HEALTH & CARE
CASE STUDY

Connect

Transforming care for older adults in Essex

Working together to improve outcomes for thousands of people in hospital and intermediate care

NEWTON

To date, the programme has achieved the following:

2,200

2,200 people per year are better supported to a more independent long-term outcome.

43%

Community teams have increased the number of people going home from interim D2A beds from **25% to 43%**.

20%

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

4.5 days

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.

25%

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.

21%

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 effective reablement services.

4,650

4,650 more people each year are benefiting from the Urgent Community Response Team (UCRT) to avoid hospital admission, an increase of **87%.**

£26m

Worth over **£26m p.a.** benefit to the health and care system.

Summary

The Connect programme was initiated by local government and health partners across Essex.

The programme consists of five interrelated projects which are designed to collectively achieve improved outcomes for over 7,000 people per year. It was jointly designed, led, and governed by the whole health and care system – a total of 15 different organisations – and involved the formation of specific design, delivery, and leadership teams aligned on a common goal: achieving more independent outcomes for older people.

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. The programme has also provided a blueprint for how the health and care system can work better together in future endeavours.

"The Connect programme has been an excellent example of true system partnership in action. It demonstrates what is possible when health and social care partners are properly enabled to combine forces for the good of residents."

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

"A strong evidence base and use of data at all levels has really united system partners around a shared vision and enabled us to make informed decisions as a system rather than as individual organisations. Working together to test and iterate changes on this shared agenda has enabled us to transform care at the frontline in a way that is sustainable, measurable, and crucially, is helping us to achieve fantastic improvements to the outcomes of older people in Essex who look to us for care, while making the most of our resources across the system."

Professor Michael Thorne, Independent Chair, Mid and South Essex Health and Care Partnership

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 order to understand the scale of the challenge, Newton Europe was commissioned by Essex County Council to conduct a system-wide assessment, which involved reviewing 340 cases and 2147 acute and community beds with 95 practitioners. In line with the national direction towards integrated care and the system's own aspirations, this identified specific opportunities for partners across health and social care to work better together to deliver improved outcomes for its residents.

The assessment identified some significant opportunities for improvement:

28%

28% of acute hospital admissions could be avoided for older people

27%

Only 27% of older people go home from a temporary residential placement

44%

Outcomes for 44% of older people supported by social services could be improved

36%

Only 36% of staff believe the system has a track record of successfully landing change

£21m-£26m

Overall: An opportunity to improve outcomes and achieve savings of between £21m and £26m per year for 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

An evidence-based, partnership-wide approach to change

The assessment provided a clear evidence base which framed the opportunities to improve in a way that all partners across health and social care could identify with. Having a single source of the truth meant they could align on a shared vision with a focus on delivering better outcomes, agnostic of any system partners' goals. It also underpinned how the system would articulate the benefit for any change that was made. As the work continued, this use of data also helped to drive continuous improvement. The system is now clearer on its collective performance and able to pinpoint the areas it needs to address in order to achieve measurable impact.

Ambitious, system-wide transformation

Armed with a clear evidence base, health and care partners across Essex alongside Newton, set about designing and implementing a programme comprising five interrelated projects all focussed on achieving better outcomes for older adults in Essex - identified at system-level and delivered at place-level.

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.

Discharge Outcomes

Making more independent decisions on discharge from hospital and short-term beds, aiming to enable 240 more people to go home rather than to a bed every year.

Community Pathways

Aiming to reduce delays and length of stay in community hospitals by a target of 23%.

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.

Supporting Independence

Improving long-term care assessments and decisions to help a target of 1,500 people to live more independently every year spending nine fewer days in hospital.

The Connect programme had a broad and ambitious scope with many teams involved. 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.

"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

Better connected system partners

Working together better as a partnership was as important as the operational changes, and involved multiple organisations forming single design teams, delivery teams and leadership teams aligned on a common goal. The ambition and clear purpose of the Connect programme allowed frontline staff and system leaders to work together and put individual budgets and priorities to one side.

Clarity and agreement around the principles which would underpin every part of the programme were also key enablers for the partnership, namely:

- Put the person at the centre
- Collaborate through partnership working
- Make evidence-based decisions
- Learn, develop and grow
- Lead at every level

"The success of the Connect programme really demonstrates that we can make change across Essex and that we can break down organisational barriers."

Dawn Scrafield, Chief Financial Officer, Mid and South Essex NHS Foundation Trust

Lead at every level: Frontline-led change

To ensure that all the changes had the greatest impact and were going to be sustainable for the long-term, they were all locally driven by and completely co-designed with frontline teams.

This was not about initiating a top-down integrated care project to change structures or governance. This was about real, bottom-up changes at the frontline which would better connect health and care teams and improve ways of working to have a significant, lasting impact on outcomes for older people across Essex.

Learn, develop and grow: Building skills for sustainability

As well as ensuring that the changes were fully embedded and sustained by front-line teams, it was an important part of Connect to build the skills to continuously improve and to tackle new areas too.

The programme was led by a full-time, core team of six from different partners. They each completed a two week 'Connect Academy' to develop problem solving, change management, analysis, and communication skills. The team continuously developed their skills as they delivered the programme, upskilling other staff in the system along the way, and are now leading the sustainability phase of Connect as well as moving on to new priority areas requiring transformation. The individuals involved have experienced significant personal development and created valuable new capability in the system.

Alongside the core team, a 'Connect Academy-lite' was delivered to dozens of key staff and leadership across the system. This ensured teams had a common language of improvement and clarity on the aims and approach of the programme. The legacy of this is seen throughout the system today, from how frontline staff are using data to improve outcomes in their daily decisions, to senior management ensuring they have the right evidence and prioritisation for future projects.

"I think this is different to other change programmes because it also embeds competence and skills in people as well. It's not a programme that's done to people, it's done with people. It's a lot more collaborative and really promotes new skills and new behaviours, which is really nice to see."

Dominic Ward, Assistant Director for Frailty and Intermediate Care, Mid and South Essex NHS Foundation Trust

Outcomes-focused changes

The programme consisted of many interconnected projects. These are just a few of the outcomes-focused changes that were made:

A new urgent community response team (UCRT) bringing together what used to be four rapid response services delivered by three community organisations.

There is now a single integrated service that responds to people experiencing an acute medical crisis Awith partners (including IC24, who provide the 111 service for the area and East of England Ambulance Service) and using data to drive its work, the UCRT has seen referrals increase by 87%, particularly from 111 and 999, helping to avoid acute admissions and reducing demand elsewhere in the system.

Bringing together live data from five acute hospitals, four community providers and adult social care to create a single view of pathways and outcomes for people leaving hospital for the first time.

This visibility has become essential - from frontline staff being able to prioritise the people on the right pathway, to system leadership making strategic decisions on capacity and flow.

A re-designed process for older people moving from short term reablement care from the main provider, ECL, to long term care at home.

ECL teams, social workers, and the sourcing teams in Essex County Council worked together to completely re-design the process and allow faster transfer of care, freeing up 20% more capacity in ECL which is a valuable resource, allowing over 1,000 more people to benefit from this service every year.

A blueprint for future transformation

The changes initiated through the Connect programme will have become the blueprint for how this partnership develops future programmes across its health and care system. Relationships formed as part of the programme across health and care as well as across clinical, operational, and leadership networks also places the system on a firmer footing for future endeavours, whilst improving the experience of staff in all roles as they are now enabled to work better together for the good of Essex residents.

Furthermore, because Connect has improved the level of skills and capabilities across the system – for example, a much more structured approach to measuring benefits and reviewing actions and improvements – this approach will be applied to other programmes of work.

"Connect has been a pretty marvellous programme, I have to say. It brings together all of the partners across our integrated care system and really demonstrates the impact that we can have together rather than in isolated organisations. It's had the effect of moving us from an emotionally driven system to an evidence driven system."

Stephanie Dawe, Group Chief Nurse and Chief Operating Officer, Provide