital bed management system, which has helped to speed up discharges at the trust.

The importance of national support and action

MTW is grateful for the national support given in the last year. **Community diagnostic centres**, which were rolled out in October 2021 to act as local hubs for checks, scans and tests, are viewed as "absolutely crucial" to delivering more elective and cancer care at MTW. The local centre has delivered 12,000 additional scans in the last six months.

Sean describes close working relationships with local social care leaders in the patch, and proactive work to enable strategic level partnerships. Likewise, collaboration with the community sector has been essential to recovery. Sean says: "Our A&E and elective successes are because we have incredibly good community partners. Even when it feels challenging, we know they are doing everything they can to support us."

However, there are challenges in social care and in the community, including around capacity and funding.

Infrastructure is also seen as a critical part of the puzzle, and there must be the right facilities and sufficient space to see patients. The team recognise the financial constraints the NHS is operating under, and the scope to work innovatively at a local level, for instance by using independent capacity or unused town centre space to support activity like diagnostics tests. However, additional capital funding would support MTW, and others, to address elective backlogs by delivering extra theatre space and equipment.

Looking forward

The MTW team acknowledge there is further to go and are committed to making further progress on elective backlogs, and other national targets. They also want to continue supporting wider system partners, and developing partnership working with acute, community, and social care providers across their ICS. More specifically, the team are looking at ways to create separate locations for emergency care and elective care, because as Greg says: "Every winter we run into problems."

CASE STUDY 2

North West Ambulance Service NHS Trust

Themes >

- Using ambulance service data to target high-risk groups
- Collaborating with primary care partners
- Tackling health inequalities

Background

North West Ambulance Service NHS Trust (NWAS) operates across 5,400 square miles, serving seven million people in Cumbria, Lancashire, Greater Manchester, Merseyside, Cheshire and Glossop. It delivers care across five integrated care systems (ICSs) and runs 111 and patient transport services.

NWAS serves a population that is more deprived than the English average on the index of multiple deprivation (IMD). Deprivation is an important driver of 999 demand as shown below. Internal modelling suggests if the north west had the same deprivation profile as England (20% of population in each quintile), NWAS would receive 85,000 fewer incidents a year.

Tackling health inequalities

The Core20PLUS5 is a national approach to reducing health inequalities. It targets interventions at the most deprived 20% of the population (as defined by the IMD), plus groups experiencing poor health outcomes, and highlights five clinical areas, including hypertension case finding, for particular attention.

"There are an estimated half a million people with undiagnosed hypertension in the north west," says Christine Camacho, public health registrar at NWAS, "as an ambulance service we record the blood pressure of approximately one million patients a year." However, this data is generally not used for population health interventions. If an individual calls an ambulance but is not conveyed to hospital, information about their blood pressure, even if it is high, will not be shared with any other part of the health and care system.

So, when it came to thinking about the Core20PLUS5 framework, Christine says that, because of their focus on high intensity users and the routine collection of this data, "hypertension case finding seemed like an obvious place to start."

Furthermore, other national policy and strategy documents, including the NHS Long Term Plan and the PCN Direct Enhanced Service, focus on the prevention of strokes, heart attacks and dementia by improving the detection and treatment of contributing factors like hypertension.

CASE STUDY 2

Using ambulance sector data to enable collaboration with primary care partners

In 2021, NWAS launched a pilot to share the basic data it collects on hypertension with a primary care network (PCN) in Greater Manchester, which is made up of eight GP practices. The purpose of the pilot was to use the data collected by NWAS to identify undiagnosed hypertension and under-treated individuals.

Blood pressure readings for patients registered to these practices were sent by the NWAS team to an agreed PCN contact. They in turn invited patients for a review appointment with a practice nurse or GP. Details of patients with hypertension who were conveyed to hospital were excluded from this list.

In this pilot, details of 71 patients with high blood pressure, who had not been conveyed to hospital, were passed on to the local PCN. Overall, 40% of those reviewed received an intervention in primary care. Six people received new diagnoses of hypertension, four people with existing hypertension had their medication optimised, and four more had borderline hypertension and were referred for lifestyle interventions.

"We switched to using an electronic patient record (EPR) last year, which made it possible to think about things at a population health level, and was an enabler to delivering this work," Christine says. The pilot also received approval from NWAS information governance, making it possible to share information and work collaboratively with PCN colleagues.

Relationships with primary care colleagues have also been important. "We already had a positive relationship with the PCN we worked with for this pilot. We had rotational paramedic posts there, and that helped to open the door," explains Christine.

The importance of a dedicated public health role

A dedicated public health professional working within an ambulance trust is crucial to establishing this way of working. Christine has used NWAS data to create heat maps of falls, drug related overdoses and mental health presentations, to support an enhanced understanding of patterns of demand in the north west.

Wider support is needed to scale up the approach

Despite the success of the pilot, there are challenges in expanding and developing this approach, and areas where further national support is required.

"There needs to be the right infrastructure, and a standardised and routine approach to data sharing with primary care colleagues to support more collaborative working," explains Christine.

Rich data collected by ambulance services is underutilised and it needs to be accessed across systems to unlock potential benefits. "If you're looking at something like falls, acute trusts have data about all those who have been admitted to hospital, but ambulance services have information on most falls and where they have taken place," says Christine.

However, there is scope to improve the quality of ethnicity data. At present, it is captured across access points from 111, 999 and patient transport services, and can be patchy. National work is ongoing to support the sharing of information through the new Ambulance Data Set, and this is important because it is currently difficult to understand outcomes by ethnicity. "As a starting point, if you can't look through an ethnicity lens then you don't know what health inequalities you have in front of you," says Christine.

National support is also needed to ensure there is sufficient public health capacity within the sector. Christine explains: "If public health isn't someone's job, it won't happen." Dedicated national funding for public health roles would help ambulance services to work collaboratively with system partners to tackle health inequalities.

The health and care system needs to think differently about the role of ambulance services. Christine says: "Ambulance services are perceived as being there to deliver only urgent care, but they must be brought into wider conversations around population health."

Christine identified challenges around relationship building at scale, noting that NWAS covers 40 local authority areas and around 300 PCNs.

Christine notes: "Most ambulance services will not line up with place footprints, and this is important as funding will flow from ICSs to place." There needs to be a mechanism by which funding for health inequalities programmes can flow through systems to ambulance services delivering essential work in this space.

The future of the hypertension pilot and beyond

NWAS is now exploring how to expand the delivery of this pilot by working with other PCNs in its patch.

While the hypertension pilot dealt with a small number of patients, there is great potential to reach many high-risk groups who are under-accessing care. There is scope for ambulance trusts to adopt public health approaches in many areas, including falls, drug related deaths, improving outcomes for people experiencing homelessness and social prescribing.

Christine's advice to health and care colleagues developing similar work is to: "Go where the interest is – if you're working with one of your ICSs, finding a way to align priorities is a good place to start."

CASE STUDY 3

The Clatterbridge Cancer Centre NHS Foundation Trust

Themes >

- **Partnership working between cancer care and urgent care teams**
- **Collaborating across systems**
- **Improving quality and patient experience**

Background

The Clatterbridge Cancer Centre NHS Foundation Trust (CCC) is one of the UK's leading specialist cancer centres. CCC provides non-surgical cancer treatments to a population of 2.4 million people across Cheshire and Merseyside and employs 1,700 specialist staff.

It is part of the Cheshire and Merseyside Health and Care Partnership, which is one of the largest integrated care systems (ICSs) in the country.

Treating cancer patients with urgent care needs

There are some persistent challenges in managing cancer patients at home. Care delivery is often focused on cancer centres, and there can be gaps where services span multiple ICSs. Cancer patients can therefore find it difficult to access appropriate and timely urgent care close to home.

In 2017, North Mersey cancer partnership group and Macmillan Cancer Support partnered to explore the challenges of managing cancer patients with urgent care needs in North Mersey.

The project found cancer patients were more likely to be conveyed to hospital by ambulance or admitted through A&E departments compared to those with other chronic diseases. As Dr Ernie Marshall, consultant medical oncologist, CCC, describes: "Clinicians were sometimes fearful of managing cancer patients, it was easier to send them to hospital."

Bringing together partners from urgent care and cancer care

In 2021, the Cheshire and Merseyside urgent cancer care board (UCCB) was established to address some of the challenges identified in the North Mersey report. Its primary function is to collectively reduce avoidable emergency department presentations for cancer patients while supporting the development of safe alternatives through coordinated service improvement and innovation.

The UCCB is jointly led and funded by CCC, the Cheshire and Merseyside cancer alliance, and the Cheshire and Merseyside urgent and emergency care network. It brings those three partners together with other local stakeholders, including patients' groups, primary care, national NHS bodies and third-party organisations.

The board has supported better partnership working and collaboration between cancer care and urgent and emergency care at both an operational and strategic level. The teams communicate regularly and attend meetings held by partner organisations, and a framework has been developed to support the work.

Opportunities borne out of the pandemic

Laura Jane Brown, acute oncology senior project manager, CCC, says: "Although Covid-19 was a horrendous challenge, it opened up multiple opportunities." The shift to remote working and the use of technology to aid remote communication made it possible for local cancer specialists to speak to other experts regionally and at a national level. This has been important for the team, because, as Dr Ragit Varia, acute medical lead for the urgent cancer care programme based at St Helens and Knowsley Teaching Hospitals NHS Trust, says: "The more you talk to people, the more opportunities come about."

Furthermore, the pandemic prompted a focus on keeping patients, and especially cancer patients, out of hospital where possible. This gave a range of system partners a common purpose and encouraged collaboration to provide appropriate alternatives to emergency care.

This is critical because national cancer strategies are mainly focused on planned care, meaning there is often, as Ernie describes: "Limited strategic bandwidth to consider the urgent care needs of cancer patients."

In addition, the team from combined intelligence for population health action, which is a population health management platform for the NHS, were brought in to support with data during the Covid-19 pandemic. As Laura explains: "We caught the ear of the team, and we are now working as a system to build an acute oncology regional dashboard." At present, data on cancer patients accessing urgent care is quite fragmented, and not always visible to the wider system. The dashboard will give greater oversight of planned and unplanned cancer care.

A better understanding of this group of patients can also drive quality improvement and reduce avoidable variation in care. Ernie says: "In some cases patients coming into urgent care with cancer are interfaced between acute and oncology teams, but in others the need is not recognised, and the referral is not made."

Alignment with existing national priorities

The UCCB is aligned with the national same day emergency care strategy, and Ernie says: "From the outset we wanted to consider both hospital and community pathways." The team have been engaging informally with urgent community response (UCR) teams to explore the opportunities. Ernie says: "At first they saw UCR as focused on frailty and were hesitant to take on cancer patients." However, there is growing agreement about the opportunity this presents, and there are now more formal discussions about how UCR can

support cancer patients seeking urgent care. Ernie reflects: "We're not there yet, but we've shown the value of including cancer eligibility on those pathways."

Ragit says: "A lot of work is being undertaken around UCR and virtual wards, making it the right time to work with partners on admission avoidance."

Fulfilling the UCCB's potential

The team acknowledge they are at the beginning of their journey with UCCB. They are in the process of describing baseline data, identifying opportunities, and building the right relationships to take this collaboration forward.

The team see great potential here, and point to the fact that, at a national level, 20% of cancer patients are admitted to hospital for a short stay. With the right coordination and collaboration, there are significant opportunities around admission avoidance, improving patient experience, and enabling alternative pathways that reduce the number of days people with cancer spend in hospital.

Next steps

A key next step is the expansion and redevelopment of a regional cancer hotline. This will provide a single point of contact that uses the optimum pathways being built, including the streaming of calls into urgent community response teams.

NHS England is interested in this approach; the national same day emergency care project has created a cancer focus that draws on the learning from Cheshire and Merseyside.

However, the team recognise there are challenges ahead. Ernie reflects that: "Workforce resilience will limit what we can do, and that's why we need a system-wide approach." Also, keeping up the drive and momentum amidst other operational challenges will be difficult.

However, they are confident they can continue to build on the progress they have made over the last year. Despite the pressures they have faced, people have remained committed even in a year that has seen unprecedented operational pressure on NHS services. As Laura says: "Committed and passionate people are at the heart of this."

CASE STUDY 4

Central London Community Healthcare NHS Trust

Themes >

- Admission avoidance and early supported discharge
- Collaborating across systems
- Tackling health inequalities

Background

Central London Community Healthcare NHS Trust (CLCH) is one of the largest community providers in the country, spanning four integrated care systems (ICSs) which between them include 11 London boroughs plus West Hertfordshire. CLCH covers a large geographic area, operating out of 650 sites, employing 4,500 staff and delivering care to around two million patients a year.

Virtual wards: national policy

Virtual wards allow patients to receive care they need at home, supported by a mix of new technology (for example, rapid diagnostic tests), remote monitoring and in-person visits.

The model existed before Covid-19 but was used in response to the pandemic. Covid-19 virtual wards were rolled out across the country, and since then, NHS England has sought to significantly expand the care delivered in this way. NHS England has asked ICSs to deliver 40 to 50 virtual wards 'beds' per 100,000 of the population by December 2023, with £200m of funding available nationally for 2022/23, and £250m on a match funded basis for 2023/24.

Building on progress made during Covid-19

1. The CLCH team as a partner in the South and West Hertfordshire Health and Care partnership (SWHHCP), which includes West Hertfordshire Teaching Hospitals Trust (WHTH), have built on progress made during the pandemic to deliver two different virtual wards models for Heart failure and chronic obstructive pulmonary disease (COPD) patients.
2. Older and frail patients, operating in South West London, provided by CLCH.

After launching in December 2021, by August 2022, 280 patients had been treated in the COPD and heart failure virtual ward, and 211 in the frailty virtual ward.

Both virtual wards started with a focus on early supported discharge, because, Dr John Rochford, complex care GP and clinical director at CLCH, says: "This is where the energy was." Both teams have now extended their work to include admission avoidance.

Delivering two different virtual wards models

The two models share aims to reduce length of stays, prevent avoidable admissions, and improve patient experience and outcomes.

In South West Hertfordshire, the mean length of stay for heart failure patients in the virtual ward is less than two thirds the length of the mean hospital stay for heart failure. For COPD, the number of non-elective admissions to WHHT has fallen from 131 in 2019 to 62 in May 2022. In South West London, the mean length of stay for all patients at the local St George's Hospital is 11 days, while for the frailty virtual ward it is 6.5 days. The frailty virtual ward has supported 63 patients to avoid hospital admission since December 2021.

Importantly, both virtual wards have received excellent feedback from patients. For the frailty virtual ward, 100% of patient feedback in the initial six-month evaluation was positive. COPD patients score the WHHT virtual ward an average of 8.5/10 for patient experience, and heart failure patients score it 9/10.

Tackling inequalities

Both virtual ward models have a strong in-person element. John says: "We deliver an equitable amount of care as people would receive in hospital."

Dr Niall Keenan, cardiology consultant and clinical lead for the South West Hertfordshire virtual ward, explains: "There is a concern that virtual pathways could increase readmissions, but this is not happening," partly because "patients are getting comprehensive in-person care" through the virtual ward.

Tackling health inequalities and digital exclusion is also a key consideration for both teams. John explains: "A comparison of the population health of the boroughs and our caseload mix shows we are not selecting less complex patients and creating an inequality here. We take nearly all referrals, and where technology is a challenge, we find a solution."

For the COPD and heart failure virtual ward, Niall says: "At first, we were going to ask people to use their phones, but realised some people didn't have one, so we give everyone the devices needed." However, Niall reflects: "Exclusion is not as obvious as you would think – there are more affluent patients who are more socially isolated and less digitally confident than others."

Collaborating across systems

Shared planning, leadership and governance across systems is essential. Over the course of 2021/22 the SWHHCP worked collaboratively to understand the benefits and costs of virtual wards, agree clinical pathways, and develop a joint business case.

The South West Hertfordshire model is driven by a multi-disciplinary team that meets several times a week, and includes acute, community and primary care clinicians. They also work with voluntary sector partners.

Niall reflects: "We are working more closely with community and primary care partners than ever before."

John also talks about the importance of shared governance, and says: "Clinical governance must be considered at the start, and be the driving force behind delivery."

Ashwin Anenden, complex care GP, CLCH, says: "Good relationships, trust, and integration with secondary care colleagues has been essential." Partnership working has supported the discharge of more complex patients to the virtual ward, and Ashwin says: "We recently supported a patient to go home five days earlier than planned, which was important as this was where she felt she would recover best."

Unlocking further potential

Niall says national ambitions to further scale up virtual wards will need new resources and will not be delivered "on a wing and prayer." John hopes the new statutory ICSs will be able to build on work begun in response to the pandemic and will support collaboration ahead of competition.

But to achieve that, he says systems will need to move beyond "short-term thinking" encouraged by time-limited national funding, which has created barriers to recruitment by discouraging trusts from creating permanent roles running virtual wards. Adequate numbers of staff, with the right skills and experience, is crucial. John considers the scale of the national ask, and says, "a target of 40 to 50 virtual ward beds per 100,000 of the population is basically a district general hospital – you can't have 11 staff running 10 wards."

Niall says: "Most patients need to be spoken to every day, otherwise they wouldn't be in a hospital bed. If you don't have the right staff to patient ratio, you won't be diverting people from hospital beds – you will be hitting key performance indicators but not maximising value."

Looking to the future

Niall and the team in South West Hertfordshire are now looking to develop a virtual wards dashboard and enhance their understanding of any inequalities in service provision. They are also developing other virtual care models, including for diabetes, frailty and pneumonia, with other pathways at earlier stages of exploration.

At CLCH, John and colleagues are now looking into expanding into an anticipatory care model. They are keenly aware of growing older and frail populations and the need to develop their approach to meet these changing demands.

Both teams are keen to continue learning from each other, and from other colleagues across the country who are delivering virtual wards.

CASE STUDY 5

Avon and Wiltshire Mental Health Partnership NHS Trust

Themes >

- **Reducing unwarranted variation**
- **Collaborating to deliver person-centred mental health services**
- **Addressing mental health**

Background

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) provides inpatient and community-based mental health care to 1.9 million people across the south west. AWP is the main provider of secondary mental health services in two integrated care systems (ICSs) – Bristol, North Somerset and South Gloucestershire (BNSSG), and Bath and North East Somerset, Swindon and Wiltshire (BSW).

Collaborating in a complex provider landscape

There is a complex history of commissioning and a mixed economy of mental health service provision across the two systems AWP operates in. This has led to variation in service delivery across and within the BSW and BNSSG ICSs. Dominic Hardisty, chief executive, AWP, reflects that: "Nowhere is that more apparent than in mental health, it's a lottery based on history."

While system partners understood these challenges before the pandemic, Covid-19 prompted further collaboration across both systems. As Dominic says, "when the chips were down, we worked together for patients, and as we emerged, we wanted to continue collaborating to deliver person-centred care close to home." System partners agreed that, for patients, partnership working should mean that there were no obvious dividing lines between services.

A mental health decision making group operates in each ICS. Although work was paused during the height of the pandemic, around 18 months ago these groups were re-started, and have been making significant progress since.

Dominic chairs or joint chairs the BSW and BNSSG ICS mental health decision making group, alongside a vice-chair with a commissioning background. This group involves partners from the NHS, local authorities, and the third sector.

Transparency between partners to nurture system thinking

A mental health finance oversight group (MHFOG) has been set up to support the work of the mental health decision making groups in the BSW and BNSSG ICSs. MHFOG does not have delegated financial responsibility but advises and supports the mental health decision making across the two systems.

The MHFOG also provides an overview of all the money that is being spent on mental health services in each system. In turn, this enables the systems to align contracts, make service changes, and where appropriate, rebalance funding allocations.

The group is led by Simon Truelove, finance director, AWP, who has worked in several provider and commissioner roles across the patch over the last 20 years. Simon says: "This gives me a credibility that I'm not just fighting the battle for AWP." Dominic reiterates the importance of, "wearing the system hat" and says, "it's not about individual organisations, you are focusing on what's best for patients."

Transparency is central to the effectiveness of MHFOG, and there are open discussions between partners about slippage on investments and how they can work collaboratively to ensure that the system can break even or offer money back into the integrated care board. Simon says: "This is true system working, there are no silos." Similarly, he describes the importance of challenging his own trust, as well as others, to demonstrate the value of investments into the sector.

However, there are challenges in shifting towards thinking as a system rather than an individual organisation. MHFOG has adjudicated in disputes between partners about appropriate levels of investment for services, examining where demand and resources were mismatched and helping partners reach agreement. In turn, this has helped to harmonise levels of investment between the BSW and BNSSG ICSs.

Driving forward efficiency and quality for service users

Amid significant resource constraints, the work of MHFOG and the mental health decision making groups enable those working in this footprint to make the best use of mental health money for service users. Also, having a cross system view of funding and spending allows key partners to see potential problems and unwarranted variation, and supports them to work collaboratively to solve these challenges.

For instance, there are three crisis houses in the BSW ICS, and one was funded through a separate, non-recurrent revenue stream to the others. MHFOG investigated this and encouraged partners to question the reasons for this variation. Ultimately, the group advised the mental health decision making group that there should be one consistent delivery model for these crisis houses.

MHFOG is currently working with local information teams to explore ways to reduce demand on secondary mental health services. In one place, third sector partners have been sending staff into AWP teams so that a multidisciplinary team can make an instant referral into the voluntary sector where appropriate. This has cut waiting times for patients and reduced pressure on secondary mental health services.

Overall, collaboration through the decision making and oversight groups has helped system partners to understand each other better. In the past, third sector colleagues in the patch have questioned the proportion of funding going into statutory mental health services. Now, there is a more joined up approach, and an enhanced understanding of what needs to be delivered by each partner.

Next steps

In the BSW and BNSSG ICSs, the key next step is to formalise the existing mental health decision making groups. At present, the groups operate within a deliberately loose structure, but they believe there is an opportunity to mature and develop in this system. While the BSW ICS is further ahead in this process, due to a different history and context, BNSSG is following a similar trajectory and shares the same ambitions.

For MHFOG, they are looking to move towards open book accounting for all partners, which would mean sharing key financial information across each system, to build on the transparency and trust that exists within the group.

At a national level, the move to block contracts is viewed as supporting collaboration between different organisations and across pathways. Simon is optimistic about the impact that this will have, and says: "We'll see much more of this – that's what system working is all about."

Despite optimism about local collaboration and the national direction of travel, shortages of staff and capital funding remain very significant challenges for the mental health sector. Dominic says: "The mental health investment standard has gone further to achieve parity of esteem than anything else," but he emphasises the urgent need for further capital funding to underpin this progress.

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Conclusion

This year, we have found ourselves at a critical juncture for system working. ICSs were put on a legal footing in July 2022, and the journey towards greater health and care integration has moved into a new phase of development.

As this report shows, NHS trusts and foundation trusts are at the centre of this [journey]. They have been acting as the engines of transformation, using their distinctive position to drive forward and steer the development of system working for the benefit of the communities they serve.

And trust leaders have been putting great energy and commitment into progressing the ambitions of system working. This is no small feat considering the many other operational and strategic challenges they face. But the prize is clear; collaboration brings with it significant benefits and opportunities to deliver better care for patients and service users.

At this stage, ICSs are operating in various forms and across different footprints. Local determination is at the core of system working, and we can see this play out successfully in the case studies included in this report.

While one size evidently does not fit all, there are some important thematic learnings to take from trusts delivering on some of the key priorities for ICSs.

Developing good relationships with partners is key to improving service delivery for the benefit of patients. The Clatterbridge Cancer Centre NHS Foundation Trust have developed strategic and operational relationships between urgent care and cancer care, while Avon and Wiltshire Mental Health Partnership NHS Trust have built trust between system partners enabling transparent and open conversations about funding across systems. In several examples, trust leaders say relationships and partnerships prompted by Covid-19 have laid the groundwork for deeper collaboration.

Collaboration can also help to drive forward the health inequalities agenda, which is core ambition of system working. North West Ambulance Service NHS Trust have worked closely with primary care colleagues to share data across the sectors, enabling more targeted preventative interventions. Central London Community Healthcare NHS Trust and their acute partners worked together to expand the delivery of virtual wards, which has helped to reduce length of stay and avoidable hospital admissions, while also keeping a clear focus on tackling health inequalities.

Initiatives to support staff are also central to delivering on the priorities for systems. Maidstone and Tunbridge Wells NHS Trust ascribe their effectiveness in meeting elective recovery targets to the prioritisation of staff wellbeing and the promotion of a clinically led approach to recovery. In turn, this allowed the trust to support long waiters from neighbouring trusts, and work collaboratively to tackle system level challenges around health inequalities.

There is further to go in implementing and embedding system working given the extent of operational pressures, and given that ICSs come from different starting points, covering different levels of deprivation and different geographical footprints. There are also unresolved questions to iron out as systems develop and mature, to sustain good governance and clear lines of accountability.

Government and national support is still needed in support of ICSs and their health and care partners. This means boosting the recruitment and retention of staff with a long-term, fully funded, national workforce plan; securing enough capital investment; cross-departmental action to prevent ill-health and support people to lead healthy, independent lives and government action to place social care on a sustainable footing.

However, the work detailed in these case studies shows there is cause to be optimistic about the impact of system working. Trusts and their partners are already effectively rolling out new cross-sector ways of working, and are committed to driving forward the ambitions of ICSs. This will be key to ensuring the whole health and care system delivers first-class care.

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Interactive version

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Trusts IN SYSTEMS

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