Newton

Delivering meaningful impact across health and care

CASE STUDIES

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FOREWORD

On the one hand, a lot has changed since we were last at the NHS Providers Annual Conference, including a new government. On the other, much hasn't and health and care organisations and systems continue to face some of their greatest challenges, amidst severe financial pressure.

That being said, we are optimistic about the future for all our public services. Across the country, we're working alongside trusts and health and care systems to deliver change which tackles the intense pressures of today, whilst transforming for a brighter future.

Increasingly our clients are choosing us as their strategic delivery partner for change at the complex interfaces of health and care; whether that involves advancing integrated ways of working to improve and transform urgent and emergency models of care, moving care closer to home or shifting towards proactive, targeted models of preventative care.

In just the last year, we've worked with a number of health and care systems to deliver complex transformation programmes which are making a real impact on the things that matter – better outcomes for residents, a better experience for staff and better value, as well as significant financial savings. We're committed to delivering that impact – which is assured by our 100% fee guarantee – but we're also deeply proud of what we're achieving in partnership with our clients.

In one system, we've achieved a 39% reduction in the short-stay units of a hospital's acute medical unit, and in the rest of the hospital there are now 40% fewer patients with no current reason to reside at any time. In another system, we've helped set up a single integrated team to support the whole urgent and emergency care pathway, which is the first of its kind nationally and is fundamentally changing the way people with urgent needs are supported. We've provided diagnostic support to some of the most challenged systems nationally on their urgent and emergency care services, several of which are moving into transformational implementation phases in the coming months.

Further examples of our completed programmes can be found in this brochure, each reflecting the unique context, challenges and ambitions of the different systems and localities that we work with. However, all share a consistent outcome of achieving improved outcomes for individuals, a better experience for staff and a brighter and more financially sustainable future for the health and care system.

Robin Vickers
Partner, Health and Integration

A new HomeFirst model of intermediate care in Leeds

The challenge

Across the country, health and care systems are facing a range of challenges in the delivery of intermediate care due to rising demand, driven in part by an aging population with increasingly complex health conditions.

In Autumn 2022, the Leeds Health and Care Partnership, which brings together health and care organisations in the city, commissioned Newton to conduct an initial review to help identify how the system could improve the delivery of intermediate care for the residents of Leeds. The review showed that whilst thousands of people from across Leeds were receiving great health and care, there were a number of challenges in the system related to patient flow and the transfer of people into intermediate care, which meant that individuals were not always achieving their best outcome.

Impact

Based on this evidence, the Leeds Health and Care Partnership, supported by Newton, set out to transform the way that intermediate care is delivered in Leeds through the HomeFirst programme, which aims to achieve a person-centred, home-first model of intermediate care that is joined up and promotes independence.

By working together in a true partnership, system partners have delivered a new model of intermediate care within existing workforce, funding and organisational arrangements. Fundamental to the success of the HomeFirst programme has been building on the culture and relationships across partners in the system; embedding a culture of collaborative decision making and service delivery.

As a result of the changes made, the HomeFirst programme sees more residents achieving their best outcome whilst simultaneously relieving seasonal pressures on the acute and unlocking significant financial benefit within the system.

The HomeFirst programme

The HomeFirst programme consists of five interrelated projects which focus on maximising independence and ensure that residents always achieve their best outcome.

The five projects are:

- **Active Recovery at Home:** redesigning the home-based intermediate care offer to maximise capacity and deliver the best outcomes for people accessing these services.
- **Enhanced Care at Home:** transforming preventive services to avoid escalations in need with a specific focus on avoidable acute hospital admissions.
- **Rehab & Recovery Beds:** transforming bed-based intermediate care to improve outcomes and minimise length of stay in short-term beds.
- **System Visibility & Active Leadership:** making use of the wealth of data in the system to produce system and service level dashboards, while establishing the right cross-partner governance to use these for effective decision-making.
- **Transfers of Care:** redesigning the discharge model to minimise discharge delays and ensure the system achieves the most independent outcomes for people leaving hospital.

The new ways of working have been designed, trialled, iterated and scaled by experts including frontline staff and operational managers from across the system.

Everybody is now working together, so we're working in the hospital together with community and primary care colleagues and with social care to ensure that we've got a truly integrated way of person-centred support based on need."

Phil Wood, CEO, Leeds Teaching Hospital

System Visibility

Before the HomeFirst programme, system partners in Leeds regularly met to discuss system performance, but the lack of a unified data source meant these meetings were often inefficient and unfocused. Each partner organisation produced a lot of data, but without a single version of the truth, efforts were duplicated, and trust was eroded. Leeds needed a way to consolidate their data and a leadership model to ensure decisions were evidence-based at every stage.

The introduction of the system visibility dashboard addressed this need by bringing existing data into a single, regularly updated platform. This dashboard supports decision-making at all levels, providing patient-identifiable data for joint case management at the team level and highlighting areas needing additional support at the service and system levels. This tool, combined with the Active Leadership framework, enables partner organisations to review data collectively and take coordinated action to resolve issues.

For the first time, heads of service from all health and care organisations in Leeds can effectively review system pressures and delays, allowing for timely, cross-organisational actions to relieve pressure before it escalates. The team has been able to identify the hidden delays further down the system which were often driving some of the delays to discharge, which would otherwise go unnoticed. The System Visibility tool and Active Leadership approach has transformed how Leeds manages system performance, fostering collaboration and enabling more effective, data-driven decision-making.

What the dashboard has given us is one version of the truth so that we can actually focus on what we need to do for the people of Leeds to improve their outcomes and we're doing it together. So rather than having a culture where we don't necessarily trust each other, and we don't necessarily trust each other's data, we've now got real agreement and consensus and can move forward, taking actions together collaboratively."

Nicola Nicholson, Associate Director of Strategies and Programmes, West Yorkshire ICB

OUTCOMES

The HomeFirst programme has seen many positive outcomes, from seasonal pressures on the acute hospital being relieved, to a reduction of the system's reliance on long-term care. Most importantly, residents of Leeds are receiving highly effective services and are supported in achieving significantly improved outcomes.

As of September 2024, the programme is having the following impact on outcomes across intermediate care in Leeds:

- **169** more people able to go home after their time in intermediate care rather than a long-term bedded setting each year
- **8.2** day reduction in the average length of stay in short-term beds
- **421** more people going directly home after their stay in hospital each year
- **786** fewer adults admitted to hospital each year
- **31%** reduction in length of stay for complex patients with no current reason to reside
- **522** additional people benefitting from reablement each year
- The effectiveness of the home-based reablement offer has increased by **8%** (in terms of long-term home care hours following the service), with a **19%** increase in the proportion of people leaving the service fully independent
- **33%** decrease in readmission rates after receiving home-based reablement
- This performance translates to **£23.7m** per annum of equivalent financial benefit to the system. These benefits are spread across system partners and are a combination of cost-out, future cost avoidance, or investment in quality.

Embedding and sustaining the changes is an important component of the work allowing for long term change that can be maintained by teams. There is more to do to deliver the full vision of the Programme and ensure that Leeds Health and Care Partnership is able to support the changing needs of the population in years to come, but the impact and approach of HomeFirst delivers a strong foundation to build from.

The benefits have been huge, both for staff and for the patients. For the patients, it means that they're seen in a more timely manner and prioritised, appropriately. The referrals are triaged immediately, so there's no delay, and from a staff perspective it means that we're receiving the right patients who are right for our service."

Occupational Therapy Clinical Lead

The beauty of HomeFirst is that it has brought people together through a partnership and *TeamLeeds* approach to look at all the key transitional points where people move from the community to hospital, from hospital to home, and from hospital to community care beds. It feels so much more joined-up now because we have had so much commitment to doing this as a system rather than individual organisations."

Sam Prince, Executive Director of Operations, Leeds Community Healthcare NHS Trust

I need to get back my mobility because I used to go out quite a lot before I were ill. They've been great, really great. I've picked up now, and I'm doing alright."

Person being supported at home by Active Recovery

Improving theatre productivity in West Hertfordshire

The challenge

Across the country there are over 7 million patients on waiting lists for elective care; the backlogs existed before the COVID-19 pandemic, but the impact of the pandemic has compounded the problem and more people than ever are waiting for surgery.

In January 2023, Newton and West Hertfordshire Teaching Hospital NHS Foundation Trust (WHTH) started a programme of work to improve the effectiveness of their operating theatres. At the start of the programme the Trust had 5,500 patients waiting for surgery with many of these people having been waiting for well over a year. The Trust had limited visibility over how theatres were operating, meaning that surgeries were often being cancelled on the day, and it was difficult to have grip on the situation.

WHTH needed to improve their theatre effectiveness to ensure that they were providing the best standard of care for their patients.

A clinically and data-led approach to improving theatre productivity

The programme, co-designed by Newton and WHTH, has embraced a clinically-led change approach from the outset, empowering clinicians and the teams around them to design and own the solutions to improve theatre performance. To kickstart this, 105 staff across the division (clinicians, theatre staff, waiting list coordinators, divisional management and more) took part in workshops to set a clear vision for the programme.

Key principles underpinning this vision were:

- Calm, efficient surgeries with smooth patient flow minimising delays. Multi-disciplinary teams working together to create a fantastic patient experience.
- Every operating list is at full capacity, to ensure prompt finishes without finishing early.
- Prompt starts and smooth turnarounds, with a standardised process to call for the next patient and lists reviewed ahead of the day to prevent order changes.

An on-the-day process for theatres has been agreed by all involved in the process, from those booking the surgeries to the surgeons, to prevent delays ensuring that surgeries start sooner and turnarounds between surgeries are efficient. A separate booking process ensures that the lists created will have the right number of patients, helping them to run to time and enabling full utilisation of valuable theatre time.

These changes have been enabled by a newly implemented theatre performance tool.

> **With this clinically led approach, this time I really think we will be able to make a change together."**
>
> Clinician, West Hertfordshire Teaching Hospitals Trust

> **We've seen what worked: Clinical engagement, visibility of data, commitment to action - we need to do more of this."**
>
> CEO, West Hertfordshire Teaching Hospitals Trust

The theatre performance tool

The theatre performance tool which has been implemented as part of this programme of work is providing WHTH with greater visibility than ever before. The theatre management software provides two main views:

- Booking view – enabling improved forward-looking visibility, of how full lists are, and providing confidence that a list will be well utilised. This is encouraging ownership of lists, and allows for flexibility in booking.
- Reporting view – showing how theatres have been utilised and where cancellations have occurred, allowing clinicians, theatre staff and management to continuously identify blockages and ensure they are addressed going forwards.

The tool also provides easy use of surgeon-specific median operation times to ensure lists can be optimally used.

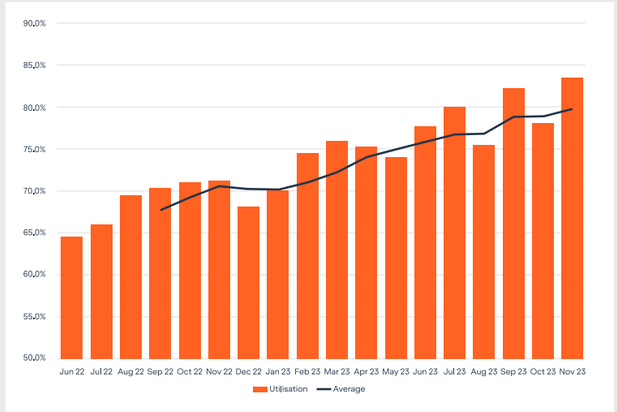
Since implementing the tool, lists are better planned, theatres are more utilised and patients are not waiting so long for surgery. In addition, staff are enabled to have better grip on services and can work proactively to ensure that the new processes are being followed.

THE IMPACT

- **40%** reduction in late starts
- **20%** reduction in time to turnaround between cases
- An additional **3,000** cases per year, reducing the impact of industrial action

Operating theatre utilisation

- A **22%** increase in trust-wide utilisation across all elective activity



Transforming care for older adults in Essex

The challenge

Across Essex, thousands of older people receive great care every day. However, in 2019, system partners identified that sometimes older people with health and care needs were finding themselves with the wrong kind of support. In line with the national direction towards integrated care and the system's own aspirations, partners across health and social care came together to deliver improved outcomes for residents.

The Connect programme started with a system-wide comprehensive, evidence-based assessment. This involved reviewing 340 cases and 2147 acute and community beds with 95 practitioners to identify the specific opportunities for partners across health and social care to work better together to deliver improved outcomes for its residents.

Ambitious, system-wide transformation

Essex, alongside Newton, set about designing and implementing a programme comprising five interrelated projects all focused on achieving better outcomes for older adults in Essex - identified at system-level and delivered at place-level.

1. **Admission avoidance:** Aiming to reduce the number of older people admitted to an acute hospital by 11% by better connecting them to other services, including the integrated Urgent Community Response Team.
2. **Discharge Outcomes:** Making more independent decisions on discharge from hospital and short-term beds, aiming to enable 240 more people go home rather than to a bed every year.
3. **Community Pathways:** Reducing delays and length of stay in community hospitals by a target of 23%.
4. **Reablement:** Ensuring everyone who can benefit from reablement has the opportunity to do so, aiming to enable 1200 more people to receive the most effective intermediate care every year.
5. **Supporting Independence:** Improving long-term care assessments and decisions, to help a target of 1,500 people to live more independently each year.

The scale of the programme and the interdependencies between these projects would enable an improvement beyond what had been achieved before, transforming the experience for people, carers, and staff.

Change designed to last

To ensure that Essex work together to continuously improve outcomes and maintain the sustainability of the programme, a number of principles were agreed upon that cut across all interrelated projects. These were:

- Better connected system partners: Multiple organisations formed unified design, delivery, and leadership teams with a common goal, prioritising collaboration and shared principles.
- Lead at every level: Changes were driven and co-designed by frontline teams, focusing on bottom-up improvements to connect health and care teams and enhance outcomes.
- Learn, develop, and grow: Throughout the programme partners upskilled the workforce for continuous improvement through training and development to ensure that all changes would be sustainable.
- Outcomes-focused changes: The programme implemented interconnected projects aimed at improving outcomes, with a strong emphasis on data-driven decision-making and evidence-based practices.

"I think the programme's biggest difference is its ambition. We haven't had many programmes that work across systems like this. I think that's the real uniqueness of the Connect programme and it keeps people at the heart of what it's trying to do. It's not just about efficiency, it's about outcomes."

Nick Presmeg, Executive Director for Adult Social Care, Essex County Council

THE IMPACT

Despite involving the delivery of a complex, large-scale transformation programme during the height of the Covid-19 pandemic, the programme is achieving significantly improved outcomes, improved staff experience and financial benefit.

To date, the programme has achieved the following:

- **2,200** people per year are better supported to a more independent long-term outcome.
- **4,650** more people each year are benefiting from the services of the Urgent Community Response Team (UCRT) to avoid hospital admission, an increase of **87%**.
- Hospital discharge teams have introduced early identification and multi-disciplinary working to support a **20%** reduction in placements to bedded settings post-discharge from acute.
- Community teams have increased the number of people going home from interim "Discharge to Assess" beds from **25%** to **43%**.
- The Community Pathways project has sustainably reduced length of stay delays in community hospitals by **4.5** days, releasing **24-27** beds of capacity and allowing closure of a site.
- Introduced new ways of working for community social work teams with a focus on Supporting Independence and aligning social work teams to PCN footprints, helping **25%** of people to be supported more independently.
- Developed new ways of working with the main reablement provider ECL, which has led to a **20%** reduction in length of stay and a **21%** increase in effectiveness, lowering onward demand for care.
- Worth over **£26m** p.a. benefit to the system.

I think the Connect Programme is critical to the survival of our health and care system. I think if we don't join up and transform effectively and meaningfully together, our system's very survival would be under threat. The Connect Programme enables us not only to survive, but to thrive and to develop together so that we can become a very effective system that delivers true value-based care; value to person, value to population and value to system."

Dr Sarah Zaidi, GP and Clinical Lead, Essex Partnership University NHS Foundation Trust

It is a really excellent example of a "win-win", where the resident has a better life than they would have had and, at the same time, the financial burdens on the system are also relieved."

Cllr John Spence, Cabinet Member for Adult Social Care and Health, Essex County Council

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