PROVIDERS DELIVER

SHIFTING CARE UPSTREAM

OCTOBER 2024

NHS Providers

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Shifting care upstream

Contents

Foreword

Welcome to the latest report in our Providers Deliver series which aims to share and celebrate the work of NHS trusts and foundation trusts.

The government has put the NHS front and centre of its policy agenda, having expressed concern about patients not being able to get the care they need when they need it. Focusing on demand and waits for frontline services including urgent and emergency care and mental health services, the relentless pressures are clear. Despite increased activity across many services, NHS performances remains a long way off where patients need it to be.

This Providers Deliver report illustrates how NHS trusts and their partners are ensuring people can access and receive the care they need in the right place, at the right time. The case studies in this report show how trusts are driving forward the 'left shift' and increasing the amount of patient need that is being met within the community and out of hospital. It also builds and moves the conversation on from our earlier report, *Providers Deliver: Patient flow*, which focused on trusts' innovative solutions to improving patient flow in the face of unparalleled pressures post-pandemic (NHS Providers, 2023).

Examples in this report include an acute trust which has made 'home first' central to its strategy; a community trust which is utilising remote monitoring of individuals; and a mental health trust that has collaborated with housing providers to prevent patients deteriorating to the point of crisis. Our report demonstrates just a small selection of how NHS trusts are already aligning with the 'three shifts' of the new government: hospital to community, analogue to digital and treatment to prevention.

By working across organisational boundaries, including with primary care, and partnering with the voluntary, community, and social enterprise (VCSE) sector and social care, NHS trusts are better serving their local populations and achieving more for taxpayers. Collaborative working is essential in allowing each partner to play to its strengths and deliver care in the most effective and efficient way.

Ultimately, we agree with Lord Darzi's assessment that while the NHS is in a critical condition, the vital signs are strong (Darzi, 2024). The case studies in this report highlight that. However, Lord Darzi's investigation makes important and powerful points on the need to shift care into the community and ensure financial flows align with these ambitions.

To improve patient care and boost productivity – and ensure an NHS fit for the future – we need an enabling operating environment that promotes a more preventative and holistic approach to care. This will help trusts to deliver care in the most appropriate setting as well as support the government's ambitions to provide more care closer to home. We need a clear strategy for substantially increasing the proportion of patient demand met within primary and community care, with necessary investment and prioritisation.

NHS Providers has urged the government to work with and support the NHS to address current demand and pressures. Our *Picture of Health* briefing highlights the five shared commitments the government should focus on, to deliver the 'next generation' NHS (NHS Providers, 2024).

Sir Julian Hartley
Chief Executive
NHS Providers

Introduction

The health needs of the population are changing; people are presenting with more acute and more complex care needs. The UK has an ageing population, bringing with it distinct health and social care challenges (Age UK, 2024). Persistent health inequalities have exacerbated demand for services and stalled or even reversed progress in improving health outcomes, with declining rates in healthy life expectancy recorded over the previous decade (BMJ, 2024).

The UK compares badly with other countries for health outcomes – demonstrated in higher avoidable mortality rates – and the situation is getting worse (The King's Fund, 2023). The Health Foundation has projected that by 2040, 9.1 million people will be living with major illness, an increase of 37% (The Health Foundation, 2023). NHS services are already struggling to keep pace with changing levels of demand – a recent survey by NHS Providers found 82% of trust leaders do not believe they have the capacity to meet current demand for children and young people's services (NHS Providers, 2024a).

The health and care sector will need to adapt so that it can provide the most appropriate support to best meet these changing patient needs. The Labour government has outlined three key shifts as part of its commitment to build an NHS fit for the future: from 'hospital to a primary care and community service', from 'analogue to digital' and from 'treatment to prevention'.

The shift towards greater delivery of care in the community, through technology and innovative ways of working, and with a meaningful focus on prevention, is much needed, and we welcome the calls to develop a 'neighbourhood health service'. For many people, receiving care in a hospital is not the most appropriate setting for their needs. Instead, they could be better supported in, or closer to, their own home. Ensuring people are able to receive the right care, at the right time and in the right place has been the longstanding strategic intent for the health and care sector.

The drive to deliver more care in the community is reiterated in the recent report by Lord Darzi (Darzi, 2024). He highlights the importance of having a more joined-up approach to care provision, delivered in local communities. This is not only better for individuals, but also helps alleviate pressure across the wider system, including urgent and emergency care (UEC) pathways and lengthy waiting lists.

A recent report by Age UK shows that significant numbers of emergency hospital admissions of older people could have been avoided if they were supported earlier, before their health deteriorated to crisis point (Age UK, 2024). This is true across a range of clinical conditions and service users, including those with mental health needs who could be better supported in the community at an earlier stage. Providing more preventative and person-centred health and social care results in better outcomes for individuals and improved patient flow across the wider system. It is therefore vital that national policy makers make good on their commitment to delivering more care in the community by ensuring funding follows ambition.

This report looks at several case studies which highlight just some of the successes trusts are having to enable people to access and receive the care they need in the right place at the right time.

- **Tackling the wider determinants of health to improve patient flow**
  Hampshire and Isle of Wight Healthcare NHS Foundation Trust has identified housing and community inclusion as key areas that impact the mental health and wellbeing of its patients. It has set up a number of new approaches to take preventative action in these areas, including providing supported accommodation pathways to improve flow out of inpatient settings, embedding early intervention within local authority housing teams, and employing Citizens Advice case workers on hospital wards.
- **Reducing demand in emergency care by providing support at home**
  Over the last few years, East Lancashire Hospitals NHS Trust has been strengthening its community teams and focusing efforts on supporting patients in their own homes, easing pressure on emergency departments and ambulance conveyances. The 'home first' approach is at the heart of a coordinated response to stop unnecessary admissions and support the earliest possible discharge of every patient.
- **Improving mental health crisis care from the ground up**
  Following a £1.1m investment in 2018, North Staffordshire Combined Healthcare NHS Trust developed a crisis care centre, which brings together a range of teams offering services to people of all ages throughout the year, offering an accessible service for anyone who feels they are in distress or need advice or reassurance. The trust has also been working 'upstream' on the mental health crisis pathway by reaching out into the community and linking people through to the right service.
- **Harnessing a culture of continuous improvement to deliver care in the right place**
  Leaders at Walsall Healthcare NHS Trust cite the culture of improvement and collaboration across the trust and wider system partners as a crucial enabler to providing the right care in the right setting. Staff have a real appetite to improve care at every stage of the pathway and are encouraged to refine their approach to ensure people are receiving the best possible support in the most appropriate place. This helps drive the development of new ways to help keep people well at or closer to home.
- **Taking the next step from Hospital at Home to early intervention**
  Building on the work of their Hospital at Home service, Hertfordshire Community NHS Trust is looking at how it can provide more proactive support for individuals through targeted interventions within its *Minus nine* project. The project aims to identify the need and intervene for patients approximately nine days before a hospital admission or crisis intervention. To do this, the trust will look to identify the highest risk patients across the system and aim to provide wrap-around care at an earlier stage. Rollout for the project is planned for winter 2024/25.

This report shares some of the approaches trusts have taken to deliver more care in the community, innovating in a challenging operational context. Trusts will continue to develop fresh, forward-thinking initiatives to support people at, or closer to, their own home, and at an earlier stage of their illness.

CASE STUDY 1

Improving mental health crisis care from the ground up

North Staffordshire Combined Healthcare NHS Trust

Themes >

- Making services accessible for all
- Community-based approach
- Collaboration across the system

Background

North Staffordshire Combined Healthcare NHS Trust (North Staffordshire) is a provider of mental health, learning disability, substance misuse and primary care services. The trust provides inpatient services for adults with acute mental health needs. It has a young people's inpatient service and an assessment and treatment ward for people with a learning disability. It is also one of the few trusts providing NHS drug and alcohol inpatient services. Working across 30 hospital and community-based sites, the trust serves nearly half a million people of all ages and backgrounds.

In line with national trends, the trust has experienced a surge in demand from children and young people. In recent years, it has seen a rise in the number of mental health crises, including through referrals from GPs.

Developing crisis care provision

Following a £1.1m investment in 2018, the trust developed a crisis care centre at the Harplands Hospital site in Stoke on Trent. This centre, opened in 2019, brings together a range of teams offering services to people of all ages.

The trust believes it is unique in what it sets out to provide. The crisis care centre offers an accessible service for anyone who feels they are in distress or needs advice or reassurance. People can ring or text the crisis care number to speak to a mental health professional who will direct them to the most appropriate service.

North Staffordshire also has good links with key system partners. While setting up the service, feedback from GPs showed they wanted one referral point for patients with mental health needs. The crisis care centre acts as this central point and the trust then works to navigate patients to the most appropriate pathway. It also works closely with the ambulance service and the police who access the service via a 'professionals' line'.

The centre provides a walk-in service, and as it is co-located with inpatient services (a three-minute walk away), people can be referred on site and linked across as appropriate to their needs. Furthermore, the 'high-volume users' team works from the centre and supports patients who regularly attend A&E. There is a separate '136 suite', which can serve as a place of safety for individuals who are detained under Section 136 of the Mental Health Act, where a mental health assessment can be carried out.

CASE STUDY 1

Between April 2023 to April 2024, the all age access team accepted 26,774 referrals, which included routine and urgent and crisis referrals. From the crisis care service line, they received a further 10,000 crisis or urgent referrals, inclusive of community/street triage, the home treatment team, high volume users, the mental health liaison team and 'place of safety' (Section 136). Following the opening of the crisis care centre there has been an increase of 104% in contacts and a reduction in did not attend rates.

The centre has evolved since its inception to better meet the needs of the population it serves, demonstrating continual improvement. For instance, in response to patient concerns about noise levels in the reception area, quieter spaces with welcoming sofas were created. Children can now also access the service via a separate entrance and with support on hand for families to receive the care they need.

In establishing the centre, the trust recognised the challenges of bringing together multiple teams under one roof. The leadership team say it was vital to take staff along with them, highlighting the big picture and reflecting the needs of the population so that everyone was aligned on the centre's purpose.

Reaching out into the community

The trust is also doing valuable work 'upstream' on the mental health crisis pathway. It has an all-age wellbeing portal to support the self-management of mental health issues. This comprehensive online resource provides information, guidance and support for health professionals, patients and family members. There is also an electronic referral option available.

The trust is working with Communities Together Stoke on Trent – part of the national community led support programme – and a local football club, Port Vale FC, to enable early intervention and community support to help prevent people from reaching crisis point. Through the club's community lounge, they can receive support and can be directed to the most appropriate service, whether that is a food bank, money advice, or mental health assistance. Support time recovery workers, part of the crisis care pathway, are also on hand to help link people through to the right service.

The trust covers areas with high levels of deprivation. Seldom heard populations are actively considered as part of its approach at the crisis care centre and community lounge. Feedback from Asian communities revealed that offering both physical health monitoring and a welcoming atmosphere, like a cup of tea in the community lounge, encouraged attendance, especially for those who might delay seeking help.

CASE STUDY 1

Working across the system

North Staffordshire's collaborative efforts with West Midlands Ambulance Services University NHS Foundation Trust have yielded significant success in reducing emergency department (ED) admissions. The mental health liaison team's pilot programmes within EDs, which divert patients to the crisis care centre, have been shown to ensure timely and effective care. These initiatives have been met with positive feedback from system partners, demonstrating their value in providing appropriate care at the right time. The trust also has strong partnerships with local authorities, which is particularly important in ensuring children and young people are not being cared for in an inappropriate setting.

Looking to the future

North Staffordshire's strategy outlines how over the next five years its services will evolve to meet the needs of the local population. The crisis care centre will be central to achieving the directorate's strategic priorities which are to:

- reduce suicide rates year by year by 2028
- reduce waiting times for services
- embed mental health services within NHS 111
- increase workforce to develop their services.

The trust says the national expansion of 'NHS 111, press 2 for mental health service' has offered a valuable new resource for patients. In the weeks following the expansion of 111, they have been receiving an average of 350 calls a month for urgent/crisis presentations. Recognising that the populations' needs are constantly evolving, the service is committed to continuous improvement and ensuring it remains relevant.

The trust would like to go further, recognising that investing in the right environment can improve patient care, but it faces significant space and capital constraints. Focusing on beds is not sufficient. Having the appropriate support and the ability to escalate care when necessary and quickly transition patients to community-based services is also vital. Adequate capital investment is essential to enabling this.

CASE STUDY 2

Tackling the wider determinants of health to improve patient flow

Hampshire and Isle of Wight Healthcare NHS Foundation Trust

Themes >

- Addressing health inequalities – housing and community inclusion
- Early intervention and prevention
- Partnership working

Background

Hampshire and Isle of Wight Healthcare NHS Foundation Trust (Hampshire and Isle of Wight Healthcare)[1] is a mental health, learning disability and community trust in the southeast of England, serving a population of 1.5 million people.

The trust's service design and delivery has a strategic focus on population and health equity, and a new leadership function has been created to drive this agenda across the trust. Work has already commenced on shaping the priorities for the new trust and this includes embedding NHS England's Patient and Carer Race Equality Framework (PCREF) (NHS England, 2023). The merging organisations have already agreed to prioritise reducing health inequalities within their quality objectives. Underpinning the focus on population health is executive-level support and direction, with the trust employing a director for population and health equity, alongside an associate director, who together have worked to embed an organisational culture in support of the population health agenda.

Housing and community inclusion are key areas that impact mental health and wellbeing, and the trust has designed several targeted interventions. The trust recognises that by focusing on upstream, preventative action to tackle the wider determinants of health – including addressing the social pressures in an individual's wider life – it can alleviate demand for services in secondary care and emergency settings. The trust's view is that by acting as an anchor institution within its local area it can work effectively with partners, such as local authorities and voluntary, community and social enterprise (VCSE) organisations, to see positive change.

Step out – supported accommodation pathway

In 2020 the trust created *Step out*, a supported accommodation pathway to enhance flow out of the inpatient rehabilitation estate in Southampton. The trust works in collaboration with a social landlord to identify suitable housing options in the community. The 'housing first' ethos means the trust works closely with patients to understand their housing needs – such as availability of transport links, proximity to social connections and employment opportunities – to ensure the individual is placed in the right accommodation.

1 Hampshire and Isle of Wight Healthcare formed on 1 October 2024 following a merger between Solent NHS Trust, Southern Health NHS Foundation Trust, community, mental health and learning disability services from Isle of Wight NHS Trust, and child and adolescent mental health services delivered in Hampshire by Sussex Partnership Trust. The initiatives described in this case study originated in Southern Health NHS Foundation Trust and are now being taken forwards in the new organisation.

CASE STUDY 2

This encourages stability and long-term residence, with the aim of alleviating patient stress over insecure housing, improving patient recovery and preventing unnecessary hospital re-admissions.

The local authority has allocation rights into around 95% of the landlord's available housing stock, meaning the landlord has around 5% of their stock to use at their discretion – such as for innovative solutions like the *Step out* pathway. There are no housing costs to the trust as they are covered by patients' housing benefits. However, the trust provides the community teams who support patients to manage their transition into community-based accommodation. Unfortunately, not all local authority boroughs in the area have the same levels of housing allocation, which prevents the trust from expanding this initiative wider – despite widespread support among local authority partners.

To date, the trust has supported nine patients into homes within the local community. The small overall figure reflects the person-centred approach taken, the time taken to find accommodation to suit the needs of the patient, and the challenges of the local housing environment. But feedback from the patients has been overwhelmingly positive, reporting it has broken the cycle of moving in and out of hospital care.

It's the greatest support that I could ever have – it provides that platform for you to push on, to become independent.
Hayden, Hampshire and Isle of Wight Healthcare mental health service user

Alongside the improvements to patient experience, the trust has been able to discharge patients three months earlier than usual via this supported pathway, leading to efficiency savings and improved patient flow through their mental health units.

Embedding early-intervention mental health support in housing

While the *Step out* intervention focuses on managing patients out of hospital and into accommodation, since 2021 the trust has implemented a complementary initiative by employing clinicians within local authority housing teams. Their work is predominantly focused on individuals in temporary accommodation, people who are homeless, or those at risk of homelessness. The overall aim is to encourage them into independent long-term living, targeting those in earlier stages of illness and preventing patient admissions that occur because of challenges with sustaining affordable and safe housing.

CASE STUDY 2

Most of the clinicians are employees of Hampshire and Isle of Wight Healthcare, with honorary contracts in the local authority. This ensures the clinicians can access records of both organisations and to clinical registration and learning and development via the trust. The funding for these roles is, mostly, via the Rough Sleeper Initiative grant funding programme available to local authorities. This grant funding pays for the clinician's salary, office costs and expenses.

The clinicians engage individuals in health-led conversations that consider their holistic health and wellbeing needs. An evaluation of the project found over two-thirds of people in this population group were not previously known to secondary care mental health services and had unmet health needs prior to the trust embedding clinicians within local authority housing teams. The clinicians don't hold an NHS caseload so can dedicate time and resource to prioritising the needs of these individuals, referring or signposting those requiring support to the most appropriate services. The clinicians can be flexible and responsive with their time and provide tailored support, ensuring care is patient-centred.

Clinicians are also embedded within the housing needs assessment process, where they can highlight the health and wider needs of individuals, for example, by ensuring patients with paranoia aren't placed in shared accommodation or those with social isolation aren't placed alone.

Hampshire and Isle of Wight Healthcare currently employs five clinicians across six local authority areas. In the first 18 months of the project, clinicians helped to prevent ten accommodation breakdowns and evictions. The team enabled patients to access the care and support they needed, including registering for the GP. The clinicians were also able to support nine homeless individuals to come in off the streets, where local authority colleagues had previously been unable to engage with them. This initiative highlights the importance of providing multi-disciplinary and holistic support to individuals.

Partnership with Citizens Advice in inpatient settings

Feedback from staff at the trust revealed social stress had contributed to a high proportion of patients on inpatient wards reaching crisis point and subsequently being admitted. Staff on wards were not equipped or trained to deal with the wider problems patients were facing including family breakdowns, legal issues and financial insecurity. In response, the trust launched an innovative project to embed Citizens Advice case workers on hospital wards.

The trust piloted the project in one hospital in July 2022, but it is now live across four adult acute mental health hospitals. Each hospital has one Citizens Advice case worker located on inpatient wards for two days a week, dedicated to providing face-to-face support for service users, with a third day spent supporting patients within the community. The case worker can build relationships with patients while in hospital and follow up with outreach support after discharge, such as meeting people at libraries to provide advice on benefits support. The trust recognised this was more effective in ensuring uptake of follow-up services, especially for those who had encountered barriers in accessing support.

CASE STUDY 2

In the first 24 months of delivery, the Citizens Advice case workers had supported a total of 286 patients in inpatient settings, addressing over 1,500 distinct advice needs. The project has revealed the complexity of patient need, with the average patient registering between five and seven distinct advice needs (compared to the average Citizens Advice user having between two and three at a traditional Citizens Advice setting). The most common concerns related to finance, housing, and family mediation.

Analysis from Citizens Advice has estimated the financial benefit for the 286 people supported as a total in excess of £556,000, particularly in helping patients to access benefit payments they were not previously aware of. In addition, feedback from trust staff has been hugely positive, with reports of reduced stress levels and higher job satisfaction. The trust is conducting a formal research evaluation in order to consolidate the impact and share learnings more widely. It was recently announced as a finalist in the NHS Parliamentary Awards 2024 within the Excellence in Mental Health Care category for this initiative.

CASE STUDY 3

Reducing demand in emergency care by providing support at home

East Lancashire Hospitals NHS Trust

Themes >

- Strengthening community teams
- Working with external partners
- Tackling recruitment challenges

Background

East Lancashire Hospitals NHS Trust (ELHT) provides acute and community healthcare for people of East Lancashire and Blackburn with Darwen. ELHT also provides some general practice and primary care services to a segment of its population.

The trust covers a wide geographical patch with big variations in levels of deprivation. Employing 10,000 staff and treating over 700,000 patients a year, healthcare services are offered across five hospitals and various community sites. In July 2024, Blackburn with Darwen adult physical health community services, previously part of the mental health trust, completed a transfer across to ELHT to ensure equitable and more resilient provision for their communities.

The trust has experienced increased demand in A&E, with a 23% rise in attendances over the past 12 months. This has been driven by more presentations of people over 65 with increased frailty, as well as patients coming from local care homes or receiving palliative care. The trust borders Manchester, Preston and Yorkshire, and receives patients from each of these areas. The area has the lowest number of GPs per head across the system which has resulted in disparities in access to primary care, leading to further pressure on urgent and emergency services.

To manage demand and ensure all patients receive the care they need in the most appropriate setting, the trust, together with place partners, has developed an urgent and emergency care improvement plan centring around three pillars (East Lancashire Hospitals NHS Trust, 2024):

1. Community response focused on step-up pathways and care home improvements.
2. Crisis response and wrapping care around the individual.
3. Improving care in hospitals and same day emergency care.

Some of the initiatives to bring these pillars to life are set out below. The trust's approach aligns with its overall commitment to providing preventative, proactive and holistic care for patients in their own home.

CASE STUDY 3

Taking a 'home first' approach

Over the last few years, the trust has been strengthening its community teams and focusing efforts on supporting patients in their own homes, easing pressure on urgent and emergency settings and ambulance conveyances.

The 'home first' approach is at the heart of a coordinated response to stop unnecessary admissions and support the earliest possible discharge of every patient, which focuses on ensuring everyone receives the right care and has the right to return to their own home post-discharge. Central to this is the Intensive Home Support Service (IHSS), which provides a 24/7, year-round service and is accessed through a direct phone line. The IHSS team assesses the patient's individual needs to determine the care they require and agree a care plan. The IHSS also oversees the trust's urgent community response service and provides access to health and social care support to their communities within two hours across East Lancashire and Blackburn with Darwen. In total, the IHSS had 15,508 referrals across several workstreams in the last year. Since its inception the 'home first' service has had 18,488 successful discharges, with the number growing year on year.

In 2022, the IHSS initiated a 'front door' service in its emergency pathways which allows staff to identify patients who are well enough to receive care at home and avoid further waiting in the emergency department. Typical presentations include falls and breathing difficulties including shortness of breath. Interventions include advanced assessments, monitoring, support, and therapy, delivered through a multi-disciplinary team with access to a GP and hospital doctor. They can also commission crisis care packages via their intermediate care allocation team.

Between October 2022 and August 2024, the IHSS has assessed around 3,000 patients through the extended front door model. In that time, the team has prevented 816 confirmed admissions and discharged 2,291 (82%) patients. Compared to the rest of the trust, which has a readmission rate of 13%, this model has meant that only 6.3% of patients are readmitted within 28 days with the same presentation.

Also supporting the IHSS is 'hospital at home', the virtual ward service launched in September 2022, through which the trust has accepted over 23,000 referrals and allowed 90.6% of patients referred to the scheme to remain in their usual place of residence. ELHT has the highest capacity and highest utilisation rate of virtual wards among providers across Lancashire and South Cumbria.

CASE STUDY 3

Working with partners and building confidence

Developing strong relationships and gaining confidence from partner organisations has been crucial in making improvements in urgent and emergency care – including social care, mental health and voluntary, community and social enterprise (VCSE) organisations. The trust has an open-door policy which encompasses care home partners, who are encouraged to seek support through the IHSS. In addition, Age UK has worked in collaboration with the trust to provide a range of support services. This includes providing essential support with assisting patients returning home and settling in, particularly for those living alone or experiencing anxiety.

Overcoming challenges

Nevertheless, as with any new initiative, the IHSS service has faced challenges, primarily related to recruitment. Now the service is established and has gained a positive reputation, these have eased. In addition, specific strategies, such as running targeted recruitment events and offering conditional job offers on the day, have accelerated hiring processes.

While financial challenges for the service remain a concern, the trust continues to demonstrate the positive impacts on patients, staff, and the wider community and highlight the value of integrated services in easing demand elsewhere in the trust.

Ken was supported at home by the IHSS after a stay in hospital. He said:

"You feel better just thinking you are going home. I had only been home two hours, and a nurse came round. It was brilliant, one to one support – that's what I liked. You are in your own environment; you have your family around you and I always feel safer at home. Having the IV drip at home, I couldn't fault it. You are being treated at home, the nurses know what they are doing, and they were superb. I'd recommend it to anyone. The IHSS is a brilliant idea. It stops people going into hospital and you get as good a treatment at home."

Expansion and replication

The trust is hoping to build on the success of the IHSS service and its wider community offer to expand its work to move care upstream, alleviating pressure on emergency departments and urgent care – an approach it says could be replicated across the region. For example, the trust is currently collaborating with North West Ambulance Service NHS Trust to reduce unnecessary hospital admissions. Their new initiative 'call before convey' involves paramedics contacting the integrated community hub before transporting patients to the hospital, facilitating a more timely and appropriate response from the IHSS team. They are already seeing positive results, with fewer attendances among individuals over 65 and a decrease in overall hospital admissions.

CASE STUDY 4

Identifying and preventing need in the community

Hertfordshire Community NHS Trust

Themes >

- Home first approach to care
- Shift to early intervention
- Whole system productivity
- Innovation through technology

Background

Hertfordshire Community NHS Trust (HCT) provides community-based healthcare services to more than 1.2 million people living in Hertfordshire and beyond. HCT supports people at every stage of their lives, from health visiting and school nursing to community rehabilitation and palliative care. Leaders at the trust are developing their work with system partners to achieve the shift to prevention and proactive care – with particular concerns over ageing populations in the region, living with frailty and co-morbidities.

HCT strives to provide outstanding services and improve the health and wellbeing of the communities it serves. The trust provides joined-up local care, harnessing modern processes, systems and technologies to enable the best for staff and patients. This continual drive towards innovation has supported the trust in expanding its 'hospital at home' (HaH) service over the past few years, which is focused on admission avoidance and the delivery of patient-centred care to support people in their own homes.

Building on this, HCT is now focusing on how it can support people before they reach crisis point by identifying the individuals most at risk and making targeted early interventions. Leaders at HCT believe this direction of travel is vital to ensure it can support its ageing population both now and in the future.

Providing the Hospital at Home service

The HaH service was set up in 2022 and has since helped more than 13,000 patients receive care in their own home, with approximately 200 individuals using the service at any one time. The service operates from 8am to 8pm, seven days a week, taking referrals from health and social care partners across the system to provide both step-up and step-down care, with approximately 80% of referrals relating to admission avoidance and 20% relating to early supported discharge. The core team is made up of GPs, paramedics, nurses, therapists, pharmacists, administrative support officers, mental health professionals and social care colleagues who provide a hybrid service of remote care from an Integrated Care Coordination Hub and face to face care in the patient's home.

The HaH service ensures joined up working across all parts of the care pathway to prevent people being unnecessarily admitted to hospital. The service takes a capability approach to ensure that any patient who can safely be supported at home rather than in hospital is accepted and this is not limited to specific patient cohorts. Once an individual has been referred into the service, the team has access to a wide range of support services and technologies to ensure individuals get the right care at the right time in the right place.

CASE STUDY 4

They make use of a myriad of health devices including a remote monitoring system that allows individuals to receive care from a team of healthcare professionals working in a central hub with access to the patient's health data. In addition, technology is being used to deliver a course of antibiotics that would usually require three to four nurse visits each day. Instead, a nurse is able to visit once to set up the elastomeric device which delivers the antibiotics throughout the day with their vital signs being remotely monitored. This reduces the level of disruption for individuals throughout the day and frees up time for staff to deliver care elsewhere.

A key asset of the HaH service is its access to local acute hospital consultants, who attend regular multi-disciplinary team (MDT) meetings with the core HaH team and can be accessed when required to provide specialist advice.

The impact of Hospital at Home

Since the service first started, HaH has prevented 2,600 A&E or ambulance referrals being admitted to hospital, instead delivering the care needed at home. It has also assisted 2,200 people on inpatient wards to leave hospital early, saving approximately 2.2 acute bed days per step-down referral. This is beneficial for individuals and is much more cost effective.

My mother has severe Alzheimer's and Hospital at Home offered her the very best care within her home so she didn't stress about what was happening as they explained step by step to my mother and us. They came every day and didn't sign her off until they (and us) were satisfied she was over her infection. Best hospital care ever.

Patient testimony

Local acute trust data shows that in 2023/24 there had been a reduction in A&E attendances and emergency admissions across the three main patient cohorts of heart failure, respiratory and frailty compared to 2019/20.

The HaH service has also boosted productivity for urgent and emergency care (UEC) pathways across the system. In Herts and West Essex Integrated Care System, the ambulance conveyance rate reduced from 47.5% in February 2023 to 40.2% in January 2024. Ambulance staff feel empowered to make referrals into the HaH team when they believe an individual would be best cared for in their own home. The HaH team also has access to the ambulance stack and can take referrals directly where they feel this is appropriate, saving ambulance staff time and freeing up resource to support urgent incidents.

The shift to early intervention

HCT is keen to build on the success of HaH and the trust is looking at how it can provide more proactive support for individuals through targeted interventions within their *Minus nine* project. The project aims to identify the need and intervene for patients approximately nine days before a hospital admission or crisis intervention. It is currently in its early stages, with rollout planned for winter 2024/25.

The project will look to identify the highest risk patients across the system – those who are likely to need additional support to prevent an admission due to their vulnerability and who could be better supported through the delivery of wrap-around care at an early stage. Interconnected communication systems will then provide a flagging system for these patients when they make contact with a healthcare service, and staff will aim to arrange a face-to-face appointment, ensuring they are seen by the most appropriate healthcare professional. Clinicians can also refer patients who are particularly frail and vulnerable into the service, where a member of the team will conduct a visit to ensure the individual has the right support to remain safe and well at home. These patients will also receive proactive case management for between six to 12 weeks to reduce their risk of admissions and improve their quality of life.

The case for change

In order to meaningfully and sustainably support the national commitment to shift care into the community, leaders at HCT believe that greater national investment is needed to enable community providers to scale up and develop existing community-led initiatives such as HaH and *Minus nine*. This will require an investment plan for community services that is upheld at a national level to ensure systems are incentivised to move towards more proactive models of care.

CASE STUDY 5

How collaboration and continuous improvement is supporting people in the most appropriate setting

Walsall Healthcare NHS Trust

Themes >

- Culture of continuous improvement
- Integrated front door services
- Addressing health inequalities

Background

Walsall Healthcare NHS Trust (Walsall Healthcare) provides local acute and community services to a population of approximately 260,000 people. The trust is the only provider of acute services in Walsall, offering inpatient and outpatient care, as well as delivering a range of community health services from 60 sites across the area. Some of the community services provided by Walsall Healthcare include urgent community response (UCR) and home-based care, enabling those with long-term conditions and people living with frailty to receive care in their own home.

Walsall Healthcare sits within the second most deprived integrated care system in England, and the local authority borough is in the most deprived decile across the country. This creates significant population need and operational challenges, and it has driven the trust and system partners to think differently about how they deliver care to better suit the needs of their local communities.

In response to historical concerns around emergency care, the trust has spent the past five years developing a whole pathway approach to care both internally through the NHS trust and through the Walsall Together partnership (Walsall Together, 2023). This place-based partnership is made up of multiple system partners including Walsall Healthcare. Since the development of the partnership, significant improvements have been made to urgent and emergency care (UEC) performance, emergency access standards and ambulance handover times. Trust leaders are clear this is a result of integrated interventions supporting admission and attendance avoidance and a commitment from all organisations to return people to the community when it is safe and appropriate to do so, as well as internal improvements delivered within the trust.

A multi-pronged approach to delivering care in the right setting

Walsall Healthcare has various community-based initiatives across the whole care pathway. This includes a care navigation centre which supports people to speak to the right professional first time, and UCR teams which allow people to receive care rapidly in their own home, preventing the need for an ambulance conveyance wherever appropriate. Where an ambulance conveyance does happen, the trust has an integrated front door team within the emergency department (ED) which is predominantly made up of

experienced community trained clinicians. Having these staff working within the hospital is hugely beneficial as they have a strong understanding of the types of individuals who do not need to be admitted to an inpatient hospital pathway and would instead benefit from a community-based service.

This team is fundamental in preventing admissions at the front door, keeping UEC demand to a minimum, and supporting ward staff to discharge patients who no longer fit the criteria to reside. Through the intermediate care team – a multi-disciplinary team made up of a range of health and social care professionals – they can discharge patients quickly via a streamlined process. Working under one manager and a shared financial decision-making structure, the priority is getting an individual out of hospital safely and appropriately and then consideration is given to how their ongoing care will be funded.

The impact of these initiatives is clear. Metrics around the proportion of non-elective admissions with a zero-day length of stay show the trust is performing in the highest decile across the country, whereas metrics for those that are non-electively admitted overnight show the trust is in the lowest decile across the country for admitted length of stay.

The value of culture and continuous improvement

Trust leaders emphasise that this is all made possible by the commitment of staff across the trust and Walsall Together partner organisations to provide the right care in the right place at the right time.

One of the crucial enablers is the culture of improvement and collaboration across the trust and with wider system partners, along with a real hunger from staff to continually review and improve the way care is delivered in every part of the pathway. Staff are encouraged to constantly refine models of care to ensure people are receiving the best possible support in the most appropriate setting.

Another key enabler to the work of Walsall Together is the level of confidence and appetite for risk between the trust and system partners, particularly the local authority. Joint ownership of issues is vital to supporting the whole pathway approach ensuring organisations take a patient focused view of delivery rather than just a service perspective.

Leaders at Walsall Healthcare believe the trust between partners springs from humility; each organisation within the place-based partnership recognises and respects the vital role of their partners and endeavours to support each other where possible. For example, the trust is clear that if they do not support a patient in the right place, there is a risk that their health will deteriorate unnecessarily. This is not only bad for the individual but will also have knock on impacts for the package of care social care partners need to provide post discharge, resulting in additional demand on an already stretched sector.

It is therefore vital that each partner takes accountability for how they can best support patients, both for the benefit of the individual and to reduce pressure across the care pathway.

CASE STUDY 5

Tackling local health inequalities

Given the nature of the local population within Walsall, which includes areas with high levels of deprivation, the Walsall Together partnership has a strong approach to tackling health inequalities. Although Walsall Healthcare has statutory responsibilities to address health inequalities, the trust recognises these cannot be tackled by one organisation alone. The work of the place-based partnership has enabled the trust to work collaboratively with partners to address issues around access to perinatal services, smoking cessation and diabetes, including community champions employed with lived experience.

Walsall Together has a particularly strong focus on the importance of housing as a wider determinant of health. One of the key partners in the place-based partnership includes the Walsall Housing Group which enables the partnership to include access to some of the most vulnerable people in the borough (the Core20 population), through which it has developed several initiatives including work for health employment support, diabetes prevention support and a reduction in the number of asthma admissions for children and young people caused by damp homes.

How to go further, faster

Leaders at Walsall Healthcare NHS Trust are enthused by the national and political narrative surrounding the role of community services and the need to shift more care into the community. Despite the positive work being done in Walsall and across the country, there are still hospital attendances and admissions that could have been prevented. To support more people to receive care at or closer to their home, there needs to be a greater national focus on prevention and increased resource to support the expansion of community-based services.

Conclusion

NHS trusts are dedicated to providing the best possible care, in the right place and at the right time. As these case studies show, trusts are well placed to develop services that meet the needs of their communities, and they can deliver high-quality care for patients and value for the wider health system.

There is an opportunity to go further. The development of the new 10-year plan for health is a chance to further develop preventative, patient-centered and community-based models of care.

This requires national investment in and prioritisation of primary and community care to enable trusts and system partners to address rising demand and ensure care is delivered in the most appropriate settings. A focus on supporting equitable patient access to and flow through the health and care system, investment in digital capacity and equipment, and modernising the estate are key to achieving this shift. Staff need to be supported to innovate and develop the care and interventions that patients need.

However, trust leaders know that they cannot tackle current pressures and future challenges alone. Developing the skills and capacity of the social care sector is vital, along with work across the public sector to positively influence the wider determinants of health. This is key to managing long-term demand for health and care services and enabling high quality care.

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References

Age UK (2024). *State of Health and Care of Older People in England 2024*. Age UK website. https://www.ageuk.org.uk/discover/2024/september/state-of-health-and-care-of-older-people-in-england-2024

BMJ (2024). *Healthy life expectancy has fallen in England and Wales, data show*. BMJ website. https://www.bmj.com/content/384/bmj.q774.full

Darzi A (2024). I*ndependent Investigation of the National Health Service in England*. Department of Health and Social Care website. https://assets.publishing.service.gov.uk/media/66f42ae630536cb92748271f/Lord-Darzi-Independent-Investigation-of-the-National-Health-Service-in-England-Updated-25-September.pdf

East Lancashire Hospitals NHS Trust (2024). *Pennine Lancashire UEC Improvement Plan*. East Lancashire Hospitals NHS Trust document. https://nhsproviders.org/media/699379/appendix-2-pennine-lancashire-uec-improvement-plan.pdf

The Health Foundation (2023) *Health in 2040: Projected patterns of illness in England.* Health Foundation website. https://www.health.org.uk/publications/health-in-2040

The King's Fund (2023) *How does the NHS compare to the health care systems of other countries?*. The King's Fund website. https://www.kingsfund.org.uk/insight-and-analysis/reports/nhs-compare-health-care-systems-other-countries

NHS England (2023). *Patient and carer race equality framework*. NHS England website. https://www.england.nhs.uk/long-read/patient-and-carer-race-equality-framework

NHS Providers (2023) *Providers Deliver: Patient Flow*. NHS Providers website. https://nhsproviders.org/providers-deliver-patient-flow

NHS Providers (2024) *A Picture of Health: Delivering the Next Generation NHS*. NHS Providers website. https://nhsproviders.org/resources/briefings/a-picture-of-health-delivering-the-next-generation-nhs

NHS Providers (2024a) *Forgotten Generation: Shaping Better Services for Children and Young People*. NHS Providers website. https://nhsproviders.org/forgotten-generation-shaping-better-services-for-children-and-young-people/key-points

Wallsall Together (2023). *Walsall Together wins HSJ the Place Based Partnership and Integrated Care*. Walsall Together webpage. https://walsalltogether.co.uk/news-blogs/latest-news/walsall-together-wins-hsj-integrated-partnership-award

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